



SPENDING ACCOUNT & ENROLLMENT CLAIM FORM

(PLEASE TYPE OR PRINT CLEARLY)

PLEASE INCLUDE - Original receipts AND/ OR Explanation of Benefits Form from an insurance provider.

CLAIMS CANNOT BE PAID WITHOUT THIS DOCUMENTATION

LAST or FAMILY NAME: FIRST NAME:

HOME PHONE or CELL # Email address:

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

FOR REIMBURSEMENT CHEQUE - please choose **ONLY ONE** of the following 3 options:

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

2. Mail cheque to: **CUPE 3902** **OR**

#803 – 180 Bloor St. West
Toronto, Ontario. M5S 2V6

3. Mail cheque directly to medical practitioner (Name and address & postal code below).

Claimant Information	Name	Date of Birth mmm/ day/ year	Type of claims (i.e Rx. Drug, Vision, Dental)	\$ Amount
<input type="checkbox"/> Self	Name as above	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Spouse	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Dependent 1	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Dependent 2	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

SEND THIS CLAIM FORM and RECEIPTS TO:

ProsureGroup Administrators Ltd.,
#106 – 4500 Sheppard Ave., East
Toronto, Ontario. M1S 3R6

Any Questions Call Tel: 1- 416-609-0989 Ex. 32

Toll Free: 1- 888-556-5559 Ex. 32

AT THIS POINT PLEASE PRINT – SIGN AND DATE. I submit this claim in the knowledge that any false information may result in my immediate disqualification from this benefit plan and could result in further legal action.

Signed: _____

Date: _____