



# SPENDING ACCOUNT & ENROLLMENT CLAIM FORM

( PLEASE PRINT CLEARLY )

## UNIT 2

Please Include: 1. Original Receipts **OR**  
2. Explanation of Benefits form from another insurance provider

**CLAIMS CANNOT BE PAID WITHOUT THIS DOCUMENTATION**

FIRST NAME:  LAST NAME:

Home Phone No:  Email Address:

McMaster University Employee Number:  - **NOTE: This Number *MUST* be shown.**

**Mailing Address to *Send Claims***  
**ProsureGroup Administrators Ltd.,**  
106 – 4500 Sheppard Ave., East,  
Toronto, Ontario. M1S 3R6  
TEL: 416-609-0989 Ex. 32 • Toll free (888) 556-5559 Ex. 32

***Please choose 1 (one) only of the following:***

Please mail cheque to me at my Home address below.

  

Mail cheque to: **CUPE 3906  
C/o McMaster University  
Rm. B108, Wentworth House  
Hamilton, Ontario.  
L8S 4K1**

Mail cheque directly to **medical practitioner** (Name & address below)

NAME:   
ADDRESS:

Claimant Information		Name	Date of Birth Mm/ Day/ Year	Type of Claim (i.e.: Rx. Drugs. Vision, Dental)	Amount
Self	<input type="checkbox"/>	As above			\$
Spouse	<input type="checkbox"/>				
Dependent 1.	<input type="checkbox"/>				
2.	<input type="checkbox"/>				
3.	<input type="checkbox"/>				
4.	<input type="checkbox"/>				
<b>TOTAL CLAIMS - Maximum allowable is \$400.00 per person, (including Dependents) per Academic year.</b>					<b>\$</b>

I submit this claim in the knowledge that any false information given may result in my immediate disqualification from this benefit Plan and could result in further legal action:

Signed: \_\_\_\_\_ Date: \_\_\_\_\_