APPLICATION FOR DENTAL PLAN COVERAGE

1. PLEASE PRINT CLEARLY – APPLICANT INFORMATION

First Name(s) | Initials | Last Name

Address – Street/Apt.

City/Town | Province | Postal Code

Sex
☐ Male
☐ Female

Daytime Telephone Number
Area Code | Pension Number | Date of Birth Day Month Year

Provincial Health (Personal) Plan No. | E-mail Address

2. COVERAGE SELECTION

I would like to apply for coverage for the ☐ SINGLE or ☐ COUPLE or ☐ FAMILY plan.

3. PLAN TRANSFER FROM OTHER GROUP INSURANCE (OR SPOUSE'S PLAN)

If you are transferring from another group insurance plan, please complete.

Insurance Company	Policy Number	Termination Date

4. COUPLE/FAMILY INFORMATION

If you have selected couple or family coverage, please complete the following.

	FIRST NAME	LAST NAME	SEX M/F	PROVINCIAL HEALTH INSURANCE PLAN NUMBER	DATE OF BIRTH D M Y	IF CHILDREN OVER 21 INDICATE IF FULL-TIME STUDENT OR HANDICAPPED
SPOUSE					/ /	
DEPENDENT						
DEPENDENT						
DEPENDENT						

IMPORTANT – YOU MUST COMPLETE AND SIGN SECTION 5 ON THE REVERSE FOR COVERAGE TO BE IN FORCE

5. **I HEREBY CERTIFY THAT I AM A MEMBER IN GOOD STANDING OF RTAM AND MY ELIGIBILITY CEASES UPON TERMINATION OF MY RTAM MEMBERSHIP.**

I further authorize that my premium for this insurance, including any mid policy year adjustments, arrears and renewals, be deducted in monthly amounts due on or after this date of application. I understand that my policy will be automatically cancelled should Johnson Inc. receive two or more Non Sufficient Funds (NSF) notices on my account. I understand coverage will begin on the day Johnson Inc. receives my completed enrollment information. I also understand that unless I advise Johnson Inc. in writing to the contrary, the coverage I have selected will remain in effect for each policy year thereafter. Johnson Inc. will provide me with notification of my renewal before the beginning of each subsequent policy year, which is September 1.

Check Appropriate Box:

☐ **I am an RTAM Member**. I am in receipt of a TRAF, Pension (No. _______________ found on the top right corner of any letter from TRAF) and hereby authorize the Teachers' Retirement Allowances Fund (TRAF) to deduct from my pension payment the amount of my insurance premium (including mid-term adjustments and arrears) payable to **Johnson Inc.**

☐ **I am an RTAM Member.** I am not in receipt of a TRAF pension. I have enclosed a **sample cheque marked "VOID".** I authorize Johnson Inc., the plan administrator, to make monthly deductions (including mid-term adjustments and arrears) from the bank, trust company or credit union account shown on the cheque.

____________________	____________________
Signature of Applicant	**Date**
____________________	____________________
Signature of Spouse (if family or single spousal coverage selected)	**Date**

Privacy Statement

The Federal and Provincial Governments recently enacted legislation to protect the personal information of Canadians. RTAM has devised this statement to inform you of the steps taken to comply with the legislation. Maritime Life or Johnson Inc. may use your personal information for the following purpose:

They may collect personal and other information about you to provide your requested coverage and services to process claims. The primary sources of information are you, RTAM, and your medical advisors. To administer and otherwise provide you the coverage and services requested, they may collect information from individuals, groups, or companies from whom collection is necessary.

Please return the completed application form to Johnson Inc. at the address below. All inquiries about the application, policies, authorization for premium deductions or any written notice of change or cancellation are also to be directed to Johnson Inc.

Johnson Inc.
Plan Benefits Service
#301 West Chambers Bldg.
12220 Stony Plain Road
Edmonton, Alberta T5N 3Y4
Toll-free 1-877-989-2600