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Name: _____ McGill ID #: _____

Tel Number: _____ Email: _____

I, the undersigned, wish to opt out of the McGill University Dental W o v ~ ^ e f f e c t i v e _ •
_____ (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 (e Ç • ‰ } µ • [• v l š u n d e r s t a n d v • X 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 is accurate and complete.

I further acknowledge that before electing to opt out, I have had sufficient time to review the terms and