Kenneth Taylor Hall B111, McMaster University
1280 Main Street W., Hamilton, ON L8S 4M4
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Email: administrator@cupe3906.org
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CUPE 3906 DENTAL PLAN:
UNIT 1 FAMILY COVERAGE ENROLMENT

Please complete the following:

Name (please print):	**CHANGE OF STATUS FORMS 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 individual premium ($125.00) and family premium ($405.00) as well as my normal contributions toward premium and administrative costs. The annual total owed by me for this benefit will be $280 after the Employer dental deduction ($125.00) and will be deducted by The 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.

THIS FORM MUST BE SUBMITTED NO LATER THAN FEBRUARY 5, 2024 FOR UNIT 1 MEMBERS WHO ARE EMPLOYED IN THE WINTER 2024 ACADEMIC TERM. FORMS FOR UNIT 1 MEMBERS WHO WERE EMPLOYED IN THE FALL 2023 ACADEMIC TERM ARE NO LONGER BEING ACCEPTED.

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	B	15564	SMITH	ROBERTA	19750528	F	S	N	N		A	
97528	1	B	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).

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												
97528	1												
97528	1												
97528	1												
97528	1												

m/dd/yy

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

WINTER DEADLINE: FEBRUARY 5, 2024

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

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Suite 1400
Toronto, ON M2J 5C2

toll 1.888.556.5559
tel 416.609.0989 Ext.5330
fax 416.609.9551

PRE-AUTHORIZED PAYMENT FORM

PLAN NAME : CUPE 3906 UNIT 1 DENTAL PLAN

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 $140.00 starting October or November of 2023

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.

SUBMIT TO: administrator@cupe3906.org DEADLINE: FEBRUARY 5, 2024