UNITED FOOD AND COMMERCIAL WORKERS
TRUSTEED DENTAL PLAN – ONTARIO

REGISTRATION FORM

UNITED FOOD & COMMERCIAL WORKERS
TRUSTEED DENTAL PLAN - ONTARIO
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Toronto, ON M9W 6K4
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Toll Free (800) 461-4361

SECTION 1: PLAN MEMBER INFORMATION

Employer			Employment Status Full-time ☐ Part-time ☐
Social Insurance Number	Employment Date (yyyy-mm-dd)		Coverage Single ☐ Family ☐
Plan Member's name (first, middle, last)			Date of Birth (yyyy-mm-dd)
Email Address	Phone Number		Gender ☐ Male ☐ Female ☐ Non-binary
Address (number, street, and apartment)	City or Town	Province	Country
Postal Code	Marital Status ☐ Single ☐ Married ☐ Common-law Specify date of marriage or common-law:_____		

SECTION 2: DEPENDANT INFORMATION

Full name of Spouse or Partner (first, middle, last)	Date of Birth (yyyy-mm-dd)	☐ Male ☐ Female ☐ Non-binary

Does your spouse/ children have dental coverage under their own insurance plan? ☐ Yes ☐ No

If Yes, Name of other carrier:_____ Policy Number: _____

Your Dependants are your spouse and your unmarried dependent children. A spouse is a person who is legally married to you, or who has cohabited with you for at least one year if neither of you is married, or has cohabited with you for at least 3 years if either you or such person is still legally married. If you have more than one spouse, the person you designate will be considered to be your spouse. A dependent child is your natural, adopted, or step-child who has not reached his/her 18th birthday or if enrolled in a full-time course of education, has not reached his/her 25th birthday, or is over age 18 but is incapable of self-sustaining employment because of mental or physical disability.

Name of Dependent (first, middle, last)	Relationship to Plan Member	Date of birth (yyyy-mm-dd)	Name of Dependent (first, middle, last)	Relationship to Plan Member	Date of birth (yyyy-mm-dd)

BEFORE SIGNING THIS CARD. YOU SHOULD UNDERSTAND THE MEANINGS OF THE "EXPLANATION" AND THE "AUTHORIZATION". 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, and your dependents. It comes from this card, the reports your employer submits to the Plan, and the claims/applications made for benefit entitlements. It is stored by the Administrator of the Plan, 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 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 Administrator of the Plan to collect, record, use, disclose and. if applicable, destroy the personal information, noted above. 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 on 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.

_____ _____

Signature of Spouse

Signature of Dependant Children Age 18 or Over

_____ _____

Plan Member Signature

Date (yyyy-mm-dd)

Electronic signatures are only accepted with proof of authenticity.