UNIT 2 CUPE Local 3906

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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 September 28, 2026. *No opt-outs are permitted after September 28, 2026, for employees who work in the Fall 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

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	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.