UFCW LOCAL 401 DENTAL CARE PLAN – REGISTRATION FORM

845

☐ I'M A NEW MEMBER OR ☐ PLEASE CHANGE MY RECORDS EFFECTIVE _____

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 COMMUNICATION METHODS
		☐ Email ☐ Text ☐ Regular Mail

DATE OF BIRTH YEAR MONTH DAY		DATE OF EMPLOYMENT YEAR MONTH DAY	MARITAL STATUS			DATE OF MARITAL STATUS YEAR MONTH DAY
srys			☐ Single	☐ Commonlaw	☐ Divorced	
			☐ Married	☐ Separated	☐ Widowed	

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 YR MTH DAY	DOES SPOUSE HAVE THEIR OWN DENTAL PLAN?
		sms	☐ No ☐ Yes: Insurer: _____ Policy: _____

DEPENDANT'S LAST AND FIRST NAME	DATE OF BIRTH YR MTH DAY	DEPENDANT'S LAST AND FIRST NAME	DATE OF BIRTH YR MTH DAY
			svms
DEPENDANT'S LAST AND FIRST NAME	DATE OF BIRTH YR MTH DAY	DEPENDANT'S LAST AND FIRST NAME	DATE OF BIRTH YR MTH DAY
	sfys		smsm

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.

EXPLANATION --- 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 authorize the Trustees and the Plan Administrator to collect, record, use, disclose and, if applicable, destroy the personal information, noted on this card, and coordinate my records with those of the employers and sponsoring union. This authorization will survive as long as personal information is needed to fulfill my benefit entitlements, or until I revoke it in a manner that does not contravene the law. However, I realize that such revocation may impair or cancel my participation in the Plan. Furthermore, I certify that the information, given in this card, is true, correct, and complete, to the best of my knowledge and belief, and that I have the consent of my spouse and adult dependants to provide their information as it appears on this card. I authorize the use of my Social Insurance Number as an additional verification of my identity in the administration of my benefit entitlements and in the handling of any related tax matters. I understand that my Social Insurance Number will be kept in the strictest confidence and will only be used for the specified purposes.

Member's Signature: _____ Date: _____

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