REGISTRATION FORM

MANITOBA FOOD AND COMMERCIAL WORKERS DENTAL PLAN

3rd Floor, 880 Portage Avenue, Winnipeg, Manitoba R3G 0P1

BEFORE SIGNING THIS FORM, YOU SHOULD UNDERSTAND THE MEANINGS OF THE "EXPLANATION" AND THE "AUTHORIZATION" CONTAINED HEREIN. IF CLARIFICATION IS NEEDED, PLEASE CONTACT THE PLAN ADMINISTRATOR.

EXPLANATION --- Your participation in the Plan depends on the collection, storage and use of certain personal information about you and your dependents. This information comes from this form, the reports your Employer submits 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; determine coverage and benefit entitlement; satisfy the reporting requirements of the provincial and federal governments; pay taxes; 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 Plan administrator.

Employee Information:

Please print clearly and complete the entire form

SOCIAL INSURANCE NUMBER	FIRST NAME (Please Print)	MIDDLE INITIAL	LAST NAME

MAILING ADDRESS	CITY	PROVINCE	POSTAL CODE	PHONE NO.

DATE OF BIRTH DAY MO. YEAR	MARITAL STATUS ☐ MARRIED ☐ SEPARATED ☐ SINGLE or DIVORCED ☐ WIDOWED ☐ COMMON-LAW	SEX ☐ FEMALE ☐ MALE	EMPLOYER	DATE OF EMPLOYMENT DAY MO. YEAR	EMPLOYMENT STATUS ☐ FULL TIME ☐ PART TIME

Dependent Information: **(Please refer to your Booklet for the definition of "Dependent")**

Your common-law Spouse and the children of your common-law spouse must be listed on this form. If acquired later, they must be listed on the Administrator's records for at least 12 months in order to be considered your Dependents.

LIST FULL NAME OF SPOUSE AND DEPENDENT CHILDREN	RELATIONSHIP	DATE OF BIRTH DAY	MO.	YEAR	LIST FULL NAME OF DEPENDENT CHILDREN	RELATIONSHIP	DATE OF BIRTH DAY	MO.	YEAR

Does your spouse have dental coverage under another plan?

☐ No

☐ Yes. If Yes, state name of insurance company, policy number and effective date of coverage below:

_____

Is your spouse also AN EMPLOYEE under this Plan?

☐ No ☐ Yes. If yes, state your spouse's name and SIN below:

_____

AUTHORIZATION

I hereby authorize the Board of Trustees and the service agencies they employ to: collect, record, use, disclose and, if applicable, destroy the personal information noted above. This authorization will survive as long as this 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 if I withhold or revoke my consent to its use, thereby limiting or restricting the ability to determine coverage and benefit entitlement, my participation in the Plan may be impaired or cancelled.

I authorize the use of my Social Insurance Number as an additional verification of my identity in the administration of my benefit entitlements. I understand that my Social Insurance Number will be kept in the strictest confidence and will only be used for the specified purpose.

Furthermore, I certify that the information, given on this form is true, correct and complete to the best of my knowledge and belief.

_____
Signature of Member

_____
Signature of Dependent Child Age 18 or Over

_____
Signature of Spouse

_____
Signature of Dependent Child Age 18 or Over

_____
Date