



Kenneth Taylor Hall B111, McMaster University
 1280 Main Street W., Hamilton, ON L8S 4M4
 Phone: (905) 525-9140 ext. 24003
 Email: administrator@cupe3906.org
 Fax: (905) 525-3837
 Website: www.cupe3906.org

**CUPE 3906 DENTAL PLAN:
 UNIT 2 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 (\$475.00) as well as my normal contributions toward premium and administrative costs. The annual total owed by me for this benefit will be \$360.00 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 January 30th, 2026, FOR UNIT 2 MEMBERS EMPLOYED IN THE WINTER 2026 ACADEMIC TERM. PLEASE NOTE: WE CAN NO LONGER ACCEPT FORMS FOR MEMBERS WHO WORKED IN THE FALL 2025 ACADEMIC TERM.

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	C	15564	SMITH	ROBERTA	19750528	F	S	N	N		A	
97528	1	C	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).
- Class C** - Single Member and 1 dependent ONLY (i.e spouse OR 1 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												

EXPLANATION

mm/dd/yy

- | | |
|---|---|
| 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.

Benefits Consultin
Administration
Spending Account

2225 Sheppard Ave East, | toll
Suite 1400 | tel
Toronto, ON M2J 5C2 | fax

1.888.556.5559
416.609.0989 Ext.5330
416.609.9551

PRE-AUTHORIZED PAYMENT FORM

PLAN NAME : **CUPE 3906 UNIT 2 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 \$180 starting February or March 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.