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

# CUPE 3906 DENTAL PLAN:

# UNIT 1 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 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:** _____

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**Option 2 - Opting out of the Dental Plan because of Other coverage (i.e. 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:** _____

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**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 the CUPE 3906 Office (Kenneth Taylor Hall, B111) by September 30, 2017. Any premium refunds will be returned by Prosure Group within 30 days.** ***No opt-outs are permitted after September 30.***

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

## DIRECT DEPOSIT PAYMENT INFORMATION FOR CUPE 3906 UNIT 1 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

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Bank Code Transit Number Account Number

**PLEASE RETURN THIS FORM ALONG WITH YOUR UNIT 1 DENTAL OPT OUT AUTHORIZATION FORM TO THE CUPE 3906 OFFICE.**