SPENDING ACCOUNT & ENROLLMENT CLAIM FORM

Sept.1, 2013 Version 2

(P L E A S E T Y P E O R P R I N T C L E A R L Y)

Please include - Original receipts and/ or Explanation of benefits form from primary insurer.
CLAIMS CANNOT BE PAID WITHOUT THIS DOCUMENTATION

UNIT 1

LAST or FAMILY NAME | FIRST NAME

HOME PHONE or CELL # | Email address

McMaster University **Employee No.** **NOTE: This number MUST be shown**

FOR REIMBURSMENT CHEQUE - please choose ☑ only one of the following 3 options:

☐ **Please mail cheque to me (name above) at my home address below.**

OR

☐ **Mail cheque to:** **CUPE 3906**
B111 Kenneth Taylor Hall, McMaster University
1280 Main St. W., Hamilton, Ontario. L8S 4M4

OR

☐ **Mail directly to medical practitioner. Name and address as shown on attached valid receipts.**

Claimant Information	Name	Date of Birth mmm/ day / year	Type of Claims (i.e. Rx Drugs, Vision, Dental, Other)	$ Amount
☐ SELF	Name as above			
☐ Spouse				
☐ Dependent 1.				
☐ Dependent 2.				

TOTAL CLAIMS - Maximum allowable is $250 per person, (including Dependents) every 24 months

SEND CLAIM FORM & RECEIPT(S) TO

Prosure Group Administrators Ltd.
2225 Sheppard Ave East, Ste 1400, Atria III
Toronto, Ontario M2J 5C2

OR

DROP OFF Form & Receipts at
CUPE 3906
B111 KennethTaylor Hall, McMaster University
1280 Main St. W., Hamilton, Ontario L8S 4M4
Tel: 905-525-9140 ext. 24003 www.cupe3906.org

Any questions call **(Prosure Group)** **Tel: 416 - 609-0989 Ex 5332 • Toll Free: 888 - 556-5559 Ex 5332 • FAX: 416-609-9551**

PLEASE PRINT FORM after completion then SIGN & DATE. I submit this claim in the knowledge that any false information may result in my immediate disqualification from this benefit plan and could result in further legal proceedings.

Member Signature: _____ Date: _____

CUPE Authorized Rep: _____ Date: _____