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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: \_\_\_\_\_

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#### OR 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: \_\_\_\_\_

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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 [administrator@cupe3906.org](mailto:administrator@cupe3906.org) by **MAY 30, 2025**. *No opt-outs are permitted after MAY 30, 2025, for employees who are working in the SPRING/SUMMER 2025 term and did not work in the Fall 2024 or Winter 2025 term(s).*

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

Valued Vendor

Sessional Faculty and Hourly Rated Sessional Music Faculty

**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

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Bank Code

Transit Number

Account Number

(Normally up to 4  
digits)

(Normally up to 5 digits)

(Normally up to 12 digits)

**PLEASE RETURN THIS FORM ALONG WITH YOUR UNIT 2 DENTAL OPT OUT AUTHORIZATION FORM  
TO [administrator@cupe3906.org](mailto:administrator@cupe3906.org).**