Government of Canada — Gouvernement du Canada

DENTAL CARE PLAN

AUTHORIZATION TO REDIRECT PAYMENT

This form must be completed and submitted with the dental claim each time you wish to redirect payment.

I authorize that the attached claims in the amount of $______________________
be made payable to my spouse/common-law partner, ______________________
who resides at:

Address ____

____

____

Telephone: ____

______________________________ (Member's signature)

______________________________ (Dated)

______________________________ (Member's Identification Number)

______________________________ (Plan Number)

M5103 BIL-2/01