



## CO-ORDINATION BETWEEN TWO PLANS

If you and your Spouse are both eligible for benefits under this Plan, the Administrator will automatically co-ordinate the benefits between your file and your Spouse's file, if you indicate this on the reverse side of this form.

If you and your Spouse are members of 2 different plans, which provide the same benefits for which you are claiming, the steps are as follows.

**Step 1** - submit a claim for your expenses to this Plan for reimbursement. The payment details will be sent to you and your Dentist with the payment. Submit this information to your Spouse's plan for reimbursement of any unpaid balance.

**Step 2** - your Spouse must submit a claim for his/her expenses to his/her plan for reimbursement. When he/she receives details of the payment made, submit a copy of this information to this Plan for reimbursement of any unpaid balance.

**Step 3** - claims for your children should **first** be submitted to the plan of the parent whose birth month is the earlier in the year, **then** to the other plan.

## CERTIFICATION AND CONSENT

I understand that it is an offense 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 to the best of my knowledge and belief.

I authorize the release of the information contained on this claim form to the Manitoba Food and Commercial Workers Dental Plan. I understand that the fees listed in this claim may not be covered or may exceed the Plan's benefits. I understand that I am financially responsible to my Dentist/Denturist for the entire cost of the treatment.

I certify that the charges for the dental services and/or supplies which are identified on the reverse side of this form, or on the attached form provided by my Dentist/Denturist, were incurred by me, or on behalf of one of my 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 my personal information 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 you; determine coverage and benefit entitlement; 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 this information 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 entitlement, my participation in the Plan may be impaired or cancelled.

If I, or my dependents under 18 years of age, have coverage under another plan, I hereby authorize the Board of Trustees and the Plan administrator to disclose personal information about me, and such dependents, in order to determine coverage and benefit entitlement.

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

\_\_\_\_\_  
Signature of Member

\_\_\_\_\_  
Date

**If the dental expense has been incurred on behalf of your Spouse, 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 the dental expense has been incurred on behalf of a Dependent Child age 18 or over, 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