



RETIREMENT HEALTHCARE PROGRAM CLAIMS ACTIVATION FORM

This form is used to activate claim reimbursements for participants who have satisfied the eligibility provision of their employer's Retirement Healthcare Plan. Participants requesting reimbursement for special circumstances should call TIAA at **877-554-1004** or contact their former employer's benefits office for more information.

IMPORTANT: Claim reimbursements can only be paid from the TIAA-CREF Money Market Mutual Fund. You may need to transfer funds to the Money Market Mutual Fund from other funds prior to submitting claims.

To begin reimbursement of qualified medical expenses, please complete and submit this form. Once your completed form has been processed, you will receive a welcome kit containing more information about claim reimbursement options, including your Healthcare Payment Card.

Your Retirement Healthcare Plan may be used to pay for qualified medical expenses for you and, if your plan permits, for your spouse and eligible dependents. Eligible expenses are defined by Section 213(d) of the Internal Revenue Code. Your employer's Retirement Healthcare Plan may limit reimbursement for certain medical expenses. You may contact your former employer for questions regarding your Retirement Healthcare Plan or for a copy of the Summary Plan Description, which contains details regarding the employer's plan rules.

IMPORTANT: Please be aware that submitting your claims activation form may, in some circumstances, make you ineligible to contribute to a Health Savings Account (HSA). Please consult your legal or tax advisor for guidance.

INSTRUCTIONS

1. Complete each section of this Claims Activation Form using black ink.
2. Sign and date the form.
3. Make a copy and retain it for your records.

OPTION 1: Use the TIAA mobile app to quickly upload your completed document(s). It's as simple as taking a picture. Haven't downloaded the TIAA mobile app? Get it today in the [App Store](#) or [Google Play](#).

- Tap the **Message Center** icon in the upper-right corner of your main screen.
- Go to the **Files** tab, select **Upload** and then follow the instructions.

OPTION 2: If you are using your personal computer, here's what you'll need to do to upload your completed document(s):

- Log in to your [TIAA.org](#) account and select the **Actions** tab.
- Choose **Upload document(s)** from the options presented.
- Select **Upload Files** and follow the step-by-step instructions.

OPTION 3: If you prefer to fax or mail this form, use the information provided below:

FAX:
800-914-8922 (within U.S.)

STANDARD MAIL:
TIAA
P.O. Box 1280
Charlotte, NC 28201-1280

OVERNIGHT DELIVERY:
TIAA
8500 Andrew Carnegie Blvd.
Charlotte, NC 28262

Please allow 7 to 10 days for processing your request for claims activation.

If you have any questions about your Retirement Healthcare Plan, please call **877-554-1004**, select option 1, weekdays, 8 a.m. to 10 p.m. (ET).

This form is not for use by account holders in an Emeriti Retirement Health Solutions Program.





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Please print using black or dark blue ink.

1. ACCOUNT HOLDER (FORMER EMPLOYEE) INFORMATION

First Name Middle Initial

Last Name Suffix

Social Security Number/
Taxpayer Identification Number Date of Birth (mm/dd/yyyy) / /

Contact Telephone Number Extension

Marital Status Single Married Gender Male Female Email Address

Employer Name

Retirement Healthcare Account Number **W**





*Federal tax law limits reimbursement of qualified medical expenses incurred by the participant, spouse and eligible dependents. Medical expenses incurred by non-dependent domestic partners may be eligible for reimbursement subject to the rules of the employer's Retirement Healthcare Plan (see the Summary Plan Description for more details).

2. SPOUSE AND/OR ELIGIBLE DEPENDENTS

1. First Name Middle Initial
 Last Name Suffix
 Relationship* (Spouse, Domestic Partner, Dependent) Date of Birth (mm/dd/yyyy)
 Social Security Number (Enter the last 4 digits of your SSN) Gender Male Female

2. First Name Middle Initial
 Last Name Suffix
 Relationship* (Spouse, Domestic Partner, Dependent) Date of Birth (mm/dd/yyyy)
 Social Security Number (Enter the last 4 digits of your SSN) Gender Male Female

3. SIGN AND DATE FORM

Please sign your full legal name with suffix, if applicable, using black ink. Digital signatures are not accepted.

Relationship to Participant Self Spouse Eligible Dependent Other
 Your Signature Today's Date (mm/dd/yyyy)
 Name (please print) Daytime Telephone Number

