DEPENDENT ENROLMENT FORM

Member information:

Access Card ID: _____

Member's First Name _____ Member's Last Name _____

Dependent information:

PLEASE PRINT CLEARLY – BLACK INK PREFERRED.

First Name	Last Name	Birthdate yyyy/mm/dd	Relationship to member **S** = Spouse or spousal equivalent **C** = Child under 25 years

I certify that the information given is true and complete. I consent to the use of my information according to the Privacy Policy on www.equitydental.ca.

Member's Signature _____ Date _____

Once we receive your completed form, we will mail your updated Equity Dental Network access card to your address on file with the Canadian Actors' Equity Association. Please allow 2-3 weeks for processing.

Please mail this form to Equity Dental Network c/o Future Focus Dental Plans, 5700 Yonge Street, Suite 200, Toronto, ON M2M 4K2

Questions? Call (416) 920-5252 or 1-855-920-5252, or email us at memberservices@equitydental.ca Website: www.equitydental.ca