Ontario

Ministry of Health
Ontario Seniors Dental Care Program
Station P, PO Box 159
Toronto ON M5S 2S7

Ontario Seniors Dental Care Program
Authorizing or Cancelling a Representative

Instructions

Submit the completed form to the address shown above. Print clearly using black or blue ink.

For more information, please visit www.ontario.ca/seniorsdental. If you have additional questions, please contact the **Program**: 416-916-0204 **Toll-free**: 1-833-207-4435 **TTY toll-free**: 1-800-855-0511.

Fields marked with an asterisk (*) are mandatory. Complete all required information to avoid processing delays.

Please check one of the following *

☐ Authorize a representative, as shown in Section 2 below. An authorization is valid until the applicant cancels it.

☐ Cancel the existing authorization of the representative shown in Section 2 below.

1. Applicant Information – Tell Us About You

Last Name *	First Name *	Middle Name

Preferred Name

Date of Birth * (yyyy/mm/dd)	Dental Card Number *

Residential Address

Unit Number	Street Number *	Street Name *	PO Box

City/Town *	Province *	Postal Code *

2. Representative Information

Complete this section to authorize or cancel a representative to deal with Program registration and eligibility matters.

Last Name *	First Name *

Residential Address

Unit Number	Street Number *	Street Name *	PO Box

City/Town *	Province *	Postal Code *

Telephone Number *	Alternative Telephone Number ext.

Applicable year(s) for which this applies *

☐ All benefit years

☐ Only the benefit year indicated here

year

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3. Authorization

This section requires the applicant to sign the consent.

I authorize the Ministry of Health to collect personal information from, and disclose my personal information to, the above stated representative, in matters pertaining to the Ontario Seniors Dental Care Program registration and eligibility (except where my signature is required).

or

I cancel the authorization that was previously given, as selected above; and I consent to the use and sharing of my personal information as set out below.

Signature of Applicant	Date (yyyy/mm/dd)

4. Acceptance of Authorization

This section requires the representative to sign the consent.

I accept the above authorization and consent to the use and sharing of my personal information as set out below.

Signature of Representative	Date (yyyy/mm/dd)

Notice of Collection: The information collected in this form will be used by the Ministry of Health for the purpose of administering the Ontario Seniors Dental Care Program. For more information about this collection, please contact the Director, Health Promotion and Prevention Policy and Programs Branch, Ministry of Health, 393 University Avenue, 18th Floor,
Toronto ON M5G 1E6 or call 416-314-2257.

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