

Retail Wholesale Canada Multi Employer Dental Benefit Trust Fund

Administrator:
Global Benefits
Telephone: 416-635-6000
Fax: 416-631-3064
Email: benefits@globalben.com
901-191 The West Mall
Toronto, ON M9C 5K8

Group Benefits Enrolment Form

Please type or print clearly. Complete all items on the form in detail. To ensure that coverage is kept up to date for you and your dependents, it is vital that you advise your Plan Administrator of any changes, such as change of name, marital status, or dependent status.

Plan Member Information	Full-Time Employee		Part-Time Employee		
	_____ Employer Name / Location		_____ Employee Number (Payroll "EMP. NO")		
	_____ Last Name		_____ First Name	_____ Initial	_____ Social Insurance Number
	_____ Apt. Number/Street Number/Street Name		_____ City	_____ Province	_____ Postal Code
	()		()		
	_____ Home Phone		_____ Mobile Phone	_____ Email Address	
	Sex: Male		Female	Other	
	_____ Date of Birth (mm/dd/yyyy)		_____ Date of Employment (mm/dd/yyyy)		
	Marital Status: Single		*Common-Law	Married	Separated
			Divorced	Widowed	
*If Common-Law, please provide your co-habitation date (mm/dd/yyyy)					

Dependent Information <i>This section allows you to define who will be entitled to you Dental Benefits. If you require additional fields please complete another form and submit together.</i>	Spouse			Sex			Is this individual covered by another group insurance plan?			
	_____ Last Name		_____ First Name	_____ Date of Birth (mm/dd/yyyy)		M	F	O	Yes	No
	Dependent Children									
	_____ Last Name		_____ First Name	_____ Date of Birth (mm/dd/yyyy)		M	F	O	Yes	No
	_____ Last Name		_____ First Name	_____ Date of Birth (mm/dd/yyyy)		M	F	O	Yes	No
	_____ Last Name		_____ First Name	_____ Date of Birth (mm/dd/yyyy)		M	F	O	Yes	No
	_____ Last Name		_____ First Name	_____ Date of Birth (mm/dd/yyyy)		M	F	O	Yes	No

Privacy <i>This section explains Global Benefits commitment to privacy.</i>	At Global Benefits we recognize and respect the importance of privacy.
	Your Personal Information: When you apply for coverage, we establish a confidential file that contains your personal information such as your name, contact information, and coverage you have with us, and may include financial or health information. Your information is kept in the offices of Global Benefits or the offices of an organization authorized by Global Benefits.

Who has access to your information:

We limit access to personal information in your file to Global Benefits staff or persons authorized by Global Benefits who require it in order to perform their duties and to persons whom you have granted access. Your personal information may also be subject to disclosure to public authorities or others authorized under applicable law within or outside Canada.

What your information is used for:

Personal information that we collect will be used for the purposes of determining your eligibility for coverage for which you apply, providing, administering or servicing coverage you have with us, and for Global Benefits and its affiliates' internal data management and analytical purposes.

If you want to know more:

If you have questions about our personal information policies and practices, write to the Retail Wholesale Canada Multi-Employer Dental Benefit Trust Fund c/o Global Benefits Chief Compliance Officer at:

Retail Wholesale Canada Multi-Employer Dental Benefit Trust Fund
c/o Global Benefits
901-191 The West Mall
Toronto, ON M9C 5K8

T: (416) 635-6000 F: (416) 631-3064
E: privacyofficer@globalben.com

**Authorizations and
Declarations**

*This section must be signed and
dated by the Plan Member.*

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

I authorize:

Global Benefits, 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 Global Benefits or the above to exchange personal information, when necessary to determine eligibility for coverage and to administer the plan.

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

I authorize the use of my Social Insurance Number as my Certificate Number under the group plan and as my identification number in the Retail Wholesale Canada Multi-Employer Dental Benefit Trust Fund Database.

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

Plan Member Signature: _____

Date: _____
(mm/dd/yyyy)