## **UFCW LOCAL 401 DENTAL CARE PLAN – REGISTRATION FORM**

845

□ I'M A NEW MEMBER	OR □ PLE	ASE CHANGE MY RECO	RDS EFFECTIVI	E			_
SOCIAL INSURANCE NUMBER LAST NAME (Please Print)			FIRST NAME (Please Print)			INITIAL	
-      -							
APT. NO. AND STREET ADDRESS TOWN OR CITY					TELEPHONE/	TEXT NUMBER	
					()	-	
PROVINCE POSTAL CODE EMAIL ADDRESS (Please Print)					PREFERRED	COMMUNICATI	ON METHODS
					☐ Email	☐ Text ☐	Regular Mail
DATE OF BIRTH YEAR MONTH DAY	DATI YEAR	E OF EMPLOYMENT  MONTH DAY	D Cineta	MARITAL STATUS	rin Discount	DATE OF MAR	RITAL STATUS MONTH DAY
TEAR MONTH DAT	TEAR	MONITI DAT	☐ Single ☐ Married	<ul><li>☐ Commonlaw</li><li>☐ Separated</li></ul>	☐ Divorced ☐ Widowed	IEAN	MORTH DAT
Cohabitation Clause – You must be cohabiting with a commonlaw spouse for 12 months before their coverage commences. Proof of cohabitation may be requested prior to enrolment.							
SPOUSE'S LAST NAME SPOUSE'S FIRST NAME DATE OF BIRTH DOES SPOUSE HAVE THEIR OWN DENTAL PLAN?							
		YR		□ No □ Yes: Insurer:		Policy:	
DEPENDANT'S LAST AND FIRST NAME				LAST AND FIRST NA	ME	C	ATE OF BIRTH
	1	YR MTH DAY				YR 	MTH DAY
DEPENDANT'S LAST AND FIRST NAME DATE OF BIRTH DEPENDANT'S LAST AND FIR				LAST AND FIRST NA	ME		ATE OF BIRTH
	1	YR MTH DAY				YR.	MTH DAY
Overage Dependants - If a dependant is age 21 but under age 25 and in fulltime attendance at an accredited school, annual proof of acceptance/registration must be provided.							
BEFORE SIGNING THIS CARD, YOU SHOULD UNDERSTAND THE MEANINGS OF THE "EXPLANATION" AND THE "AUTHORIZATION", BELOW. IF CLARIFICATION IS NEEDED, PLEASE CONTACT THE ADMINISTRATOR OF THE PLAN.							
<b>EXPLANATION</b> — Your participation in the Plan depends on the collection, storage and use of certain personal information about you, your spouse and dependants. That information comes from this card, the reports your employers and the sponsoring union submit to the Plan, and the claims/applications made for benefit entitlements. It is stored by the Plan Administrator, and, it is used to communicate with you; compute your benefits; satisfy the reporting requirements of the provincial and federal governments; pay taxes and comply with civil and criminal law; estimate future operating costs; assess Plan performance, accommodate audits of the Plan; and, if applicable, transfer data to a new replacement plan. Personal information will be used for no other purpose without your express written permission, and will be kept confidential and secure. Also, it is available for your review, by contacting the administrator.							
AUTHORIZATION — I hereby auth information, noted on this card, and personal information is needed to for such revocation may impair or car complete, to the best of my knowle appears on this card. I authorize the entitlements and in the handling of only be used for the specified purpose.	d coordinate my record ulfill my benefit entitler icel my participation in edge and belief, and the le use of my Social In any related tax matters	ds with those of the e ments, or until I revol in the Plan. Furtherm that I have the const surance Number as	mployers and te it in a manr ore, I certify t ent of my spo an additional	sponsoring union ner that does not o that the information use and adult de verification of my	n. This authoricontravene the on, given in the pendants to p identity in the	zation will surver law. However is card, is true rovide their inf administration	ive as long as , I realize that , correct, and ormation as it of my benefit

SUITE 101, 46 HOPEWELL WAY NE, CALGARY, AB T3J 5H7 TEL: (403) 250-3534 FAX: (403) 250-9236 TOLL-FREE 1-866-961-6147

Date: \_\_

Member's Signature: \_\_\_