UNIT 2
Sessionals

SPENDING ACCOUNT & ENROLLMENT CLAIM FORM

(PLEASE TYPE OR PRINT CLEARLY)

Please include - Original receipts and /or Explanation of Benefits Form from an insurance provider.
CLAIMS CANNOT BE PAID WITHOUT THIS DOCUMENTATION

LAST or FAMILY NAME: ______ FIRST NAME: ______

HOME PHONE or CELL # ______ Email address: ______

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

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

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

______

______

☐ **2. Mail cheque to:**

CUPE 3906
#B111 Kenneth Taylor House, McMaster University
1280 Main St., W, Hamilton, Ontario. L8S 4M4 *OR*

☐ **3. Mail cheque directly to medical practitioner (Name and address & postal code below).**

______

______

Claimant Information	Name	Date of Birth mmm/ day/ year	Type of Claim (ie:dental, prescription, vision, massage)	$ Amount
☐ Self	Name as above			
☐ Spouse				
☐ Dependent 1				
☐ Dependent 2				

Claims paid at 70%. Eligibility determined by Academic Year (Sep 1 to Aug 31)

SEND CLAIM FORM & RECEIPTS TO
The Prosure Group
2225 Sheppard Avenue East
Suite 1400, Atria III
Toronto, ON M2J 5C2

OR

DROP OFF FORM & RECEIPTS at
CUPE 3906
B111 Kenneth Taylor House, McMaster University
1280 Main St. W., Hamilton, ON. L8S 4M4

l: 416-609-0989 Ex. 5332 Toll Free: 1- 888-556-5559 Ex. 5332

AT THIS POINT PLEASE PRINT – SIGN AND 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 action.

MEMBER – Signature: ______ Date: ______

CUPE Authorized Rep. ______ Date: ______