HEALTH 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 3 Postdoctoral Fellows

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**				

Current Maximum Benefit $450/academic year. Eligibility determined by Academic Year (Sep 1 to Aug 31)
Please note: Where a portion of your claim was paid by another provider, please submit an **explanation of benefits**

SEND CLAIM FORM & RECEIPTS 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 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:** _____