LiUNA!care LOCAL 183
BUILDING HEALTHY FUTURES

DENTAL APPLICATION / WITHDRAW FORM

Send to: LiUNAcare Local 183 | 2100 - 200 Labourers Way | Vaughan, ON L4H 5H9
P: 416.240.7487 | F: 416.240.7488 | w: www.liunacare183.com | e: info@liunacare183.com

☐ Application

I wish to participate in the Local 183 Dental Clinic. I understand that I am registering myself and my eligible dependents and that all claims incurred outside of the dental clinic for myself and/or my eligible dependents will be my responsibility and will not be covered by the Insured Plan. I will be responsible for any expenses incurred outside of the Dental Clinic prior to joining the clinic. I understand that I must remain a member of the Local 183 Dental Clinic for a period of 6 months from the date signed on this application. I further understand that I must withdraw from the Local 183 Dental Clinic before I can use an outside dentist. I acknowledge and understand the above and that it has been explained to me by the LiUNAcare Local 183 staff.

_____ Member's Initials

☐ Withdraw

I wish to withdraw my participation from the Local 183 Dental Clinic and I hereby authorize and direct you to do all things necessary on my behalf for this purpose. I also authorize you to release my dental records as required. I acknowledge and understand the above and that it has been explained to me by the LiUNAcare Local 183 staff.

Reason for Withdrawal: _____

_____

_____

_____ Member's Initials

A Member Information (*Please Print*)

Last Name First Name	Gender ☐ Male ☐ Female
Address	Date of Birth (yyyy/mm/dd)
Town/ City Prov. Postal Code	Country
Member Advantage Benefit Card ID Number (last 10 digits)	*Social Insurance Number (SIN) - ONLY if no Member Advantage Benefit Card ID*
Email Address	Phone #
Marital Status ☐ Married ☐ Common-Law ☐ Single ☐ Separated ☐ Divorced ☐ Widow	Cell #

B Dependent Information

In the boxes below, please list the relationship status, name and birth of all individuals

Name of Dependent	Relationship to Member (spouse, child etc.)	Birth Date Day	Month	Year	Address

C Disclosure Member Authorization

Member Signature: _____ Date: _____

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Amount Incurred under Dental Plan to date: _____

Effective Date: _____

Administrator Signature: _____ Date: _____