CUPE 3904
CONTRACT ACADEMICS OF RYERSON UNIVERSITY

cupe3904.ca

HEALTH SPENDING ACCOUNT & ENROLLMENT

2024 / 2025 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

UNIT 3 HEALTH BENEFIT FUND (HBF)

Claim form must be completed and submitted by members via email to claims@prosure-group.com.

Claims submitted to Prosure Group directly from the service provider(s) are not acceptable and will be denied.

We encourage members to submit claims by July 31; incomplete forms submitted in August will be denied.

- **Claim process is available from October 1, 2024 to August 15, 2025**
- Funds are limited and paid on a first-come-first-served basis
- Maximum of $700 **per academic year** & maximum of 1 claim **per academic year**
- All receipts must be dated August 16, 2024 to August 15, 2025 (inclusive)
- Expense(s) must be incurred in Canada and cheque(s) must be mailed to a Canadian address

Eligibility: Unit 3 Lab Monitors, Graduate Assistants, and Teaching Assistants.

At least one contract appointment in the Fall 2024, Winter 2025, and/or Spring/Summer 2025 term(s).

Inquiries: Please contact Prosure Group directly at claims@prosure-group.com

LAST or FAMILY NAME _____ FIRST NAME _____

HOME PHONE or CELL # _____ @torontomu Email address _____

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

ALL REIMBURSMENTS ARE ISSUED BY CHEQUE

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

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				

TOTAL $ 0.00

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