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## CUPE 3906 DENTAL PLAN UNIT 1 FAMILY COVERAGE ENROLLMENT

Please complete the following.

Name (please print)			<b>CHANGE OF STATUS FORMS MUST BE COMPLETED EVERY YEAR.</b>	
Student Number		Employee Number		
Department				
Date				
E-mail				

### 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 and family premium as well as my normal contributions toward premium and administrative costs. My monthly total will be \$62.91. I authorize my employer, McMaster University, to deduct these contributions from my pay.

Signature \_\_\_\_\_

Date \_\_\_\_\_

**Please complete the attached form for all family members to be enrolled.**

**PLEASE NOTE: These names will be passed on to Equitable Life to ensure coverage. A copy of this form will be kept at both CUPE 3906, and at Graduate Studies, McMaster University.**

The information gathered on this form is collected under the authority of the *McMaster University Act, 1976*. The information is used for the academic, administrative, financial and statistical purposes of the University including, but not limited to, admissions; registration and maintaining records; awards and scholarships; convocation; provision of student services, including access to information systems; alumni; and disclosure to or on behalf of the applicable McMaster student government. This information is protected and being collected under section 39 (2) and section 42 of the *Freedom of Information and Protection of Privacy Act* of Ontario. Questions regarding the collection or use of this personal information should be directed to the University Registrar, University Hall 209, McMaster University, 905-525-9140.

PLEASE WRITE CLEARLY AND LEGIBLY !

**DEPENDENT SIGN UP SHEET CUPE 3906 DENTAL PLAN**

Policy No.	Division No.	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	15564	SMITH	ROBERTA	19750528	F	S	N	N		A	19600101
97528	1	15564	SMITH	KEVIN	19800327	M	D	N	N		A	19960801
					(yyyymmdd)							(yyyymmdd)

**Please enter *Your* DEPENDENT Information below in the above EXAMPLE format**

97528	1											
97528	1											
97528	1											
97528	1											
97528	1											

**EXPLANATION**

1	POLICY NO. and DIVISION NO. are always the same
2	CERTIFICATE NUMBER - please enter your <b>McMaster University STUDENT</b> number. If you don't have a student number, enter EMPLOYEE number.
3	DISABLED - YES OR NO - if you have a <b>disabled</b> child <b>over</b> 21 years living at home enter Y(es), otherwise N(o).
4	OVERAGE DEP. - if you have a dependent child <b>over</b> 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 <b>Dependents</b> are <b>A</b> (ctive). <b>T</b> (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 <b>AFTER</b> 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.