REPRODUCTIVE HEALTH CLAIM FORM

(PLEASE TYPE OR PRINT CLEARLY)

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 total allowable is $150 per academic year (Sept to Aug)**

SEND CLAIM FORM & RECEIPT(S) TO

claims@prosure-group.com
(or mail to: Prosure Group Administrators Ltd.
2255 Sheppard Ave East, Suite 202, Atria 1 Toronto,
Ontario M2J 4Y1)

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) Toll Free: 888 - 556-5559 Ex 5332 • FAX: 416-609-9551**

PLEASE SIGN & DATE the form. 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: ______

(Please email administrator@cupe3906.org with any questions. Please note that claim forms and supporting documentation can now be submitted via email to: claims@prosure-group.com) mar 2023 verision