AGA BENEFIT SOLUTIONS

ENROLMENT FORM
Optional Dental Care Benefit only
(You must already be insured under the basic plan)

ADMINISTRATIVE INFORMATION

Employer / Policyholder name	Group No.	Division No.	Class	Department

Employee's last name	First Name	Employee No.

Date of birth (YYYY – MM - DD)	Gender: ☐ M ☐ F	Email

Address (No. / Street / Apt.)	Telephone

City	Province	Postal code

☐ **YES, I would like to receive my claim reimbursements directly into my bank account.**
It is the responsibility of the member to ensure the accuracy of the banking information entered on the Enrolment form.
If banking information is incorrect, please note that AGA cannot be held responsible for amounts not received by the member.

Branch	Bank	Account number

⑈00900⑈ ⑆99999-999⑆ 999-999-9⑈
Branch **Bank** **Account number**

REQUIRED COVERAGE AND INFORMATION ON SPOUSE AND/OR CHILDREN

Optional benefits: If offered under your plan and under its conditions.	Optional Dental Care Benefit ☐ Single ☐ Single Parent ☐ Couple ☐ Family **This benefit must be maintained for a 24-month period for yourself and your dependents, unless there is a change related to the eligibility conditions specified in the main policy.**

SPOUSE AND/OR CHILDREN IDENTIFICATION

	Last name	First name	Gender M	Gender F	Date of birth (YYYY – MM - DD)	21 years of age or older, please specify: Full-time student	21 years of age or older, please specify: Handicapped	Are the spouse/children covered by another Dental Care plan? Yes	Are the spouse/children covered by another Dental Care plan? No
Spouse			☐	☐				☐	☐
Child 1			☐	☐		☐	☐	☐	☐
Child 2			☐	☐		☐	☐	☐	☐
Child 3			☐	☐		☐	☐	☐	☐
Child 4			☐	☐		☐	☐	☐	☐
Child 5			☐	☐		☐	☐	☐	☐
Child 6			☐	☐		☐	☐	☐	☐

If you have answered "Yes" to the question: "Are your children covered by another plan?", please confirm details on the back of this page. This information is necessary to apply the rules for the coordination of benefits.

AUTHORIZATION AND SIGNATURE

Please take note of the "Notice regarding personal information confidentiality" on reverse

☐ I hereby request coverage for Optional Dental Care benefit under my employer/policyholder's group insurance plan subject to the contract terms and conditions and authorize my employer/policyholder to deduct the required contributions from my earnings. I also authorize my employer/policyholder, the insurer and their respective representatives and mandatories to give, receive and share any personal information regarding my eligibility and my insurability or those of my dependents, if any, under this plan.

Employee's signature	Date

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Children covered by another plan – Please provide the following details:

Indicate for which child the following applies – Child # : _____

Dental care

☐ Coverage by the plan of current spouse
☐ Coverage by the plan of the other parent
☐ Coverage by the plan of the spouse of the other parent
☐ Coverage by the plan of the other parent and the spouse of the other parent
☐ Coverage by the plan of an educational institution:
☐ including drug coverage ☐ excluding drug coverage

If the parents are separated, divorced or not living together:

Are you the sole custodial parent? ☐ **or**

Does the other parent have sole custodial? ☐ **or**
Do you have shared custody? ☐
If you share custody, please indicate other parent's date of birth:
(YYYY/MM/DD): _____

Indicate for which child the following applies – Child # : _____

Dental care

☐ Coverage by the plan of current spouse
☐ Coverage by the plan of the other parent
☐ Coverage by the plan of the spouse of the other parent
☐ Coverage by the plan of the other parent and the spouse of the other parent
☐ Coverage by the plan of an educational institution:
☐ including drug coverage ☐ excluding drug coverage

If the parents are separated, divorced or not living together:

Are you the sole custodial parent? ☐ **or**

Does the other parent have sole custodial? ☐ **or**
Do you have shared custody? ☐
If you share custody, please indicate other parent's date of birth:
(YYYY/MM/DD): _____

Initials: _____

NOTICE REGARDING PERSONAL INFORMATION CONFIDENTIALITY

As group insurance administrators, we are required to collect and maintain on file certain personal data concerning yourself. We are aware that this is an important responsibility, and this is why we consider the personal information protection a priority.

***The subject of Your File** – The subject-matter of your file as established at our firm bears the title "Group Insurance (Sales, Administration and Services)". The personal information concerning you is collected in this file and is kept secure under the highest standards of confidentiality.*

***Confidentiality** – We only collect relevant information needed to constitute this file for purposes of allowing us to carry out our assignment. Access to this file is limited to the firm's employees, representatives, agents, service providers and suppliers who require this information to successfully accomplish their duties. Information contained in this file cannot be disclosed without your consent; any disclosure must comply with provisions under the Act respecting the protection of personal information in the private sector. We can communicate your information to third parties who provide services on our behalf, those third parties may have their facilities in the United States or other location. Our service providers and suppliers can only use your personal information to provide the services or supplies on our behalf.*

***Access** – If you wish to have access to your file, you must send a request by e-mail at: info@aga.ca or communicate with us at numbers mentioned below.*

***Updates and corrections** – Please keep us informed regarding any changes in information contained in this file and, if required, indicate to us in writing any correction needed to ensure accuracy.*

For further information, please do not hesitate to contact Customer Service at the following numbers:

Montreal area:	***514-935-5444***
Elsewhere in Quebec:	***1 800 363-6217***
Fax:	***514-935-1147***