Alternative Dental Coverage

Name: _____ McGill ID #: _____

Tel. Number: _____ Email: _____

I, the undersigned, wish to opt out of the McGill University – Dental Plan ("Plan") effective _____ (subject to payroll processing deadlines).

I understand that participation in the Plan is optional; however, once I join, I am expected to remain in the Plan as long as I am employed by the University.

I acknowledge that I may opt out of the Plan if:

☐ I am covered under another group group dental plan (eg. my spouse's dental plan). I understand that written proof of coverage (eg. letter from my spouse's employer) must be submitted to Human Resource, and that I will not be permitted to opt-out of the McGill Dental Plan until I provide this proof. I therefore attach written proof of alternate dental coverage with this form.

☐ I have completed 3 consecutive years of membership in the Plan. I understand that I will not be permitted to rejoin the Plan within the same period of employment with the University.

I acknowledge that all information on this form and documentation provided are accurate and complete.

I further acknowledge that before electing to opt out, I have had sufficient time to review the terms and conditions of the Dental Plan.

_____ _____

Signature Date

Send this form to the HR Service Centre – by fax to 514-398-8287 or by scan/email to: hrhr@mcgill.ca.
You can also mail it to the HR Service Centre at 688 Sherbrooke St. W., 15th floor, Suite 1520, Montréal, Qc H3A 3R1.

For HR Use Only:

Dental Plan Start Date:		Initial	Date
Proof required to opt-out	Received: yes ☐ no ☐ If no, send written follow-up to member	Initial	Date
If not eligible to opt-out	Inform plan member in writing	Initial	Date

July 2020