Ontario

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

# Ontario Seniors Dental Care Program
# Change of Information

## 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.

## 1. Type of Information Change

Indicate what change(s) you want to make in the check boxes below. *

☐ Correct existing applicant information (complete Sections 2, 3 and 8)

☐ Change contact information (complete Sections 2, 4 and 8)

☐ Change of marital status and/or spousal information (complete Sections 2, 5, 8, and 9 if adding a spouse)

☐ Change of Income Declaration (complete Sections 2, 6 and 8)

☐ Withdraw consent to disclose personal information and/or personal health information (complete Sections 2, 7 and 8)

## 2. Existing Applicant Information

Please complete this section with the applicant information. This information is mandatory for your Change of Information Form to be processed.

| Last Name * | First Name * | Middle Name |
|---|---|---|
| | | |

Preferred Name

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

## 3. Correction of Applicant Information

Complete if you need to correct applicant details on the account.

| Last Name | First Name | Middle Name |
|---|---|---|
| | | |

Preferred Name

| Date of Birth (yyyy/mm/dd) | Social Insurance Number or Temporary Taxation Number |
|---|---|
| | |

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## 4. Change of Contact Information

Complete to change the address or the phone number on the account.

| Telephone Number | Alternative Telephone Number ext. |
|---|---|
| | |

**Residential Address**

| Unit Number | Street Number | Street Name | PO Box |
|---|---|---|---|
| | | | |

| City/Town | Province | Postal Code |
|---|---|---|
| | Ontario | |

☐Select if your Residential Address differs from your Mailing Address

**Mailing Address**

| Unit Number | Street Number | Street Name | PO Box |
|---|---|---|---|
| | | | |

| City/Town | Province | Postal Code |
|---|---|---|
| | Ontario | |

## 5. Change of Marital Status and/or Spousal Information

Complete to add or remove a spouse or common law partner on the Program account.

**Marital Status**

☐Married/Common Law ☐Single ☐Separated

☐Divorced ☐Widowed

**Spousal Information**

☐Add/Change Spouse/Common Law Partner

☐Remove Spouse/Common Law Partner

| Last Name | First Name | Middle Name |
|---|---|---|
| | | |

| Date of Birth (yyyy/mm/dd) | Social Insurance Number or Temporary Taxation Number |
|---|---|
| | |

Note: If you are adding a spouse/common-law partner to your account, your spouse/common law partner must complete Section 9 of this form.

## 6. Change of Income Declaration

Complete if you no longer meet the financial eligibility criteria of the Program.

☐Yes, I confirm that my income no longer meets the financial eligibility requirements as indicated at: www.ontario.ca/seniorsdental

Note: If yes, you will no longer be eligible for dental benefits under the Program.

## 7. Withdraw Consent to Disclose Personal Information and/or Personal Health Information

**Withdraw Consent to Disclose Personal Information:**

Complete if you and/or your spouse no longer consent to have the Ministry of Finance verify your tax information with the Canada Revenue Agency to determine eligibility for the Ontario Seniors Dental Care Program.

**Applicant**

☐I withdraw consent to disclose my tax information to the Ministry of Finance.

| Signature of Applicant | Date (yyyy/mm/dd) |
|---|---|
| | |

**Spouse/Common Law Partner**

☐ I withdraw consent to disclose my tax information to the Ministry of Finance.

| Signature of Spouse/Common Law Partner | Date (yyyy/mm/dd) |
|---|---|
| | |

**Note**: By withdrawing your consent, we can no longer verify your income eligibility and you will no longer be eligible to receive dental services under the Program.

**Withdraw Consent to Disclose Personal Health Information:**

Complete if you and/or your spouse no longer consent to have the Ministry of Health collect personal health information for program administration and evaluation purposes for the Ontario Seniors Dental Care Program.

**Applicant**

☐ I withdraw consent to disclose my personal health information to the Ministry of Health.

| Signature of Applicant | Date (yyyy/mm/dd) |
|---|---|
| | |

**Note**: By withdrawing your consent, we can no longer administer the program and you will no longer be eligible to receive dental services under the Program.

## 8. Declaration

This section requires the applicant to sign the Declaration.

I declare that all information provided on this Change of Information Form is accurate and complete and that I have not misrepresented information about myself. I declare that I understand that the Ontario Ministry of Health will keep this Change of Information Form on record for the purpose of updating information on my account. I understand that unless a change of address is indicated in Section 4, the address provided on my original Application Form will be the address used for correspondence. I understand that eligibility for the Program is dependent on compliance with the Terms and Conditions for the Program.

| Signature of Applicant | 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 Program. For more information about this collection, please contact the Ontario Seniors Dental Care Program, Ministry of Health, Station P, PO Box 159, Toronto, ON, M5S 2S7 or call 1-833-207-4435.

## 9. Spouse's Consent for the Collection, Use and Disclosure of Personal Information

**I consent to:**

1. The collection of the information that I provide on this form by the Ministry of Health and the Program Administrator (who collects on behalf of the Ministry of Health) for the purpose of administering the Program, including determining my spouse's eligibility.
2. The disclosure of the information that I provide on this form by the Ministry of Health and the Program Administrator to the Ministry of Finance for the purpose of administering the Program, including determining my spouse's eligibility.
3. The disclosure of the information collected in this form by the Ministry of Finance, on behalf of the Ministry of Health, to the Canada Revenue Agency (CRA) for the purpose of enabling the Ministry of Finance and the Ministry of Health to administer the Program, which includes determining my spouse's eligibility under the Program.
4. The disclosure by the CRA to the Ministry of Finance, my income and expense information and related identifying information about me from the CRA tax records, on condition that the information will be used solely by the Ministry of Finance to verify my income and to determine eligibility under the Program. This authorization is valid for the two taxation years immediately preceding the date of application and each subsequent taxation year(s) for which eligibility under the Program is determined.
5. The Ministry of Health, the Program Administrator, and the Ministry of Finance sharing my information that relates to eligibility under the Program with one another, for the purpose of administering and processing my file.

**I understand:**

- That the Ministry of Finance and the Program Administrator will act on behalf of the Ministry of Health to deliver the Program. As part of the administration of the Program, the Ministry of Finance and the Program Administrator will collect, use and disclose my personal information on behalf of the Ministry of Health;
- That the Program Administrator is an agent of the Ministry of Health as defined in the *Personal Health Information Protection Act*, 2004, S.O. 2004, c. 3, Sched. A;
- That the disclosure of my personal information will continue until I withdraw my consent;
- This consent will remain in effect until it is withdrawn, and that if the consent is withdrawn, this will affect eligibility under the Program;
- That I can withdraw my consent at any time by completing the Ontario Seniors Dental Care Program Change of Information Form (5128-20E).

**If you consent to the collection, use and disclosure of your personal information as described on this form, please complete and sign below.**

**I consent to the collection, uses and disclosures of my personal information described on this form.**

I have the legal authority to consent to this disclosure as I am:

☐ Spouse of Program applicant

☐ the Spouse's Legal Representative (including a substitute-decision maker, power of attorney for personal care, or a court appointed guardian of the person). You must attach a copy of the legal document that authorizes you to act on their behalf.

Name of Spouse/Common Law Partner or Legal Representative

| Relationship to Spouse/Common Law Partner | Contact Telephone Number |
|---|---|
| | |

| Signature of Spouse/Common Law Partner or Legal Representative | Date (yyyy/mm/dd) |
|---|---|
| | |