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Unit 1 - Vision Care Claim Form

Claimant Information

Last Name: _____
 Given Name(s): _____
 Student/Employee No. _____ Phone: _____
 Email address: _____
 Mailing Address: _____

Have you made a claim within the last two years? Yes No
 If yes, amount: \$ _____

Amount of current claim (maximum \$250* per 24 months): \$ _____
Note: You must submit the original receipt (no copies).

*Vision Care claims are processed on a first come first serve basis during the Fall and Winter terms (or until expenditures reach the \$90,000 cap). During this period, members receive the amount they apply for (up to \$250). During the Summer terms (or after the \$90,000 cap is reached), vision claims are held until the end of the term. The maximum amount members receive depends on how much money is left in the vision care fund.

Employment Information

Department currently/most recently employed by: _____
 Position currently/most recently held: TA RA in lieu
 Term(s) employed this academic year: (check all that apply)
 FALL WINTER SPRING/SUMMER N/A
 If you checked N/A, when were you last employed as a TA/RA? _____

Claimant Authorization

I submit this claim with the knowledge that any false information given will result in my immediate disqualification in this benefit plan and may result in further legal action.

Signature: _____ Date: _____

FOR OFFICE USE ONLY CUPE Local 3906 Authorization

We certify that to the best of our knowledge the above claimant is a member in good standing and is entitled to this claim under the rules of the plan.

Signature: _____ Date: _____
 Position: _____

PLEASE ATTACH ORIGINAL RECEIPTS TO THE BACK OF THIS APPLICATION (NO COPIES).