Administrator:
BENEFIT PLAN ADMINISTRATORS LIMITED
P.O. BOX 3071, STATION 'A'
MISSISSAUGA, ONTARIO L5A 3A4

U.F.C.W. LOCALS 175/633
ONTARIO DENTAL BENEFIT TRUST FUND
Member Information Card
PART-TIME EMPLOYEE

MALE	FEMALE
SINGLE	FAMILY

EMPLOYER:

MEMBER'S NAME: (LAST) (FIRST) (MIDDLE) HOME PHONE NO.

MEMBER'S ADDRESS: (STREET & NO.) (CITY) (PROVINCE) (POSTAL CODE)

DATE OF BIRTH: DAY MONTH YEAR | DATE OF COMMENCEMENT OF PART-TIME EMPLOYMENT | IDENTIFICATION NUMBER

DEPENDENT CHILDREN	NAME	DATE OF BIRTH			NAME	DATE OF BIRTH		
		DAY	MONTH	YEAR		DAY	MONTH	YEAR

REV-10/06 **SEE OVER**

COLLECTION OF PERSONAL INFORMATION

Benefit Plan Administators Limited (BPA) on behalf of the Trust Fund collects personal information from you, your employer or your former employer, and your union local, to determine eligibility and benefit entitlements under your Plan. Your employment history may be shared with your union local for the purpose of monitoring the contributions required to be made under the terms of the Collective Agreement.

Your personal information is kept confidential and safeguarded. BPA will only release relevant personal information to your eligible dependents specific to their benefit entitlements. Your personal information (and the personal information of your eligible dependents) may be disclosed to insurance carriers, auditors and other benefit providers so that they can perform services in connection with the administration of the Plan. Disclosure will be limited to the specific information required for a particular purpose. Personal information may also be disclosed as required or permitted by law.

I understand that my identification number will be kept in strictest confidence and will only be used to match my information with the correct member file.

I consent to the collection, use and disclosure of personal information as stated above.

Member's Signature _____ Date _____

Please complete **both sides** of the card in detail. Any benefits you may be entitled to under your Benefit Plan may not be paid until this card is **completed, dated, signed and filed with the Plan Administrator.** A new card is required to change any information.

PLEASE RETURN *MEMBER INFORMATION CARD* TO:
BENEFIT PLAN ADMINISTRATORS LIMITED
P.O. BOX 3071, STATION 'A' MISSISSAUGA, ONTARIO L5A 3A4