



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

DIV 203

CUPE 3906 DENTAL PLAN:

OPT-OUT AUTHORIZATION

Please complete the following and attach the Direct Deposit Payment Information form along with any necessary proof of coverage.

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

Option 1 - Opting out of the Dental Plan because of Spousal coverage

Whereas I have dental benefits already provided through my spouse's dental plan, I wish to opt out of participation in and coverage under the CUPE Dental Plan. I understand that in order for me to opt out, I must provide, from my spouse's employer, proof that I am covered under his/her dental plan, a copy of which is attached to this application. Documentation **MUST** be provided each year.

Signature: _____

Date: _____

Option 2 - Opting out of the Dental Plan because of other coverage (e.g., Parental)

Whereas I have dental benefits already provided through another dental plan, I wish to opt out of participation in and coverage under the CUPE Dental Plan. I understand that in order for me to opt out, I must provide proof that I am covered under this other dental plan, a copy of which is attached to this application. Documentation **MUST** be provided each year.

Signature: _____

Date: _____

If you are considering opting out, be aware that this form, a direct deposit payment form and accompanying documentation **MUST** be completed and returned to administrator@cupe3906.org by October 2nd, 2020. *No opt-outs are permitted after October 2nd for employees working in the fall term.*

PLEASE NOTE: Your signature on this form confirms that the documentation that accompanies it is accurate and meets the above criteria.

Valued Vendor

DIRECT DEPOSIT PAYMENT INFORMATION FOR CUPE 3906 UNIT 2 DENTAL REFUND

To ensure the accuracy of our account information, please complete and sign this form and attach a void cheque or bank printout confirming your account information.

Payee Name:

Address:

City Province Postal Code

Phone: () E-mail :

Signature: Date:

Please deposit any amount(s) payable to me directly to my bank account as follows:

Name of financial institution:

Address of financial institution:

City Province Postal Code

ACCOUNT INFORMATION: (COMPLETE ONE ONLY)

CAD\$ Account

Bank Code grid

Transit Number grid

Account Number grid

Bank Code Transit Number Account Number

PLEASE RETURN THIS FORM ALONG WITH YOUR UNIT 1 DENTAL OPT OUT AUTHORIZATION FORM TO administrator@cupe3906.org.