CUPE 3904
CONTRACT ACADEMICS OF RYERSON UNIVERSITY

UNIT 2

www.cupe3904.ca

SPENDING ACCOUNT & ENROLLMENT

CLAIM FORM Version 2021

(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: Decemeber 10, 2021

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

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

Funds are limited and paid on a first come first serve basis: Receipts must be dated Sept. 01 to Dec.10, 2021 & Minimum Claim $100!

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)

Funds are limited and paid on a first come first serve basis: Receipts must be dated Sept. 01 to Dec.10, 2021 & Minimum Claim $100!

Any questions please contact Prosure Group Administrators Ltd. at:

Phone: 416 - 609 - 0989 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: _____

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