Kenneth Taylor Hall B111, McMaster University
1280 Main Street W., Hamilton, ON L8S 4M4
Phone: (905) 525-9140 ext. 24003
Email: cupe3906@mcmaster.ca
Fax: (905) 525-3837
Website: www.cupe3906.org

CUPE 3906 DENTAL PLAN:
POST-DOCTORAL FELLOW FAMILY COVERAGE ENROLMENT

Please complete the following:

Name (please print):	**CHANGE OF STATUS FORMS MUST BE COMPLETED EVERY YEAR.**
Employee Number:	
Department:	
Date:	
E-mail Address:	

Coverage for Immediate Family Members Eligibility: Spouse (Married, Common-Law, Same Sex), Children

I wish to be enrolled for full family benefits under the CUPE Dental Plan. I understand that I am responsible for the difference between the individual premium and family premium as well as my normal contributions toward the premium. My monthly total will be $63.61. I authorize my employer, McMaster University, to deduct these contributions from my pay.

Signature: _____ **Date:** _____

Please complete the attached form for ALL family members to be enrolled.

The Family Enrolment form MUST be completed within 30 days of the start of your contract (for new Post-Docs) or during the 30-day change of coverage period (for returning Post-Docs) and returned to the CUPE Office (B108 Wentworth House). Barring exceptional changes in circumstance (such a change in marital status), no changes may be made until the next change of coverage period. The 30 day change of coverage period begins on anniversary of the first day of your contract.

Family coverage is automatically renewed every year. Family coverage may be cancelled during the change of coverage period by submitting a signed letter to the union. Members who cancel their family coverage will be barred from re-enrolling family members in the plan for two years.

PLEASE NOTE: These names will be passed on to Equitable Life to ensure coverage. The information contained on this form will be kept by both CUPE 3906 and at McMaster University.

The information gathered on this form is collected under the authority of the *McMaster University Act, 1976.* The information is used for the academic, administrative, financial and statistical purposes of the University including, but not limited to, admissions; registration and maintaining records; awards and scholarships; convocation; provision of student services, including access to information systems; alumni; and disclosure to or on behalf of the applicable McMaster student government. This information is protected and being collected under section 39 (2) and section 42 of the *Freedom of Information and Protection of Privacy Act* of Ontario. Questions regarding the collection or use of this personal information should be directed to the University Registrar, University Hall 209, McMaster University, 905-525- 9140.

PLEASE WRITE CLEARLY AND LEGIBLY !

DEPENDENT SIGN UP SHEET CUPE 3906 DENTAL PLAN

Policy No.	Division No.	CLASS	Certificate No. (STUDENT NO.)	Last Name	First Name	Date of Birth	Sex	Spouse (S) or Dep. (D)	Disabled (Y or N)	Overage Dep. (Y or N)	Overage Approved	Status (T or A)	Status Eff. Date
97528	1	C	15564	SMITH EXAMPLE	ROBERTA	19750528	F	S	N	N		A	
97528	1	C	15564	SMITH	KEVIN	19800327	M	D	N	N		A	
						(yyyymmdd)							(yyyymmdd)

NOTE:

Class A - Single Member

Class B - Family member (more than 1 dependent covered i.e. spouse plus at least one child).

Class C - Single Member and 1 dependent ONLY (i.e spouse OR 1 child).

Please enter *Your* DEPENDENT Information below in the above EXAMPLE format

Policy No.	Division No.	CLASS	Certificate No. (STUDENT NO.)	Last Name	First Name	Date of Birth	Sex	Spouse (S) or Dep. (D)	Disabled (Y or N)	Overage Dep. (Y or N)	Overage Approved	Status (T or A)	Status Eff. Date
97528	1												
97528	1												
97528	1												
97528	1												
97528	1												

EXPLANATION

1	**POLICY NO. and DIVISION NO.** are always the same
2	**CERTIFICATE NUMBER** - please enter your **McMaster University STUDENT** number.
3	**DISABLED - YES OR NO** - if you have a ***disabled*** child ***over*** 21 years living at home enter Y(es), otherwise N(o).
4	**OVERAGE DEP**. - if you have a dependent child ***over*** 21 years of age, still attending school full time, please enter Y(es), otherwise N(o).
5	**OVERAGE APP. -** leave blank / empty
6	**STATUS** - if *you* are on the plan then your **Dependents** are **A**(ctive). **T**(erminated) will be applied for reporting purposes once you cease to be on the plan.
7	**STATUS EFF. DATE**- In most cases this will be same date your coverage was effective, UNLESS your status (Married/ Common Law) changed **AFTER** your original effective date. If this is the case - for Dependents use date of Marriage or CL co-habitation for Status Eff. Date.

IF YOU NEED MORE SPACE THAN IS AVAILABLE ABOVE , PLEASE USE SPACE BELOW TO PROVIDE DETAILS - OR EXPLANATION.