UNIT 2

SPENDING ACCOUNT & ENROLLMENT CLAIM FORM

Sept 1, 2013 Version 2

(P L E A S E T Y P E O R P R I N T C L E A R L Y)

Please include - Original receipts and/ or Explanation of benefits form from primary insurer.

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 REIMBURSMENT CHEQUE - please choose ☑ only one of the following 3 options:

Please mail cheque to me (name above) at my home address below.

____

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OR

Mail cheque to:
CUPE 3906
B111 Kenneth Taylor Hall, McMaster University
1280 Main St. West, 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				
			TOTAL	

TOTAL CLAIMS - Max. Benefit increased to $500 per person, (including Dependents) per academic year.

1	Are you submitting UHIP Claims ?	YES	NO	UHIP restricted to $100 of the $500 max.
2	Are you submitting Childcare Claims ?	YES	NO	Childcare restricted to $100 of the $500 max.

SEND CLAIM FORM & RECEIPT(S) TO

Prosure Group Administrators Ltd.
2225 Sheppard Ave East, Ste 1400, Atria III
Toronto, Ontario M2J 5C2

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) Tel: 1- 416-609-0978 Ex 5332 or Toll Free: 1 - 888-556-5559 Ex 5332 FAX: 1- 416-609-9551

PLEASE PRINT FORM after completion then SIGN & 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 proceedings.

Signed: ____________ Date: ____________