



# UNIT 2

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

Spring / Summer 2022

Deadline to apply: August 15, 2022

## 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**

LAST or FAMILY NAME	<input type="text"/>	FIRST NAME	<input type="text"/>
HOME PHONE or CELL #	<input type="text"/>	Ryerson Email address	<input type="text"/>

**Ryerson University Employee No.**  **NOTE: This number MUST be shown**

Health claims must be submitted by email to [claims@prosure-group.com](mailto: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 in 2022: Minimum Claim \$100!

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**

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

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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**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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