



SPENDING ACCOUNT & ENROLLMENT CLAIM FORM

UNIT 2

(PLEASE PRINT CLEARLY)

Please Include:

1. Original Receipts **OR**
2. Explanation of Benefits form from another insurance provider

CLAIMS CANNOT BE PAID WITHOUT THIS DOCUMENTATION

FIRST NAME:

LAST NAME:

Home Phone No:

Email Address:

McMaster University Employee Number:

- **NOTE: This Number *MUST* be shown.**

Send Claims to

ProsureGroup Administrators Ltd.,
 106 – 4500 Sheppard Ave., East,
 Toronto, Ontario. M1S 3R6

TEL: 416-609-0989 Ex. 32 • Toll free (888) 556-5559 Ex. 32

OR Drop Claims Off at
CUPE 3906

B108 Wentworth House, McMaster University
 1280 Main St W, Hamilton, ON

TEL: 905-525-9140 ext 24003 www.cupe3906.org

Please choose 1 (one) only of the following:

Please mail cheque to me at my Home address below.

Mail cheque directly to **medical practitioner** (Name & address below)

NAME:

ADDRESS:

Claimant Information		Name	Date of Birth Mm/ Day/ Year	Type of Claim (i.e.: Rx. Drugs, Vision, Dental)	Amount
Self	<input type="checkbox"/>	As above			\$
Spouse	<input type="checkbox"/>				
Dependent 1.	<input type="checkbox"/>				
2.	<input type="checkbox"/>				
3.	<input type="checkbox"/>				
4.	<input type="checkbox"/>				
TOTAL CLAIMS - Maximum allowable is \$125.00 per person, (including Dependents) per Academic year.					\$

I submit this claim in the knowledge that any false information given may result in my immediate disqualification from this benefit Plan and could result in further legal action:

Signed:

Date: