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Email: administrator@cupe3906.org
Fax: (905) 525-3837
Website: http://cupe3906.org

# CUPE 3906 DENTAL PLAN:

# UNIT 2 FAMILY COVERAGE ENROLMENT

**Please complete the following:**

| | |
|---|---|
| Name: | **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 single member premium contribution ($170.00) and the family premium member contribution ($946.00). The annual total owed by me for this benefit will be $776.00 after the Employer dental deduction ($170.00) and will be deducted by Prosure Group. I understand I will need to complete a separate pre-authorized payment form that will be provided to me.**

**Signature:_____ Date:_____**

## Please complete the attached form for all family members to be enrolled along with the Prosure Group Pre-Authorized Payment form.

**PLEASE NOTE: These names will be passed on to Equitable Life of Canada and the Prosure Group to ensure coverage. A copy of this form will be kept by CUPE 3906.**

**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 | ROBERTA | 19750528 | F | S | N | N | | A | |
| 97528 | 1 | C | 15564 | SMITH | KEVIN | 19800327 | M | D | N | N | | A | |
| | | | | | | (yyyymmdd) | | | | | | | (yyyymmdd) |

EXAMPLE

**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 | | | | | | | | | | | | |
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| **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.**

SUBMIT TO: administrator@cupe3906.org

DEADLINE: OCTOBER 2, 2020

ProsureGroup
Prosure Group is a People Corporation company
Benefits Consultin
Administration
Spending Accoun

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Suite 1400 tel 416.609.0989 Ext.5330
Toronto, ON M2J 5C2 fax 416.609.9551

# PRE-AUTHORIZED PAYMENT FORM

**PLAN NAME : CUPE 3906 UNIT 2 DENTAL PLAN (Division 203)**

**PLAN MEMBERS NAME: _____**

**BANK #: _____ TRANSIT #: _____**

**ACCOUNT #: _____**

I hereby authorize The Prosure Group to deduct my family dental premium from my account, indicated above.

The premium will be deducted in two monthly installments of $388.00 starting October 1, 2020.

**Signature: _____ Date: _____**

**Name: _____**

**Email Address: _____**

Please attach a void cheque or a bank printout verifying your account information and return it along with your Family Dental application and information form to administrator@cupe3906.org by the deadline.