



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
<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"/>

Eligibility determined by Academic Year (Sep 1 to Aug 31)

Please note: If a portion of your claim was paid by another provider, please include an **explanation of benefits**.

SEND CLAIM FORM & RECEIPTS TO

THE PROSURE GROUP

2255 Sheppard Avenue East, SUITE 202, Atria 1
Toronto, ON 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) Toll Free: 1- 888-556-5559 Ex. 5332

July 2025 version

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:**