UnitedHealthcare®

RETIREE CLAIM FOR REIMBURSEMENT FORM

Save postage and get reimbursed faster! Simply file your claim online at UHCRetireeAccounts.com instead of submitting this paper form.

Step 1: Participant Information – Complete your information below:

Participant First Name: _____ Participant Last Name: _____

Participant Address: _____

Former Employer / Plan Sponsor Name: _____ Last 4 Digits of SSN: _____

Step 2: Tell Us About Your Expenses – Provide the details about your eligible healthcare and/or premium expenses below:

- Use one line in this section for each expense type. If you have multiple expenses of the same type, for example copays, you may request payment on one line for the entire date range.
- If you have more eligible expenses than space allows in this section, please submit as many Retiree Claim for Reimbursement Forms as needed.

	Dates of Service (MM / DD/ YY)		Expense Amount	Type of Expense	Name of Person Receiving Service or Product	Name of Service Provider
	Month the insurance premium covers, date of the office visit, or date an item was purchased. *Example: 1/1/15 thru 1/31/15*		The amount you would like to be reimbursed. *Example: $125.00*	Was the expense for an Insurance Premium, Co-Insurance, Copay, Deductible, Medical, Vision, Dental (must specify reason for visit). *Example: Insurance Premium*	Name of person who received the service or for whom item was purchased. *Example: John Doe*	Name of the insurance company, doctor, medical facility, clinic or pharmacy, where the service took place. *Example: ABC Insurance Co.*
1		thru	$			
2		thru	$			
3		thru	$			
4		thru	$			
5		thru	$			

(Continued on next page. Signature page is required for reimbursement of expenses.)

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Step 3: Provide Proof of the Expense(s) You Listed in Step 2:

Please provide legible copies of receipts or itemized statements for the expenses which you want to be reimbursed for. If we are unable to read the documents due to the quality of the copy, we may need to request additional information. The receipts or itemized statements must include the following pieces of information for each expense you are claiming:

1. Date of Service
2. Expense Amount
3. Type of Expense/Reason for Visit
4. Name of the Person Receiving the Service or Product
5. Name of the Service Provider

Step 4: Sign and Date the Retiree Claim for Reimbursement Form (Required for Reimbursement):

By submitting this form, I certify that: all expenses I am submitting for reimbursement were incurred by me or another individual eligible under my company's retiree plan, which is a health reimbursement arrangement (HRA). All expenses I am submitting for reimbursement were incurred during a period I was covered by the company's retiree plan, which is an HRA. None of the expenses I am submitting for reimbursement have been reimbursed by or, if applicable to my plan, are reimbursable from any other source. I am fully responsible for the sufficiency and accuracy of information relating to the reimbursement submission, and that if an expense for which reimbursement is claimed is subsequently determined to not be an eligible expense under my plan, I may be liable for repayment to the plan and payment of all related taxes, including federal, state, or local income tax, on amounts paid from the plan. I acknowledge and agree that I have had an opportunity to consult with my tax advisor prior to submitting this form.

Any person who knowingly and with intent to injure, defraud, or deceive, files a statement of claim containing any false, incomplete or misleading information, may be guilty of a criminal act punishable under law.

X _____ **X** _____

Participant Signature Date

STEP 5: Submit the Retiree Claim for Reimbursement Form:

Mail or fax all pages of your Retiree Claim for Reimbursement Form, **along with proof of your expenses**, to the address listed below. Once received, it may take up to five (5) business days to process your request.

UnitedHealthcare
PO Box 30516
Salt Lake City, UT 84130-0516

Fax: 855-244-5016
(Faxed claims received after 12PM Eastern will be marked as received the following business day)

Contact Us: UnitedHealthcare, PO Box 30516, Salt Lake City, UT 84130-0516 | Phone: 877-298-2305 | www.UHCRetireeAccounts.com

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