CUPE 3904
CONTRACT ACADEMICS OF RYERSON UNIVERSITY

UNIT 3

www.cupe3904.ca

HEALTH SPENDING ACCOUNT & ENROLLMENT

2023 CLAIM FORM

(PLEASE TYPE OR PRINT CLEARLY)

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

CLAIMS CANNOT BE PAID WITHOUT THIS DOCUMENTATION

Deadline to apply: December 15, 2023

LAST or FAMILY NAME _____ FIRST NAME _____

HOME PHONE or CELL # _____ @torontomu Email address _____

Ryerson University Employee I.D. _____ ***NOTE: This number MUST be shown***

Health claims must be submitted by email to claims@prosure-group.com.

Any questions please contact Prosure Group Administrators Ltd. Phone: 416 - 609 - 0989 Ex. 5332

ALL REIMBURSMENTS ARE ISSUED BY CHEQUE

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

_____

_____

- **Claim Eligibility $700 per Calendar year**
- **Receipts must be dated Dec 16, 2022 to Dec 15, 2023; Minimum Claim $100**
- **Expense(s) must be incurred in Canada and cheque(s) must be mailed to a Canadian address**
- **Funds are limited and paid on a first come first serve basis**

	Claimant Information	Name	Date of Birth mm/ day / year	Type of Claims (i.e. Rx Drugs, Vision, Dental, Other)	$ Amount
☐	SELF - Receipt 1				
☐	SELF - Receipt 2				
☐	SELF - Receipt 3				
☐	SELF - Receipt 4				

Receipts must be dated Dec 16, 2022 to Dec 15, 2023; Minimum Claim $100!

CLAIM ELIGIBILITY: **$700** per Calendar year (**NO** Dependent coverage)

$ 0.00

TOTAL

Any questions please contact Prosure Group Administrators Ltd. at:

Phone: 416 - 609 - 0989 Ex. 5332 • FAX: 416 - 609 - 9551 • TOLL FREE: 888 - 556 - 5559 Ex 5332

Funds are limited and paid on a first come first serve basis.

AFTER COMPLETING THE INFORMATION ABOVE PLEASE SIGN & DATE BELOW

I submit this claim in the full knowledge that an false information may result in my immediate disqualification from this benefit plan and could result in further legal consequences.

Signed: _____ Date: _____ mm / dd / yyyy