UNIVERSITY OF TORONTO

HUMAN RESOURCES & EQUITY

CUPE 3902, UNIT 3 Employee and Dependent Special Circumstances Fund – Medical Expenses

Application for assistance for medical expenses; for non-medical expenses, please use the **CUPE 3902, Unit 3 Employee and Dependent Special Circumstances Fund – Non-Medical Expenses form**. Your claim will be adjudicated based on the information you provide, subject to availability of funds.

For more information on this fund, including a list of sample exemptions, please see http://www.hrandequity.utoronto.ca/employee-groups/#CUPE-Local-3902-Unit-3.

Form submissions should be made to cupeunitfund.hre@utoronto.ca

Employee Information

Employee Name (print)	
Personnel Number	
Date of Application	

Expense Details

All fields below are mandatory and must be completed for this application to be considered for reimbursement. You may attach supplementary information where indicated.

Is this claim for a medical expense for:	☐ Member ☐ Spouse/ Partner Name: _____ ☐ Dependent Child Name: _____ Date of Birth: _____

Select the type of medical expense that best describes your application:	☐ Dental ☐ Drug ☐ Medical Devices ☐ Paramedical ☐ Other (explain below) _____

Are you enrolled in the Health Care Spending Account (HCSA) for CUPE 3902, Unit 3?	◯ Yes ◯ No
Have you used all of your existing HCSA balance for the current year?	◯ Yes ◯ No If no, please explain:
Do you have other medical coverage through spouse/partner's plan?	◯ Yes ◉ No
If Yes, have you already submitted your claim to that plan? What was the outcome? (maximum 250 words)	
What is the total amount for which you are requesting reimbursement?	

Please briefly describe the unforeseen emergency medical situation, including whether it was an accident or injury arising from work and include any medical treatment received/prescribed: (maximum 250 words)	
Please provide an itemized breakdown of the expense(s) for which you are seeking assistance / reimbursement from the Fund Please attach a copy of any receipts.	
Is there any other information you can provide to assist with assessing your application? (maximum 250 words)	

By signing below, you are confirming your understanding that any funding approved will be in the form of an additional allocation that will not normally exceed $1,000 to your HCSA.

Any claims reimbursement will be handled directly by GreenShield Canada in accordance with their normal procedures, and in accordance with the Income Tax Act

Any unused additional allocation to your HCSA will expire at the end of the Plan Year (August 31 each year), including any special allocation arising from this fund unless otherwise noted.

By signing this application I consent to the sharing of this information with Green Shield Canada and the HR Benefits section.

This application will be kept in a confidential file for six plus one years beyond the end of the Plan Year in which it is submitted and then destroyed.

Date Submission:		**Employee Signature:**	

For HR Use Only

Reviewed By:	
Approved for additional allocation of $ to HCSA:	
If denied outline reason:	
Date GreenShield notified:	
Date Member Notified:	