CUPE 3904
CONTRACT ACADEMICS OF RYERSON UNIVERSITY

UNIT 3

www.cupe3904.ca

HEALTH SPENDING ACCOUNT & ENROLLMENT

2022 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

Claim Eligibility $700 per Calendar year. Deadline to apply: December 9, 2022

Funds are limited and paid on a first come first serve basis: Receipts must be dated in 2022 & 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 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 REIMBURSMENT CHEQUE - please choose only one of the following 2 options:

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

Expense(s) must be incurred in Canada and cheque(s) must be mailed to a Canadian address

OR

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

Receipts must be dated in 2022 & Minimum Claim $100!

CLAIM ELIGIBILITY: **$700** per Calendar yeaar (**NO** Dependent coverage)

$ 0.00

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