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CUPE 3906 DENTAL PLAN UNIT 1 OPT-OUT AUTHORIZATION

Please complete the following and attach any necessary proof of coverage.

Name (please print)			CHANGE OF STATUS FORMS MUST BE COMPLETED EVERY YEAR.	
Student Number		Employee Number		
Department				
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 _____

Option 2 - Opting out of the Dental Plan because of Other coverage (i.e. 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 _____

IMPORTANT

If you are considering opting out, be aware that this form **MUST** be completed and returned to the CUPE 3906 Office (Wentworth House, B108) by **September 9, 2011** to opt out for September. Opt-outs received by September 30 will take effect on October 1. *No opt-outs are permitted after September 30.*

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

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