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DIV 001

CUPE 3906 DENTAL PLAN:

OPT-OUT AUTHORIZATION

Please complete the following and attach the Direct Deposit Payment Information form along with any necessary proof of coverage.

Name (please print):	
Student/Employee Number:	
Department:	PLEASE NOTE: OPT-OUT FORMS MUST BE COMPLETED EVERY ACADEMIC YEAR. DID YOU KNOW? OPTING OUT OF THE GRADUATE STUDENT ASSOCIATION'S DENTAL COVERAGE DOES NOT OPT YOU OUT OF YOUR CUPE 3906 DENTAL COVERAGE.
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 **MAY 30, 2025**. *No opt-outs are permitted for Unit 1 members working in the SPRING/SUMMER 2025 Term after May 30, 2025.*

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

Valued Vendor

Teaching Assistants and Research Assistants (in Lieu of TAs)

DIRECT DEPOSIT PAYMENT INFORMATION FOR CUPE 3906 UNIT 1 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 RETURN THIS FORM ALONG WITH YOUR UNIT 1 DENTAL OPT OUT AUTHORIZATION FORM
TO administrator@cupe3906.org.**