UNIT 2 CUPE Local 3906

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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:** _____

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:** _____

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 JANUARY 31, 2025. ***No opt-outs are permitted after JANUARY 31, 2025, for employees who are working in the Winter 2025 term and did not work in the Fall 2024 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 (Normally up to 4 digits)	Transit Number (Normally up to 5 digits)	Account Number (Normally up to 12 digits)

PLEASE RETURN THIS FORM ALONG WITH YOUR UNIT 2 DENTAL OPT OUT AUTHORIZATION FORM TO administrator@cupe3906.org.