THE Great-West Life ASSURANCE COMPANY

The Public Service Dental Care Plan is administered by The Great-West Life Assurance Company on behalf of the Government of Canada.

PUBLIC SERVICE DENTAL CARE PLAN

AUTHORIZATION FOR CLAIMS SUBMISSION AND RE-DIRECTION OF PAYMENT

POLICY STATEMENT

Under the Public Service Dental Care Plan (PSDCP) rules, a member may re-direct payment of one or more claims to the member's spouse or common-law partner. The Employer and the Plan Administrator have agreed, in the interest of proper plan administration, to allow a plan member to authorize a spouse or common-law partner to submit dental claims on a member's behalf when the claims are in respect of dental treatment or services for the member's spouse or common-law partner or eligible covered child(ren). Further, in situations where the member's eligible child(ren) are not in the care and custody of the member, the member may authorize the person having care and custody of the eligible covered child(ren) to file claims and receive claims' reimbursement in respect of dental treatment or services for the member's eligible covered child(ren).

The member may ask that this authorization be rescinded by writing to the Plan Administrator.

AUTHORIZATION

By this document, I _____ , a member of the
(Name)
Public Service Dental Care Plan, authorize the following:

☐ I authorize _____, who is
(Name)

- ☐ my spouse
- ☐ my common-law partner
- ☐ the person having care and custody of my eligible covered child(ren)

to submit, on my behalf, dental claims for services and treatments in respect of my spouse/common-law partner/eligible covered child(ren) to the Plan Administrator, The Great-West Life Assurance Company;

AND/OR

☐ I authorize the Plan Administrator to direct benefit payments under the Public Service Dental Care Plan with respect to services and treatments for my spouse/common-law partner/eligible covered child(ren) to

_____ , who is
(Name)

- ☐ my spouse
- ☐ my common-law partner
- ☐ the person having care and custody of my eligible covered child(ren)

(Include name and address on page 2 of this document.)

My eligible covered child(ren) are:

1. _____ _____
(Child's Name) (Date of Birth)

2. _____ _____
(Child's Name) (Date of Birth)

3. _____ _____
(Child's Name) (Date of Birth)

4. _____ _____
(Child's Name) (Date of Birth)

This authorization will remain in force until I rescind it, which I may do at any time by advising the Plan Administrator in writing of my intention. I understand that in any instance where I assign benefits to a dentist who has provided services to my spouse, common-law partner or eligible child(ren), that assignment will take precedence over this authorization.

Signature of Member: _____ Date _____

PSDCP Plan Number: _____ Certificate Number: _____

Please re-direct payment to:

Name: _____

Address: _____

_____

Telephone: (_____) _____

Note: Please ensure that the Plan Administrator has the most current address of the person to whom payment is being re-directed.

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