Public Service Dental Care Dependant Information Form

You must complete and submit a Dependant Information form for any of the following change: dependant name changes, dependant date of birth change, removing/terminating a dependant, adding a spouse, adding a child (including adoption or guardian appointment) or student status change.

Plan members must write to the Board of Management of the Public Service to cover a sibling, sibling's child or grandchild. For more details, please see the Public Service Dental Care Plan Member booklet

PLEASE INDICATE THE APPLICABLE DENTAL PLAN NUMBER:

☐ **55555 -** National Joint Council ☐ **55666 -** Public Service Alliance of Canada ☐ **55777 -** Canadian Forces Dependants ☐ **55888 -** Royal Canadian Mounted Police

PLAN MEMBER INFORMATION

Last Name	First Name	Employee ID Number	Date of Birth (YYYY/MM/DD)

Address (number, street, city, province, postal code)

DEPENDANT INFORMATION – SPOUSE

Type of Change Add Change Remove	Last Name	First Name	Date of Birth (YYYY/MM/DD)	If adding a spouse, confirm if legal marriage or common law	Confirm date of marriage or date you started living together (YYYY/MM/DD)	If removing a spouse, confirm date of divorce or separation (YYYY/MM/DD)
☐ ☐ ☐						
☐ ☐ ☐						

Is this person eligible for benefits from any other plan, either personally or as someone else's dependant? ☐ YES ☐ NO

For 55777 only, has your relationship been established with qr & o article 1.075? ☐ YES ☐ NO

DEPENDANT INFORMATION – CHILD

Type of Change Add Change Remove	Last Name	First Name	Date of Birth (YYYY/MM/DD)	Date of Change (YYYY/MM/DD)	If child over 21 years, full-time student YES / NO
☐ ☐ ☐					☐ YES ☐ NO
☐ ☐ ☐					☐ YES ☐ NO
☐ ☐ ☐					☐ YES ☐ NO
☐ ☐ ☐					☐ YES ☐ NO
☐ ☐ ☐					☐ YES ☐ NO

Is this person eligible for benefits from any other plan, either personally or as someone else's dependant? ☐ YES ☐ NO

PRIVACY

This section explains Canada Life's commitment to privacy.

At **The Canada Life Assurance Company**, we recognize and respect the importance of privacy. When you apply for coverage, we establish a confidential file that contains your personal information. This file is kept in the offices of Canada Life or the offices of an organization authorized by Canada Life. You may exercise certain rights of access and rectification with respect to the personal information in your file by sending a request in writing to Canada Life. Canada Life may use service providers located within or outside Canada. We limit access to personal information in your file to Canada Life staff or persons authorized by Canada Life who require it to perform their duties, to persons to whom you have granted access, and to persons authorized by law. Your personal information may be subject to disclosure to those authorized under applicable law within or outside Canada. Personal information that we collect will be used for the purposes of determining your eligibility for coverage and administering the group benefits plan. This includes investigating and assessing claims, and creating and maintaining records concerning our relationship. For a copy of our Privacy Guidelines, or if you have questions about our personal information policies and practices (including with respect to service providers), write to Canada Life's Chief Compliance Officer or refer to www.canadalife.com.

AUTHORIZATIONS AND DECLARATIONS

This section must be signed and dated in INK by the employee.

I hereby, send you the information on coverage for my spouse and/or unmarried dependent children under the group benefits plan and I confirm that I am authorized to act on their behalf.

I have read and understand and agree with the contents of the section on this form entitled "Privacy".

I authorize:

- Canada Life, any healthcare provider, my plan administrator, other insurance or reinsurance companies, administrators of government benefits or other benefits programs, other organizations, or service providers working with Canada Life or the above to exchange personal information, when relevant and necessary to determine my eligibility for coverage and to administer the plan.

I agree that a photocopy or electronic copy of the Authorizations and Declarations section is as valid as the original.

I certify that the information given is true, correct and complete to the best of my knowledge.

For Québec applicants: I request that this form be in English.
Je demande que ce formulaire me soit remis en anglais.

Plan member signature: _____ Date (mm/dd/yy): _____

MAIL OR EMAIL THIS FORM TO:

For Canadian residents except residents of Quebec:

Health and Dental Claims Centre
P.O. Box 6025, Station Main
Winnipeg MB
Canada
R3C 3C7

Email: PSDCP-Dependent-Update@canadalife.com

For Quebec residents, other than the National Capital Region:

Montreal Benefit Payments
Place Bonaventure
800 de la Gauchetière Street West Suite 5800
Montreal QC
Canada
H5A 1B9

Email: PSDCP-Dependent-Update-FR@canadalife.com

For employees residing outside Canada

Canada Life Health and Dental Benefits
Foreign Benefits Payments
P.O. Box 6000
Winnipeg MB
Canada
R3C 3A5

Email: PSDCP-Dependent-Update@canadalife.com

Clear