

CERTIFICATION AND CONSENT

I understand that it is an offence to make a false or misleading statement regarding the personal and claims information provided herein and declare that the information is true, correct and complete.

I certify that the charges for the dental services, identified by my dentist on the reverse side of this form, were incurred by me, or on account of one of my eligible dependents.

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 strictest confidence and will only be used for the specified purpose.

I understand that personal information about me and that of my eligible dependents as provided herein, as well as other personal information currently held or to be collected in the future, is required to: communicate with me; compute my benefits and those of my eligible dependents; satisfy any reporting requirements of the provincial and federal governments; 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.

I hereby authorize the Board Of Trustees and the service agencies they employ to collect, record, use, disclose and, if applicable, destroy my personal information and that of my dependents who are under 18 years of age. I understand that all personal information will be kept confidential and secure, and that it will only be used for the purposes identified herein. Also, I understand that I may review the information, referenced herein, for myself or my dependents, who are under 18 years of age, to ensure that it is up-to-date, and that I may withhold or revoke my consent for its use, at any time. 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 entitlements, my participation in the Plan may be impaired or cancelled.

If I, or my dependents under 18 years of age, have coverage through another plan, I hereby authorize the Trustees to disclose personal information about me and my dependents in order to determine eligibility for coverage in the settlement of claims.

A photostatic copy of this authorization will be as valid as the original.

Signature of Plan Member

Date

If an expense has been incurred by your eligible spouse, and is attached to this claim, please have your spouse sign the following.

I hereby consent to the collection, recording, use, disclosure and, if applicable, destruction of my personal information in the same manner as described above.

Signature of Spouse

Date

If an expense has been incurred by an eligible dependent child age 18 or older, and is attached to this claim, please have your child sign the following.

I hereby consent to the collection, recording, use, disclosure and, if applicable, destruction of my personal information in the same manner as described above.

Signature of Dependent
Child Age 18 or Over

Date