UNIT 3

SPENDING ACCOUNT & ENROLLMENT CLAIM FORM

(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.**

Mailing Address to *Send Claims*
Prosure*Group* Administrators Ltd.,
106 – 4500 Sheppard Ave., East,
Toronto, Ontario. M1S 3R6
TEL: 416-609-0989 Ex. 32 • Toll free (888) 556-5559 Ex. 32

Please choose 1 (one) only of the following:

☐ Please mail cheque to me at my Home address below.

☐ Mail cheque to: **CUPE 3906**
C/o McMaster University
Rm. B108, Wentworth House
Hamilton, Ontario.
L8S 4K1

☐ 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	☐	As above			$
Spouse	☐				
Dependent 1.	☐				
2.	☐				
3.	☐				
4.	☐				
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:**