Dental Plan

RSMC & Urban Bargaining Units

This plan provides dental services. It's called "Dental Care Plan no. 51057 and the company that looks after it is Great-West Life.

The Dental Plan is **mandatory** and is administered by Great-West Life, along with the Vision/Hearing Plan.

You must enrol in this plan by filling out a **Dental Care Plan (51057) - Application for Coverage (Employee)** form.

Eligible:

All Rural and Suburban Mail Carriers. who have completed six months of continuous service are eligible

Urban Operations Bargaining Unit: regular employees & temporary employees in Group 3 (maintenance) who have completed six months of continuous service are eligible — but coverage doesn't start immediately.

NOT Eligible:

Temporary employees *(except for those working in Group 3 - maintenance positions)* are not eligible. When temporary employees become regular (permanent) employees, they become eligible for the plan.

RSMC relief employees, helpers and replacements are not eligible.

Retirees are not eligible.

What are the costs?

The monthly premiums for the Dental Plan are:

Single: $.75 bi-weekly
Family: $1.68 bi-weekly

The Dental Plan covers you, your spouse and your children. You need to put your **dependants** *(spouse & children)* on the Dental Plan. Great West Life administers the Extended Health Care, Vision/Hearing and Dental Plans. The company uses the same Dependent Information Form for all three plans, so you only need to fill out one form.

*Your **spouse** is defined as*

- *the person to whom you are married and with whom you live, or*
- *the person to whom you were (or are) legally married and whom you support, or*
- *the person with whom you have been living in a common-law relationship for at least one year*

A divorced spouse is not considered a spouse under this plan.

***Children** must be unmarried and financially dependent on you for support and (unless they are full-time students) under the age of 22. A child who is a full-time student is covered up to the age of 25. There is no age limit for offspring who are differently-abled and unable to support themselves, provided they were differently-abled and covered (as children under age 22, or as full-time students under age 25) when coverage would otherwise have ended.*

When does coverage start – Urban Operations?

Coverage begins on the first day of the month following your completion of six months of continuous service (work) as a regular employee *(or as a temporary employee in Group 3)*. For example, if you start working on January 6, you'll be **eligible** on July 6 (which is when you'll have completed six months of service), but your **coverage** won't begin until the first of the next month — August 1.

When does coverage start – RSMC?

Scenario 1: CUPW members hired before April 1, 2007

- You are covered if you completed six months of continuous service (work) as a regular employee as of October 1, 2007 (meaning you have worked six months for Canada Post since April 1, 2007).
- Your coverage only applies to dental work completed **after** October 1, 2007. You will not be covered under this plan for dental work that is done before October 1, 2007, even if you are billed for the dental work after October 1, 2007.

Scenario 2: CUPW members hired after April 1, 2007

- If you were hired after April 1, 2007, your coverage begins the first day of the month following your completion of six months of continuous service (work) as a regular employee. For example, if you started working for Canada Post on May 6, 2007, your coverage would begin on December 1, 2007.

When does coverage end – Urban & RSMC?

Coverage for you, your spouse and your children ends on the date in which the following occurs:

- when your employment ends
- when you retire
- when you are on strike
- when you die *(your spouse/child may apply to continue coverage)*
- your last day at work, when you go on leave of absence without pay for more than 30 calendar days (except for maternity, parental, adoption, or sick leave)

However, you may be able to be reimbursed for dental work that had already been started before your employment ended.

Your spouse or child may lose coverage earlier than you do if they are no longer eligible.

Does my coverage continue when I am off work (on leave)?

Sick Leave (paid or unpaid)	coverage continues
Disability Insurance (DI)	coverage continues
Maternity, Parental and Adoption Leave	coverage continues
Any other leave of absence without pay of more than 30 calendar days (e.g., Education Leave, Care and Nurturing Leave, Sabbatical Leave	coverage ends on your last day of work

When you return to work, Canada Post will deduct the money owing over a period twice as long as the period of your leave.

Example: Here is an example of how it works. You return from five months of leave and owe a total of $6.55 in premiums for the time you were on leave (five months x $1.31). Canada Post will deduct the $6.55 over a period that's twice as long as your five-month leave (ten months). You'll pay back the premiums at the rate of approximately $0.65 a month.

Important: Before going on any type of leave, you should check with your steward to confirm your entitlements, and ensure that the employer and the CPC Human Resources office are informed.

What expenses/services does this plan cover?

1) Basic services The plan covers 80% of the costs (up to a maximum reimbursement of $1,000 per calendar year). *Your maximum may be reduced during the first year of coverage if you became effective after June 30.*

- oral examinations (twice a year, at least five months apart)
  - x-rays:
    - bite wing (twice a year, at least five months apart)
    - full mouth (at least 24 months apart)
  - routine diagnostic and laboratory procedures
  - scaling and polishing (twice a year, at least five months apart)
  - fluoride application (twice a year, at least five months apart)
  - fillings (amalgam, silicate, acrylic, or composite)
  - extractions and alveolectomy at the time of extraction
  - replacement of existing fillings if the existing filling is at least two years old or the existing filling was not previously covered under this plan
  - dental surgery, including general anesthesia, and related diagnostic x-ray and laboratory procedures
  - necessary treatment for relief of dental pain, including the cost of medication
  - and its administration when given by injection in the dentist's office
  - space maintainers for missing primary teeth and habit-breaking appliances
  - consultations required by the attending dentist
  - surgical removal of tumours, cysts and neoplasms, and incision and drainage of abscesses
  - endodontic services (root canal therapy)
  - periodontal services (treatment of gums and bones supporting the teeth)
  - pit and fissure sealants for children under the age of 15

2) Major services The plan covers 70% of the costs (up to a maximum reimbursement of $1,500 per calendar year). *Your maximum may be reduced during the first year of coverage if you became effective after June 30.*

- crowns, onlays and inlays
- replacement of existing crowns or onlays if the existing restoration is at least five years old and cannot be made serviceable
- procedures involving the use of gold only if a lower-cost substitute is not considered consistent with generally accepted dental practice (otherwise, reimbursement will be based on the lower-cost substitute)
- relining, rebasing and repairs to existing dentures
- creation and placement of initial bridge or denture (full or partial), provided that the appliance was required because at least one natural tooth needed to be extracted while the person was covered under the plan
- replacement of existing bridge or denture if:

- the existing appliance is at least five years old and cannot be made serviceable
- the existing appliance is temporary and is replaced by a permanent one, provided the temporary appliance was installed while the person was covered by the plan
- the replacement appliance is required because an initial opposing denture had been installed while the person was covered by the plan
- the initial appliance was irreparably damaged as the result of an accidental injury
- one additional natural tooth must be extracted and the existing bridge or denture cannot be made serviceable; if the existing appliance could have been made serviceable, the plan will reimburse only the portion of the cost
- related to the additional extracted tooth

3) Orthodontics *(children only)* The plan covers 50% of the costs (up to a maximum lifetime reimbursement of $2,000 per child).

- treatment and appliances for the realignment of teeth or jaws using braces or other dental procedures to straighten teeth and keep them in the correct position
- **applies to children only, who must be under age 22**

What's NOT covered?

- work that is not the least expensive method (if you choose a more expensive option, the plan will pay for the cost of the least expensive option)
- work that was done before its time limit for coverage (for example, items such as crowns or bridges can usually only be replaced every five years)
- various types of cosmetic work

Some factors that determine how much money you will get back on your dental claim are:

- deductibles
- fee guides
- how much your dentist charges
- "the least expensive treatment"
- the calendar year

Deductible:

The deductible for single is $50 & the deductable family coverage is $80. *The first family member who uses the plan pays $50. The next person in the family who uses the*

plan pays the remaining $30 of the deductible. If the family has three people in it, the third person who uses the plan doesn't have to pay any deductible.

Dental Fee Guides:

For year:	When the fee guide is applied to employees:
2012	April 1st, 2013
2013	April 1st 2014
2014	April 1st, 2015

Coordination of Benefits:

1. When two Spouse *(as defined above)* who both work for Canada Post and they are both on the Dental Plan, as employees with family coverage, they can claim benefits from two dental plans. *When this type of coordination of benefits you don't have to worry about whose plan pays what when you file a claim. Great-West Life does these calculations.*

2. You can also have a coordination of benefits with two Spouse *(a defined above)*, where only one Spouse works at Canada Post *(with family coverage)* and the other Spouse has family coverage under a different plan and with a different employer.

In this case each Spouse must apply for reimbursement with their own "Primary Plan" before applying for coordination of benefits with the "Secondary Plan".

When putting in a claim for a dependant child's dental benefits the parent who has legal and permanent custody of the child must first submit the claim to their benefit plan (*"Primary Plan"*) before applying for coordination of benefits with the "secondary Plan". When legal and permanent custody is shared then the parent with the first birthday in the year must submit the claim to their benefit plan as the "Primary Plan" before applying for coordination of benefits with the "Secondary Plan".

Dental work done outside of Canada while on vacation:

You and your family can be reimbursed for emergency dental work done outside Canada when you are on vacation. Also, a dependent child studying outside Canada is eligible for coverage. The service will be reimbursed as if it had been done in your home province or territory, as long as Great-West Life considers the expense "reasonable".

You must get a receipt for the money you paid and a written description of the service, including the international tooth number(s). You mail these items to Great-West Life, being sure to include the number of your plan and your Canada Post identification number (HRID number), and also being sure to make a copy of what you've sent. The Deductible on the Dental plan is $50 per year.

EHC Plan & Dental Work:

The Extended Health Care Plan (# 51391) **covers dental work required due to an accident, as well as some dental surgeries. If you are covered under the Extended Health Care Plan, be sure to note this on your dental claim form**

How do I use this benefit?

The primary tool you use for this benefit is a **dental claim form** — the form that says "Canada Post Corporation Dental Care Plan" at the top. But how you claim depends on your dentist. Most dentists have a preferred way of handling billings with patients who have dental plans. Three options are:

1. ***You pay the dentist's bill in full.*** *You give your dentist a claim form. The staff at the dentist's office will write in the work that's been done, and the cost of each item on the form. You fill out the rest of the form, make sure that all the information is correct, and sign it. **You** mail the completed form to Great-West Life, being sure to keep a copy. GWL will mail you a cheque for the amount of money you are owed under the plan.*

   You can also submit a claim online through GWL Groupnet for members. To do this you must register and sign up for direct deposit. It is important note that if you have not previously signed up for Direct Deposit, you will need to allow at least 2 business days from the time you submitted your request for changes to take place.

2. ***You pay the dentist's bill in full.*** *The dentist shows you a printout of an electronic claim form containing a list of the dental work done, and the cost of each item. You make sure that the information is correct. The **dentist** sends the claim to Great-West Life electronically, giving you a copy for your records. GWL will mail you a cheque for the amount of money you are owed under the plan.*

3. ***Your dentist agrees that Great-West Life can pay him or her directly.*** *The dentist sends the claim form to Great-West Life, which will send the cheque directly to the dentist. The dentist will then bill you for the remainder of what is owed.*

Be sure to bring a claim form with you to the dentist
(unless your dentist uses electronic forms).

Also get pre-authorization for any important or major dental work

Tips for using this benefit

- **Do** get pre-authorization for any important dental IN WRITING. Sometimes a dentist says work will be covered under your plan because he or she believes it is: ask the dentist to call Great-West Life, and wait for the confirmation that GWL will mail you.

- **Do** work with your dentist to schedule your dental work so that you get as much of it as possible paid for out of the plan. The authorization from GWL says the treatment is covered under your plan, but it may not tell you how much of your yearly maximums you've already spent.
- **Do** send in your claim as soon as possible. Claims more than a year old (i.e., received more than 12 months from the date of the expense) will be rejected.
- Employees covered by this plan should try to schedule dental appointments after April 1, to take advantage of the rates in the more recent version of the dental fee guide.
- If you've used up your maximums, **do** try to schedule non-urgent dental work to be done in the next calendar year.
- **Don't** forget to sign all the claim forms filed on this plan — not just your claims, but also claims for other family members on your plan.
- If your spouse has a dental plan with Canada Post or with another employer, **do** highlight the fact you have coordination of benefits on your claim form.

You can also check your Great West Life account on the GWL website at: www.greatwestlife.com

You log onto the Great-West Life website using the number of a GWL plan and your Canada Post employee number (HRID number).

Or contact GWL with any questions at:

Great-West Life
P.O. Box 3050
Winnipeg MB
R3C 4E5

1-(800)-957-9777 or 1-866-716-1313

Dental Plan # 51057

On the following pages you will find:

1) GWL Dental Plan (51057) Claim form
2) CPC Statement of Claim / Out of Country Expense form
3) GWL Extended Health Care / Prescription Drug Plan (51391) Claim form
4) CPC Dental Care Plan (51057) - Application for Coverage (Employee) form
5) Dependent Information form

CLAIM FORM
DENTAL CARE PLAN (51057)

Please print

Canadian Dental Association

Canadian Life and Health Insurance Association

The Great-West Life Assurance Company

PART 1 DENTIST

UNIQUE NO. | SPEC. | PATIENT'S OFFICE ACCOUNT NO.

I HEREBY ASSIGN MY BENEFITS PAYABLE FROM THIS CLAIM TO THE NAMED DENTIST AND AUTHORIZE PAYMENT DIRECTLY TO HIM/HER.

PATIENT

LAST NAME _____ GIVEN NAME _____

ADDRESS _____ APT. _____

CITY _____ PROV. _____ POSTAL CODE _____

DENTIST

PHONE NO. _____

SIGNATURE OF SUBSCRIBER _____

FOR DENTIST'S USE ONLY, FOR ADDITIONAL INFORMATION, DIAGNOSIS, PROCEDURES, OR SPECIAL CONSIDERATION.

I UNDERSTAND THAT THE FEES LISTED IN THIS CLAIM MAY NOT BE COVERED BY OR MAY EXCEED MY PLAN BENEFITS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO MY DENTIST FOR THE ENTIRE TREATMENT. I ACKNOWLEDGE THAT THE TOTAL FEE OF $_____ IS ACCURATE AND HAS BEEN CHARGED TO ME FOR SERVICES RENDERED.
I AUTHORIZE RELEASE OF THE INFORMATION CONTAINED IN THIS CLAIM FORM TO MY INSURING COMPANY/PLAN ADMINISTRATOR. I ALSO AUTHORIZE THE COMMUNICATION OF INFORMATION RELATED TO THE COVERAGE OF SERVICES DESCRIBED IN THIS FORM TO THE NAMED DENTIST.

DUPLICATE FORM ☐

SIGNATURE OF PATIENT (PARENT/GUARDIAN) _____

OFFICE VERIFICATION

DATE OF SERVICE DAY	MO.	YR.	PROCEDURE CODE	INTL. TOOTH CODE	TOOTH SURFACES	DENTIST'S FEE	LABORATORY CHARGE	TOTAL CHARGES

THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED AND THE TOTAL FEE DUE AND PAYABLE, E. & O.E.

TOTAL FEE SUBMITTED

INSTRUCTIONS

All claims under this group benefits plan are submitted through the plan member. We may exchange personal information about claims with the plan member and a person acting on his or her behalf when necessary to confirm eligibility and to mutually manage the claims.

1. Have your dentist complete Part 1.
2. Employee completes Parts 2 and 3.
3. If you wish benefits to be paid directly to the dentist, sign the assignment portion of Part 1 above. Assignment of benefits is irrevocable. Great-West Life may discuss details of this claim with the assignee.
4. Send this claim to:

QUEBEC RESIDENTS, OTHER THAN NATIONAL CAPITAL REGION RESIDENTS:
Montreal Benefit Payments
Place Bonaventure
800 de la Gauchetière Street W Suite 5800
Montréal QC H5A 1B9

FOR ALL OTHER RESIDENTS:
Winnipeg Benefit Payments
PO Box 3050 Station Main
Winnipeg MB R3C 0E6

1.800.957.9777
TTY line - available for the deaf or hard of hearing
Toll Free: 1.800.990.6654

PLEASE KEEP A COPY OF THIS FORM, RECEIPTS AND ANY OTHER RELEVANT DOCUMENTATION FOR YOUR RECORDS

PART 2 EMPLOYEE (Please print)

1. Employee's Last Name _____ First Name _____

Date of Birth (Day Month Year) _____ | Plan Number 5 1 0 5 7 | Employee ID No. _____

Employee's Address _____ Phone Number _____ Postal Code _____

2. Relationship of patient to employee _____ | Patient's Date of Birth (Day Month Year) _____ | Is the patient a dependent child with a disability age 22 or over? ☐ Yes ☐ No

3. If patient is a dependent child between 22 & 25 years old, is he/she a full-time student? ☐ Yes ☐ No

4. Are you or any member of your family entitled to dental benefits from any other group insurance? ☐ Yes ☐ No

If yes, give name of other insurance company/dental plan	Name of family member insured	Policy No.	I.D. No.

5. If yes to question 4 above, and patient is a dependent child, give spouse's birthday (day/month): _____/_____

6. Is treatment required as the result of an accident? ☐ Yes ☐ No

If yes, give date, location, and explain how accident happened

If yes, are you a member of the Extended Health Care Plan? ☐ Yes ☐ No

7. If claim is for denture, crown or bridge, is this an initial placement? ☐ Yes ☐ No

If no, give date of prior placement and reason for replacement.

8. Is this claim being made for Worker's Compensation Benefits? ☐ Yes ☐ No

Language Preference ☐ English ☐ French

At Great-West Life, we recognize and respect the importance of privacy. Personal information that we collect will be used for the purposes of assessing your claim and administering the group benefits plan. 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 Great-West Life's Chief Compliance Officer or refer to www.greatwestlife.com.

I authorize Great-West 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 Great-West Life, located within or outside Canada, to exchange personal information when necessary for these purposes. I understand that personal information may be subject to disclosure to those authorized under applicable law within or outside Canada. I certify that the information given is true, correct, and complete to the best of my knowledge.

Employee's Signature _____ Date _____

THE Great-West Life ASSURANCE COMPANY

CANADA POST CORPORATION
STATEMENT OF CLAIM
OUT-OF-COUNTRY EXPENSES

Great-West Life
your Benefits Solutions People

Please fully complete both sides of this form. Please Print. When submitting, be sure to attach the required provincial forms available by visiting www.greatwestlife.com or calling our client services at 1.866.716.1313.

All claims under the group benefit plan are submitted through the plan member. We may exchange personal information about claims with the plan member and person acting on his or her behalf when necessary to confirm eligibility and to mutually manage the claims.

Benefits for medical expenses incurred outside of Canada are subject to the coverage limitations in your group insurance plan, as well as payment by your provincial health plan and coordinate benefits with other insurance carriers. Completion of these claim forms will allow us to pay eligible claims and coordinate benefits for your out-of-country medical expenses directly with your other insurance carriers on your behalf.

Your claim cannot be considered unless the above mentioned forms have been completed and returned to us along with all your original receipts. Please return all required forms to Great-West Life, Attention: Out-of-Country Claims Department, P.O. Box 6000, Winnipeg, Manitoba, Canada R3C 3A5. Your receipts will be retained by Great-West Life. In-Canada expenses should be claimed separately. If you have any questions, please contact Great-West Life directly at 1.866.716.1313 and ask to speak to the client service representative in the Out-of-Country Claims Department.

GENERAL INFORMATION

Plan Name CANADA POST CORPORATION

Plan Number _____ I.D. Number _____

Name of Employee _____

Complete Mailing Address _____

_____ Phone Number _____

I authorize the release of any information or record(s) requested in respect of this claim to Great-West Life or its agents and certify that the information given herein is true, correct, and complete to the best of my knowledge.

Employee's Signature _____ Date _____

At Great-West Life, we recognize and respect the importance of privacy. Personal information that we collect will be used for the purposes of assessing your claim and administering the group benefits plan. 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 Great-West Life's Chief Compliance Officer or refer to www.greatwestlife.com.

I authorize Great-West 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 Great-West Life, located within or outside Canada, to exchange personal information when necessary for these purposes. I understand that personal information may be subject to disclosure to those authorized under applicable law within or outside Canada. I certify that the information given is true, correct, and complete to the best of my knowledge.

PATIENT INFORMATION

Name of Patient _____ Birthdate _____

Relationship to Employee _____ Purpose for Travelling _____

Date of Departure _____ Scheduled Return Date _____

Actual Return Date _____ Country Visited _____ Currency Used _____

Please provide a brief description of the illness/injury which required treatment outside Canada:

_____

_____

_____

_____

Date of initial onset of symptoms _____ 1st date you received medical attention for these symptoms _____

Prior to leaving Canada, was the patient aware of, or receiving treatment for this condition? ☐ Yes ☐ No

If yes, what was the last treatment date in Canada? _____

I authorize Great-West Life to make payment directly to the providers of the service.

Employee's Signature _____

STATEMENT OF EXPENSES

Total number of invoices/bills included with this claim _____

Please itemize the expenses below. Attach a separate page if additional space is needed.

DATE	PROVIDER	AMOUNT
	TOTAL DOLLAR VALUE OF BILLS SUBMITTED	$ 0.00

STATEMENT OF OTHER INSURANCE

Are you or any other member of your immediate family entitled to travel and/or medical insurance benefits under any other policy, including other group coverage through employment, individual/private travel plans, or credit card plans.

☐ **YES** ☐ **NO**

If Yes, please provide the following information:

Type of other Coverage: (group, individual, credit card)		**Name and phone number of Other Carrier:**	
Policy or Plan Number:		**I.D. Number:**	

Have you sent a claim and/or otherwise contacted the other carrier about this claim? ☐ **YES** ☐ **NO**

Please sign the following statement if you have other insurance. This allows us to coordinate the payment of your claim with other insurance carriers. This statement must be signed before any benefits can be paid.

*I*_____*hereby authorize Great-West Life and it's agents to*
(signature)

coordinate the payment of benefits with any other insurance carriers which may also have a liability for this claim. I hereby irrevocably direct Great-West Life to make payments, receive payments, and negotiate settlements with providers and other carriers on the patient's behalf.

I further authorize Great-West Life to release and/or receive medical information from providers and other carriers to facilitate the payment and coordination of this claim.

CANADA POST / POSTES CANADA

CLAIM FORM
EXTENDED HEALTH CARE/PRESCRIPTION DRUG PLAN (51391)
VISION & HEARING CARE PLAN (51392)

THE Great-West Life ASSURANCE COMPANY

INSTRUCTIONS: Attach the bills and receipts for all expenses and itemize them by providing all the information requested.
Note: Drug bills and receipts, other than those required for government drug plans, are part of our records and will not be returned. Therefore, please retain the itemization of expenses that will accompany our cheque or explanation for Income Tax purposes.

IMPORTANT: Please answer all questions. This claim will be returned to you if it is incomplete or contains errors.
All claims under this group benefits plan are submitted through the employee. We may exchange personal information about claims with the employee and a person acting on his or her behalf when necessary to confirm eligibility and to mutually manage the claims.

Please print

EMPLOYEE'S STATEMENT

Last Name | First Name | Date of Birth (Year / Month / Day) | Employee ID No.

Address | City | Province | Postal Code

Phone Number
HOME: ( ) WORK: ( )

Language Preference
☐ English ☐ French

COORDINATION OF BENEFITS

- Are you or any other member of your family entitled to benefits under any other health care plan? ☐ Yes ☐ No
  If "Yes", name of family member insured _____
  Relationship to employee _____ Spouse's date of birth ____/____ (Month / Day)
  Name of other insurance company _____
  Policy Number _____ I.D. Number _____
- Is any member of your family (other than yourself) entitled to benefits as an employee under the Vision and Hearing Care Plan (51392)? ☐ Yes ☐ No
  I.D. Number _____
- Is treatment required as the result of an accident? ☐ Yes ☐ No
  If "Yes", give date, location and explain how accident happened
  _____
- Is a claim being made for Worker's Compensation Benefits? ☐ Yes ☐ No

INSTRUCTIONS

Send form to Great-West Life:

QUEBEC RESIDENTS, OTHER THAN NATIONAL CAPITAL REGION RESIDENTS:
Montreal Benefit Payments
Place Bonaventure
Suite 5800
800 de la Gauchetière St. W
Montreal QC H5A 1B9

FOR ALL OTHER RESIDENTS:
Winnipeg Benefit Payments
P.O. Box 3050
Winnipeg MB R3C 0E6

1.866.716.1313
TTY line - available for the deaf or hard of hearing
Toll Free: 1.800.990.6654

DEPENDENT INFORMATION

Patient Name	Relationship to Employee	Date of Birth (Year / Mth / Day)	If child is 21 years of age or older: Full-Time Student? YES NO	With a Disability? YES NO
			☐ ☐	☐ ☐
			☐ ☐	☐ ☐
			☐ ☐	☐ ☐
			☐ ☐	☐ ☐
			☐ ☐	☐ ☐

CLAIM DETAILS

Patient Name	Type of Expense	Total Charge

(IF ADDITIONAL SPACE IS NEEDED, ATTACH SEPARATE PAGE)

PLEASE KEEP A COPY OF THIS FORM, RECEIPTS AND ANY OTHER RELEVANT DOCUMENTATION FOR YOUR RECORDS

EMPLOYEE'S AUTHORIZATION

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I authorize Great-West 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 Great-West Life, located within or outside Canada, to exchange personal information when necessary for these purposes. I understand that personal information may be subject to disclosure to those authorized under applicable law within or outside Canada. I certify that the information given is true, correct, and complete to the best of my knowledge.

Employee's Signature _____ Date _____

Canada Post Corporation / Société canadienne des postes
DENTAL CARE PLAN (51057) /
REGIME DE SOINS DENTAIRES (51057)

Application for Coverage (Employee) / Demande de protection (employé)

☐ Initial Application / Demande initiale ☐ Amendment / Modification ☐ Reinstatement / Remise en vigueur

To be completed by the employee / À remplir par l'employé

1. Last Name / Nom	2. First Name / Prénom	3. Employee ID Number / N° d'identification de l'employé

4. Date of Birth / Date de naissance	5. Province of Residence / Province de résidence	6. Gender / Sexe
Y/A M/M D/J		☐ Male / Homme ☐ Female / Femme

7. Persons to be covered / Personnes à couvrir ☐ Single / Protection individuelle ☐ Family / Protection familiale

8. Coverage for extended residency outside Canada / Protection pour séjour prolongé hors du Canada ☐ No / Non ☐ Yes / Oui — Date departed Canada / Date du départ vers l'étranger Y/A M/M D/J

9. Date Family Status Changed (Please give reason) / Date du changement de la situation familiale (indiquer la raison) Y/A M/M D/J — Reason / Raison

PRIVACY / CONFIDENTIALITÉ

Protecting Your Personal Information

At **The Great-West Life Assurance Company (Great-West Life)**, we recognize and respect the importance of privacy. When you apply for coverage, we establish a confidential file that is kept in the offices of Great-West Life or the offices of an organization authorized by Great-West Life. We limit access to personal information in your file to Great-West Life staff or persons authorized by Great-West Life who require it to perform their duties, to persons to whom you have granted access, and to persons authorized by law. We use the personal information to determine your eligibility for coverage and to administer the group benefits plan.

Protection de vos renseignements personnels

À La Great-West, compagnie d'assurance-vie (la Great-West), nous reconnaissons et nous respectons l'importance de la protection de la vie privée. Lorsque vous présentez une demande d'assurance, nous constituons un dossier confidentiel qui est conservé dans les bureaux de la Great-West ou dans ceux d'une organisation autorisée par cette dernière. Nous limitons l'accès aux renseignements personnels consignés à votre dossier aux membres du personnel de la Great-West ou aux personnes autorisées par cette dernière qui en ont besoin pour s'acquitter de leurs tâches, aux personnes à qui vous avez accordé un droit d'accès et aux personnes autorisées en vertu de la loi. Nous nous servons de ces renseignements personnels pour déterminer votre admissibilité à la protection et pour administrer le régime collectif.

AUTHORIZATIONS AND DECLARATIONS / AUTORISATIONS ET DÉCLARATIONS

Authorizations and Declarations

I hereby apply for coverage under the Canada Post Corporation's Dental Care Plan.

I authorize:

- my plan sponsor to deduct from my pay the plan member contributions required under the plan if applicable;
- Great-West 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 Great-West Life to exchange personal information, when necessary to determine my eligibility for coverage and to administer the plan.

If applying for coverage for my spouse and/or dependants, I confirm that I am authorized to act on their behalf.

I agree that a photocopy or electronic copy of this Authorization 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.

Autorisations et déclarations

Par la présente, je demande la protection aux termes du Régime de soins dentaires de la Société canadienne des postes.

J'autorise

- le titulaire de régime à déduire de ma rémunération les cotisations salariales requises aux termes de régime, s'il y a lieu;
- la Great-West, tout fournisseur de soins de santé, le gestionnaire de mon régime, toute autre compagnie d'assurance ou de réassurance, les administrateurs des programmes d'État ou de tout autre programme d'avantages sociaux, toute organisation ou tout fournisseur de soins travaillant avec la Great-West à échanger les renseignements personnels nécessaires, au besoin, afin de déterminer mon admissibilité à la protection et d'administrer le régime.

Si je demande la protection pour mon conjoint ou mes personnes à charge, je confirme que je suis autorisé à agir en leur nom.

Je confirme qu'une photocopie ou une copie sous forme électronique de la présente section Autorisations et déclarations est aussi valide que l'original.

J'atteste que les renseignements donnés sont à ma connaissance véridiques, corrects et complets.

Employee Signature / Signature de l'employé : _____ Date: Y/A M/M D/J

To be completed by Human Performance Management (HPM) / À compléter par Gestion du rendement des employés (GRE)

10. Employee ID Number / N° d'identification de l'employé	11. Effective Date of Eligibility / Date du début d'admissibilité Y/A M/M D/J	12. Date Application Received / Date de réception de la demande Y/A M/M D/J

13. Coverage Commence or Change / Prise d'effet ou modification des protections Y/A M/M D/J	14. Date System Updated / Date de mise à jour du système Y/A M/M D/J

15. **Certification of Eligibility / Certification d'admissibilité**
The employee named herein is eligible to apply for Dental Care Plan coverage.
L'employé susmentionné est admissible aux protections aux termes du Régime de soins dentaires.

Authorized Signature / Signature autorisée _____ (HPM / GRE) Date Y/A M/M D/J

White / Blanc (HPM/GRE)
Canary / Jaune canari (Employee / Employé)

DEPENDENT INFORMATION

☐ Active (51391, 51057, 51392) ☐ Retirees (51391)

Please complete the information below and return to Great-West Life.
If not received, your dependent claims will not be processed.

THE Great-West Life ASSURANCE COMPANY

EMPLOYEE/RETIREE INFORMATION

YOUR NAME LAST	FIRST	EMPLOYEE ID NUMBER	DATE OF BIRTH YEAR MONTH DAY

Home Address: Street _____

City _____ Province _____ Postal Code _____ Home Tel. (Area Code) _____

CHECK REASON FOR USE: ☐ New enrollment ☐ Change in status

If change in status, please complete the following information

Effective date of change _____

Reason for change in status
- ☐ Name change
- ☐ Add dependent(s)/reason _____
- ☐ Delete dependent(s)/reason _____
- ☐ Change in spouse's other coverage

SPOUSAL INFORMATION

SPOUSE'S NAME LAST	FIRST	DATE OF BIRTH YEAR MONTH DAY

Does your spouse have any of the following coverage through his/her employer? ☐ Yes ☐ No

			Insurer	Group Number	Identification Number
• Extended Health Care	☐ Single	☐ Family			
• Vision/Hearing Care	☐ Single	☐ Family			
• Dental Care	☐ Single	☐ Family			

INFORMATION ON UNMARRIED DEPENDENT CHILDREN

LAST NAME FIRST	DATE OF BIRTH YEAR MONTH DAY	FULL-TIME STUDENT (to age 25)	DISABLED
		☐ Yes ☐ No	☐ Yes ☐ No
		☐ Yes ☐ No	☐ Yes ☐ No
		☐ Yes ☐ No	☐ Yes ☐ No
		☐ Yes ☐ No	☐ Yes ☐ No
		☐ Yes ☐ No	☐ Yes ☐ No

If more children, please use a separate sheet.

NOTE: Canadian Life & Health Insurance Association (CLHIA) regulations state:

1. A spouse must first submit his/her own claims to his/her own employer's plan
2. Claims for the covered children must first be submitted to the plan covering the parent with the earlier date of birth in the year. If both parents are born in the same month, the earlier day is used.

I HEREBY CERTIFY THAT, TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS TRUE AND CORRECT.
I UNDERSTAND THAT I MAY BE REQUIRED TO PROVIDE PROOF OF EVIDENCE REGARDING THE ABOVE INFORMATION.

Your Signature _____ Date _____

INSTRUCTIONS

MAIL COMPLETED FORM TO:

THE GREAT-WEST LIFE ASSURANCE COMPANY
Member Administration
P.O. Box 6000, Station Main
Winnipeg, MB
R3C 9Z9

You must complete a new Dependent Information form each time there is a change in your family status i.e. marriage, birth of a child, coordination of benefit changes and student status.
For any questions or forms, contact your local Payroll and Benefits Office.