Kenneth Taylor Hall B111, McMaster University
1280 Main Street W., Hamilton, ON L8S 4M4
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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:** ___________________

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:** ___________________

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 28, 2018. Any premium refunds will be returned by Prosure Group within 30 days. ***No opt-outs are permitted after September 28.***

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

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.