Canadian Dental Care Plan Member Eligibility Review Form

Verification of Access to Dental Insurance or Coverage Form (for Employers or Pension Plan Administrators)

For Canadian Dental Care Plan members:

Your employer or pension plan administrator can complete this form to provide information related to the status of your access to dental insurance or coverage. This information helps us verify if you are eligible for the Canadian Dental Care Plan (CDCP).

For employers or pension plan administrators:

When you filled out the *T4 Statement of Remuneration Paid* or *T4A Statement of Pension, Retirement, Annuity and Other Income* for the previous tax year, you reported that you provided access to dental insurance or coverage for dental services to this individual as of December 31. We need to verify this information.

Please complete this form to confirm if this individual has access to dental insurance or coverage through your organization or pension plan. This information will be used to verify their eligibility under the CDCP. All fields are mandatory; please ensure that no sections are left blank.

Note: We may contact you to further validate the information provided below.

Completion by Member		
Member Information		
First Name:	Last Name:	
CDCP Member ID (if applicable):		
Employer or Pension Plan Administrator Information		
Company/Pension Name:		
Name of Representative Completing Form:		
Title:		
Business Address:		
City:	Province :	Postal code (A1A 1A1):
Phone number (999) 999-9999:	Email Address:	

Completion by Employer or Pension Plan Administrator

Details related to the access of dental insurance or coverage

Note: "Access" refers to any type of dental insurance being offered or available to the individual, regardless of whether they choose to enroll in it, use it, or have to pay a premium for it.

Please select the option(s) below that correspond to the individual's current situation:

Has access:

- ☐ The individual has **access to** dental insurance or coverage of dental services that you offer.
- ☐ The individual, their spouse or common-law partner, and their dependant(s) have **access to** dental insurance or coverage of dental services that you offer.
- ☐ The individual and their spouse or common-law partner have **access to** dental insurance or coverage of dental services that you offer.
- ☐ The individual and their dependant(s) have **access to** dental insurance or coverage of dental services that you offer.

Does not have access:

- ☐ The individual is **no longer an employee** as of this date (YYYY-MM-DD) _____ .
- ☐ The individual **has retired** as of this date (YYYY-MM-DD) _____ and no longer has access to dental insurance or coverage of dental services that you offer.
- ☐ You **do not offer access** to dental insurance or coverage of dental services as of this date (YYYY-MM-DD) _____.
- ☐ The individual **no longer meets the age requirements** of your organization's dental insurance or coverage.
- ☐ The individual does not meet the work requirements (for example, the individual is a casual or part-time employee) and does not have access to dental insurance or coverage of dental services that you offer.
- ☐ The individual has **opted out of the dental insurance** or coverage of dental services that you offer prior to December 11, 2023, and **cannot** opt back in.
- ☐ **Other**

If you selected "Other," please provide details about the individual's access to dental insurance, including coverage for their spouse or common-law partner and dependant(s) (if applicable), to help us verify eligibility for the CDCP.

Employer or pension plan administrator representative signature:	Date (YYYY-MM-DD)
Name (Printed):	
Phone number (999) 999-9999:	
E-mail:	