



UNIT 2

www.cupe3904.ca

SPENDING ACCOUNT & ENROLLMENT

CLAIM FORM Version 2018

(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

Funds are limited and paid on a first come first serve basis: Receipts must be dated in 2018 & Minimum Claim \$100!

LAST or FAMILY NAME FIRST NAME

HOME PHONE or CELL # Ryerson Email address

Ryerson University Employee No. **NOTE: This number MUST be shown**

MAIL THE CLAIM FORM and ORIGINAL RECEIPTS TO:

**Prosure Group Administrators Ltd.,
2225 Sheppard Ave. East, Ste 1400 Atria III
Toronto, Ontario M2J 5C2**

FOR REIMBURSEMENT CHEQUE - please choose only one of the following 2 options:

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

OR

Mail directly to medical practitioner. Name and address as per attached valid receipts or address below.

Claimant Information	Name	Date of Birth mmm/ day / year	Type of Claims (i.e. Rx Drugs, Vision, Dental, Other)	\$ Amount
SELF - name as above				
Spouse				
Dependent 1.				
Dependent 2.				

My spouse is also an eligible member of this CUPE 3904 HSA plan. YES NO **Minimum Claim \$100**

CLAIM ELIGIBILITY: \$300 PER MEMBER (Including Dependent claims)

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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

AFTER COMPLETING THE INFORMATION ABOVE PLEASE PRINT then SIGN and DATE

If my spouse or common-law partner is also an eligible member of this plan then only one of us is eligible to apply for dependent children benefits. Consequently if I am applying for dependent benefits my spouse is eligible for benefits ONLY as a Single member.

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: _____

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