NOTIFICATION OF CHANGE

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.

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

PLEASE COMPLETE THE APPLICABLE SECTIONS ONLY

CHANGE IN MARITAL STATUS

- ☐ MARRIED: Maiden name _____ DATE OF MARRIAGE _____
- ☐ COMMON-LAW RELATIONSHIP: Date relationship commenced _____
- ☐ MARRIAGE / COMMON-LAW BREAKDOWN: Date you began living separate and apart _____
- ☐ WIDOWED: Date of death of spouse _____

	NAME	RELATIONSHIP	DATE OF BIRTH DAY MO. YEAR	NAME	RELATIONSHIP	DATE OF BIRTH DAY MO. YEAR
ADDITIONAL DEPENDENTS						
DELETION OF DEPENDENTS						

CHANGE IN MAILING ADDRESS

APT & STREET No.	STREET	CITY	PROVINCE	POSTAL CODE

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 for 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 Date

If you are adding a Spouse or Dependent Child age 18 or over please have them sign below.

_____ _____

Signature of Spouse Signature of Dependent Child Age 18 or Over

_____

Date