



# ADDITIONAL REBATE & 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

**Unit 2: Sessional Faculty and Hourly Rated Sessional Music Faculty**

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
<input type="checkbox"/> Self	Name as above	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Spouse	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Dependent 1	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Dependent 2	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

**Maximum Benefit \$50 rebate/academic year. Eligibility determined by Academic Year (Sep 1 to Aug 31)**

### SEND CLAIM FORM & RECEIPTS TO

Prosure Group Administrators Ltd.  
2225 Sheppard Ave. E., Suite 1400  
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

Any Questions Call (Prosure Group) Tel: 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:** \_\_\_\_\_