GREEN SHIELD
CANADA

PLEASE USE THIS FOR YOUR NEXT CLAIM SUBMISSION

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

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

Subscriber surname including alternate surname if applicable ______

Company Name ______

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 is complete and accurate, to the best of my knowledge. I authorize Green Shield Canada to exchange information with other parties as required and only when the information is needed to administer this benefit claim and/or to confirm the accuracy of this information.

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

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