



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

UNIT 2 Sessionals

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"/>

Claims paid at 80%. 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:** _____