



# HEALTH SPENDING ACCOUNT & ENROLLMENT

## 2021 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**

[www.cupe3904.ca](http://www.cupe3904.ca)

**Claim Eligibility \$500 per Calendar year. Deadline to apply: December 21, 2021**

**Funds are limited and paid on a first come first serve basis: Receipts must be dated in 2021 & Minimum Claim \$100!**

LAST or FAMILY NAME  FIRST NAME

HOME PHONE or CELL #  Ryerson   
Email address

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

**Health claims can be submitted by email to [claims@prosure-group.com](mailto: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  
Toronto, Ontario M2J 5C2  
**Questions please contact**  
Prosure Group Administrators Ltd.  
Phone: 416 - 609 - 0989 Ex. 5332

**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<br>mm/ day / year | Type of Claims<br>(i.e. Rx Drugs, Vision,<br>Dental, Other) | \$ Amount |
|----------------------|------|---------------------------------|---|-----------|
| SELF - Receipt 1     |      |                                 |   |           |
| SELF - Receipt 2     |      |                                 |   |           |
| SELF - Receipt 3     |      |                                 |   |           |
| SELF - Receipt 4     |      |                                 |   |           |

**Receipts must be dated in 2021 & Minimum Claim \$100!**

**CLAIM ELIGIBILITY: \$500 per Calendar year (NO Dependent coverage)**

**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 PRINT then SIGN and DATE**

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