ENROLLMENT FORM

Complete this form to enroll for dental benefits or to change status of existing information.

PLEASE PRINT CLEARLY

APPLICANT INFORMATION

				OFFICE USE ONLY
FIRST NAME		CHOOSE YOUR START DATE: 01/ month / year		Identification #
LAST NAME				
HOME MAILING ADDRESS		**NOTE:** Coverage begins on the first of the month you request but is **subject to written confirmation** from Green Shield Canada.		Group #
CITY PROVINCE POSTAL CODE				
Phone:	Birth Date: day / month / year	Male Female	Single Couple Family	
NUMBER OF PERSONS JOINING PLAN:	Email (print clearly):			

CO-ORDINATION OF BENEFITS (COB)

Where you or your dependents have coverage with more than one carrier, claims will be co-ordinated so that reimbursement from all coverage will not exceed 100% of the actual claim. If the Applicant or Spouse carries other dental insurance, please tick here:	Applicant	Spouse

DEPENDENT ENROLLMENT INFORMATION

Dependent	First Name	Last Name	Male (M) Female (F)	Birth Date DD/MMM/YYYY	OFFICE USE ONLY PLANCODE	EFFECTIVE DATE
SPOUSE						
1ST CHILD						
2ND CHILD						
3RD CHILD						
4TH CHILD						

I hereby apply for Dental Benefit Coverage from Green Shield Canada. By signing this enrollment form, or by providing my personal information to RMS Retirement Management Services Ltd., I acknowledge and agree that the information is complete and accurate, to the best of my knowledge. I authorize the release of my information, and the information concerning my spouse and my dependents, for the purpose of determining eligibility for benefits.

Signature of Applicant

For further information on Green Shield Canada's privacy policy and procedures, please refer to their website at www.greenshield.ca

RMS RETIREMENT MANAGEMENT SERVICES LTD (RMS)
2546 WENTWICH ROAD VICTORIA, BC V9B 3N4

Pre-Authorized Payment:

I/We have:

1) Attached my/our "VOID" cheque **or** Direct Debit form from my/our financial institution
2) Completed the following authorization to instruct my/our financial institution to allow RMS to debit premium payments directly to my/our bank account.

Financial Institution	
Name of Financial Institution	
Street	
City	Province
Postal Code	

Account Holder(s)		
Last Name	First Name	
Street		
City		Province
Postal Code		
Branch Number (5 digits)	Bank Number (3 digits)	Account Number (7 to 12 digits)

A debit in the amount of $ ________________ may be drawn on my/our account on the first day of each month beginning 01/ month / year

This amount may be increased or decreased at a future date to reflect premium changes. RMS will give me/us advance written notice of the revised amount.

I/We will give written notice to RMS, at least 10 business days prior to the next due date of the debit, if the account information changes or I/we wish to terminate this authorization.

I/We acknowledge delivery of this authorization to RMS constitutes delivery to the above noted financial institution.

Signature(s) ________________________________ Date ________ / ________ / ________
DD MM YYYY

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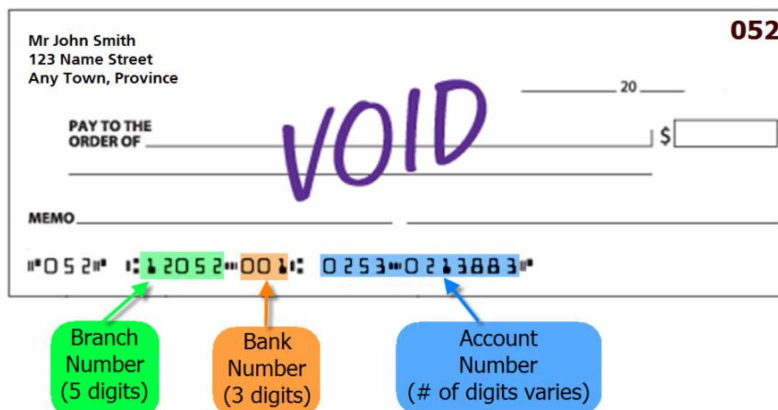
SAMPLE



SAMPLE