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DIV 203

CUPE 3906 DENTAL PLAN: OPT-OUT AUTHORIZATION

PLEASE NOTE! THIS FORM *MUST* BE SUBMITTED WITH THE FOLLOWING OR IT WILL NOT BE PROCESSED (Please check ✓ the following):

☐ **PROOF OF ALTERNATE COVERAGE** (a non-GSA insurance card or insurance statement with your name on it)

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 **September 29, 2025**. *No opt-outs are permitted after September 29, 2025, for employees working in the Fall 2025 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 _____

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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 NOTE! THIS FORM *MUST* BE SUBMITTED WITH:

☐ **PROOF OF ALTERNATE COVERAGE** (a non-GSA insurance card or insurance statement with your name on it) or it **WILL NOT be processed**

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