

This form shows the parts of the form that you must complete.



PLEASE USE THIS FOR YOUR NEXT CLAIM SUBMISSION

FOR CLAIMS REQUIRING FORM COMPLETION, REQUEST FORMS FROM CUSTOMER SERVICE: EHS Services/Medical Equipment/Supplies/Vision/Hospital/Nursing Home

CUSTOMER SERVICE CENTRE

1 888 711-1119

PLEASE INDICATE ON MAILING ENVELOPE
 Attn: Drug Dept. P.O. Box 1652, Windsor, ON N9A 7G5
 Attn: Professional Services, P.O. Box 1699, Windsor, ON N9A 7G6
 Attn: Medical Items, P.O. Box 1623, Windsor, ON N9A 7B3
 Attn: Out-of-Country Dept. P.O. Box 1606, Windsor, ON N9A 6W1
 Attn: Vision/Hospital Dept. P.O. Box 1615, Windsor, ON N9A 7J3
 Attn: Dental Dept. P.O. Box 1608, Windsor, ON N9A 7G1

**CLAIM SUBMISSION FORM
Mandatory Declaration**

Do you have any other group insurance coverage that may include the claim as a benefit?

Yes No

If yes, please indicate name of other insuring agency

If other coverage is Green Shield, indicate Green Shield Identification No.:

Submit Copies of Other Carrier's Statement along with copies of corresponding receipts.

Are any of the enclosed claims due to:

1. A work related injury Yes No

2. A Motor Vehicle Accident Yes No

If "Yes" please indicate the date of the accident (loss)

You must answer these 3 questions

Subscriber Surname including alternate surname if applicable: **Last Name** _____
 Company Name: **23786 Queen's SGPS**

Green Shield Identification Number: **SGP + Student #** 00 _____
 Patient's First Name: **First Name** _____
 Birth Date: Year [][] Month [][] Day [][]

Only include names of patients with receipts attached.

Street Address: **This address is where GreenShield will mail the cheque.** _____
 City _____ Province _____ Country _____
 Postal Code [][][][][][] Telephone [][][] - [][][] - [][][][][]

PLEASE INCLUDE ORIGINAL PAID RECEIPTS

Sign form here

Subscriber signature

By signing this claim form and/or submitting actual receipts, I agree that the information provided on this form is complete and accurate. I understand that the information provided by me to Green Shield Canada about myself and my dependants, will be used by Green Shield Canada for claims adjudication and any other services necessary in the administration of our benefits which may include the exchange of information with other parties to administer this benefit claim.

I am authorized by my spouse and/or dependants to disclose and receive information about them that is used for these purposes. I understand that this information may be seen by the cardholder.

This form is an example of a complete form.



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**CLAIM SUBMISSION FORM
Mandatory Declaration**

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Yes No

If yes, please indicate name of other insuring agency

If other coverage is Green Shield, indicate Green Shield Identification No.:

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Are any of the enclosed claims due to:

1. A work related injury Yes No

2. A Motor Vehicle Accident Yes No

If "Yes" please indicate the date of the accident (loss)

Subscriber Surname including alternate surname if applicable: **Appleseed** _____
 Company Name: **23786 Queen's SGPS**

Green Shield Identification Number: **SGP12345678** 00 _____
 Patient's First Name: **Kelly** _____
 Birth Date: Year [7][8] Month [0][4] Day [2][7]

Only include names of patients with receipts attached.

Street Address: **1234 University Avenue** _____
 City: **Kingston** Province: **Ontario** Country: **Canada**
 Postal Code: **K7L3X6** Telephone: **613-533-2924**

PLEASE INCLUDE ORIGINAL PAID RECEIPTS

Sign form here

Subscriber signature

By signing this claim form and/or submitting actual receipts, I agree that the information provided on this form is complete and accurate. I understand that the information provided by me to Green Shield Canada about myself and my dependants, will be used by Green Shield Canada for claims adjudication and any other services necessary in the administration of our benefits which may include the exchange of information with other parties to administer this benefit claim.

I am authorized by my spouse and/or dependants to disclose and receive information about them that is used for these purposes. I understand that this information may be seen by the cardholder.