UFCW LOCAL 401 DENTAL BENEFIT PLAN
OVER-AGE DEPENDANT DECLARATION

SOCIAL INSURANCE NUMBER	LAST NAME (Please Print)	FIRST NAME (Please Print)	INITIAL
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DEPENDENT'S LAST AND FIRST NAME	GENDER	DATE OF BIRTH	DEPENDENT'S LAST AND FIRST NAME	GENDER	DATE OF BIRTH
	☐ Female ☐ Male	YEAR MTH DAY		☐ Female ☐ Male	YEAR MTH DAY

DECLARATION

I declare that the above named dependent as defined below is:

- ☐ Is unmarried;
- ☐ Is not employed on a full-time basis;
- ☐ Is not eligible for insurance as a Member under this or any other group policy;
- ☐ Is either under 21 years of age, or, if a full-time student at an accredited school, college or university, under 25 years of age.

Please provide proof of enrollment in an accredited school, college or university.

OR

- ☐ Is unmarried and over the dependent age but fully dependent on me due to mental or physical disability.

Please provide proof that the child is not capable of self-support due to the disability.

AUTHORIZATION --- I hereby authorize the Trustees and the administrator of the Plan 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 participating unions. This authorization will survive as long as my 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. 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.

Date: _____ Member's Name: _____ Member's Signature: _____

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