REGISTRATION FORM

MANITOBA FOOD AND COMMERCIAL WORKERS DENTAL PLAN

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

Please print clearly and complete the entire form

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

LIST FIRST AND LAST NAME OF SPOUSE AND DEPENDENT CHILDREN	RELATIONSHIP	DATE OF BIRTH DAY	MO.	YEAR	LIST FIRST AND LAST NAME OF ADDITIONAL DEPENDENT CHILDREN	RELATIONSHIP	DATE OF BIRTH DAY	MO.	YEAR

Are your Dependants living with you? ☐ Yes ☐ No

Do any of your Dependants also work for an employer who participates in this Plan?

☐ No ☐ Yes – Name _____ SIN_____

Do any of your Dependants have dental coverage under another plan?

☐ No ☐ Yes – Name _____ SIN_____

Insurance Company/Policy# _____

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.

Member Signature Spouse Signature _____

Signature of Dependent Child Age 18 or Over _____

Signature of Dependent Child Age 18 or Over _____

Date_____