UNIT 2

www.cupe3904.ca

SPENDING ACCOUNT & ENROLLMENT CLAIM FORM (revised March 19, 2021)

(P L E A S E T Y P E O R P R I N T C L E A R L Y)

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

CLAIMS CANNOT BE PAID WITHOUT THIS DOCUMENTATION

Deadline to appy: August 15, 2021

Funds are limited and paid on a first come first serve basis: Receipts must be dated Jan. 01 to Aug.15, 2021 & 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***

Health claims can be submitted by email to claims@prosure-group.com or mailed to the address below.

MAIL THE CLAIM FORM and ORIGINAL RECEIPTS TO:

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

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

FOR REIMBURSMENT 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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