REGISTRATION FORM

MANITOBA FOOD AND COMMERCIAL WORKERS DENTAL PLAN

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

ANSWER ALL QUESTIONS AND SIGN THE REVERSE SIDE OF THIS FORM.
THIS FORM WILL BE RETURNED TO YOU IF IT IS INCOMPLETE.

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

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

DEPENDANT INFORMATION *(SEE REVERSE OF FORM FOR DEFINITION OF DEPENDANT)*

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:

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Is your Spouse also employed by an employer who participates in this Plan?

☐ No ☐ Yes. If yes, state your Spouse's name, Social Insurance Number and employer name below:

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DIRECT DEPOSIT FOR CLAIM PAYMENTS - BANKING INFORMATION

Bank Account Holder's Name (if different from Employee) ____

ATTACH A "VOID" CHEQUE TO THIS FORM, OR, HAVE YOUR FINANCIAL INSTITUTION COMPLETE THE FOLLOWING BANK ACCOUNT INFORMATION:

Name of Financial Institution		Address of Financial Institution
Branch (Transit) Number (5 digits)	Bank Number (3 digits)	Account Number (maximum 12 digits)

An electronic Explanation of Benefits (EOB) showing what has been paid will be emailed to you at the same time a Direct Deposit is made to your Bank Account. If you do not provide an email address you will be unable to participate in the Direct Deposit program.

Email address: ______________________________

PLEASE TURN OVER FOR SIGNATURES OF AUTHORIZATION

DEFINITION OF DEPENDENT

“Dependant” means your Spouse and Dependant Children.

“**Spouse**” means a person who is legally married to you, and is living with you, or a person living with you in a common-law relationship if such person is publicly represented by you as your husband or wife and such person has been living with you for a period of at least:

(a) one continuous year if neither of you are married; or
(b) 3 continuous years if either of you remain legally married to another person.

If you do not list a common-law Spouse on your initial Registration Form, such person must subsequently be listed on the records of the Administrator, for at least 12 months prior to becoming eligible for benefits.

If you have more than one Spouse, the person last designated by you, and filed with the Administrator, in writing, shall be considered to be your Spouse.

“**Dependent Child**” means your unemployed, unmarried, natural or legally adopted child, stepchild, a child over whom you have legal guardianship, or the child of a common-law Spouse, who is:

(a) under 18 years of age; or
(b) 18 years of age or older but less than 25 years of age and is enrolled in and attending a full curriculum of education at a recognized school, college or university; or
(c) 18 years of age or older and is not capable of self-sustaining employment by reason of mental or physical disability which commenced prior to the child’s 18th birthday,

provided you or your common-law Spouse contribute regularly to the support of such child.

A child of a common-law Spouse is considered to be a Dependent, after the child has lived with you for a minimum of 12 consecutive months.

Your common-law Spouse and the children of your common-law Spouse must be listed on this form. If not listed, or you enter into such a relationship after completing this form, they must be listed on the Administrator’s records for at least 12 months in order to be considered to be your Dependent.

AUTHORIZATION

I hereby authorize the MANITOBA FOOD AND COMMERCIAL WORKERS DENTAL PLAN, and its administrator, to deposit claim payments to my Bank Account as identified on the front of this form. I understand this information will be kept confidential and secure, and that it will only be used for the purposes identified herein. I further understand that I am personally responsible for the confidentiality and security of my personal information that may be sent to me by email. If my eligibility for plan coverage ends, the direct deposit agreement will be automatically cancelled.

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.

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Signature of Member

____
Signature of Dependent Child Age 18 or Over

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Signature of Spouse

____
Signature of Dependent Child Age 18 or Over

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Date