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PROTECTED once completed

PENSIONERS' DENTAL SERVICES PLAN (PDSP)
PDSP COVERAGE ACTIVATION FORM

- Use this form only if you **previously deferred** (postponed) coverage under the PDSP for yourself and/or your eligible family member(s) and you now wish to **activate** coverage under the PDSP.
- Note that coverage will be effective on the first day of the second month after the Plan Administrator receives this form, duly completed.
- Please print clearly. **Parts A, B, C, D, and F must be completed**.
  If you have any questions, please call (613) 247-5100. (In North America, the toll-free number is 1-888-757-7427)

Mail the completed form to: **Sun Life Assurance Company of Canada**
Coverage Unit - Dental
PO Box 9805 CSC-T
Ottawa ON K1G 6M6

Part A - Member Information

First and Last Name	Mailing Address (Street number and name)		Apt. no.
City/Town	Province/State	Country	Postal/Zip code
Telephone Number	Date of Birth (Year, Month, Day)	Pension Number	Your PDSP Certificate Number

Part B - Information About Eligible Family Member(s) To Be Covered

	First and Last Name	Relationship to you	Date of Birth (Year, Month, Day)
1.			
2.			

If you are activating coverage for more than two eligible family members, please attach a separate piece of paper with their names and birth dates.

Part C - Other Dental Coverage

Note that if you are activating PDSP coverage for either yourself and/or your eligible family member(s) due to the termination of coverage under another dental plan, you must apply for PDSP coverage no later than 60 days after the other coverage has ended.

Please indicate either:

☐ Date that coverage under other dental plan has ended or will end: ____________________

OR

☐ Coverage continues under dental plan specified below:

Name of Insurer/Administrator	Contract or Policy Number	Certificate Number

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Part D - Category of Coverage

If you are currently a member of the PDSP and you are activating coverage for your eligible family member(s), you must select either Category II or Category III below.

I and any family members listed above meet the eligibility requirements for membership in the PDSP (see Part E), and I submit the information in Parts A, B, and C above. I select one Category of Coverage as checked below.

☐ Category I ($16.00 per month) - Pensioner only

☐ Category II ($31.96 per month) - Pensioner and one family member

☐ Category III ($47.96 per month) - Pensioner and more than one family member

Part E - Explanatory Notes

1. The PDSP is summarized for your convenience in the enrolment booklet entitled *Pensioners' Dental Services Plan - Enrolment Information and Plan Summary*. The enrolment booklet does not contain the complete PDSP.
2. A complete copy of the PDSP and the booklet are located on the Treasury Board of Canada Secretariat Web site at the following address: http://www.tbs-sct.gc.ca. They may also be obtained by contacting the Treasury Board of Canada Secretariat Distribution Centre by phone at (613) 995-2855 or by e-mail at Services-Publications@tbs-sct.gc.ca and requesting stock number TBS 006779 for the PDSP and stock number TBS 006796 for the booklet.
3. If you live in the province of Ontario or Quebec, provincial sales tax is added to the contribution rate. If you live in the province of Quebec, Quebec income tax may also be payable on the taxable benefit.

Part F - Signature

This form includes the provisions of the PDSP, including all terms and conditions, as if they were actually printed on this form. When I sign this form and return it to Sun Life Assurance Company of Canada (the Administrator) the form constitutes the agreement between the Government of Canada and me concerning my membership in the PDSP and its application to me. I agree that the provisions of the PDSP and the agreement may be amended by the Government of Canada. The amended PDSP and agreement will then apply as if they were actually printed on the form. I understand that I can terminate my membership in the PDSP only after two complete calendar years of membership. If applicable, I authorize monthly deductions from my pension in the amount of contributions required together with any tax that applies.

X ________________________________ ______________

Your Signature **Date**

Provision of the information requested on this form is voluntary. This information is collected for the purpose of applying the PDSP Rules and is essential to providing the coverage you have requested. By providing the information, you authorize the Plan Administrator to use it, and to communicate it to, and verify it with, any government department or agency, and you authorize such government department or agency to give the Plan Administrator such and any related information for the purposes of verifying the information provided in this form, of completing your enrolment in the PDSP, and of administering the PDSP only. Refusal to respond may result in an improper application of the PDSP, which could be to your detriment. This information will be stored under Personal Information Bank Number PWGSC PCE 702. It is protected from disclosure to unauthorized persons or agencies pursuant to provisions of the Privacy Act. Under the Act, you have the right to request access to your personal information and request corrections should you believe that the information contains errors or omissions.

Ce formulaire est aussi disponible en français sous le titre «Formulaire d'activation de la protection du RSDP».