



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

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)

PLEASE INCLUDE ORIGINAL PAID RECEIPTS

Subscriber signature

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

Subscriber Surname including alternate surname if applicable

Company Name

23786 Queen's SGPS

Green Shield Identification Number

Patient's First Name

Birth Date

Year Month Day

Only include names of patients with receipts attached.

Street Address

City Province Country

Postal Code Telephone

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.



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