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**CUPE 3906 DENTAL PLAN:
 UNIT 1 FAMILY COVERAGE ENROLMENT**

Please complete the following:

Last Name (please print):		First Name (please print):	
Employee Number:		CHANGE OF STATUS FORMS MUST BE COMPLETED EVERY YEAR.	
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 (\$115.00) and family premium (\$455.00) as well as my normal contributions toward premium and administrative costs. The annual total owed by me for this benefit will be \$340 after the Employer dental deduction (\$115.00) 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 MAY 25, 2026 FOR UNIT 1 MEMBERS WHO ARE EMPLOYED IN THE SPRING/SUMMER 2026 ACADEMIC TERM. PLEASE NOTE: WE CAN NO LONGER ACCEPT OPT-OUTS FOR MEMBERS WHO WORKED IN THE FALL 2025 OR WINTER 2026 TERMS.

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)

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 <i>you</i> 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.



Prosure Group is a People Corporation company.

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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 \$170 starting February or March of 2026

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.