



UNIT 2

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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)

Last Name (please print):	First 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 30, 2026. *No opt-outs are permitted after September 29, 2025, for employees who worked in the Fall 2025 term. No opt-outs are permitted after January 30th, 2026, for employees working in the Winter 2026 term.***

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

