TIAA

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 **877-554-1004** or contact your 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.

Note: If you are submitting this form as an eligible survivor, please complete all sections of the form including participant information in Section 1. For additional instructions, please refer to the retirement healthcare plan survivor benefits kit.

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 alternatives including your Healthcare Payment Card.

Your retirement healthcare plan may be used to pay for qualified medical expenses for you, 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 (please refer to your Summary Plan Description for details).

INSTRUCTIONS

1. Complete each section of the Claims Activation Form using black or dark blue ink.
2. Sign and date the form.
3. Make a copy and retain it for your records.
4. Fax your completed form to **800-914-8922**, or mail the form to:

   Mail:

   TIAA
   P.O. Box 1259
   Charlotte, NC 28201-1259

5. 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**, Monday to Friday from 8 a.m. to 10 p.m., and Saturday from 9 a.m. to 6 p.m. (ET). (This form is not for use by participants in an Emeriti Retirement Health Solutions program.)

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Please print using black or dark blue ink.

1. PARTICIPANT INFORMATION

Participant 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

* 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 your Summary Plan Description for more details).

2. FAMILY INFORMATION (SPOUSE AND 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)
X X X X X

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)
X X X X X

Gender ☐ Male ☐ Female

3. 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)
X X X X X

Gender ☐ Male ☐ Female

4. 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)
X X X X X

Gender ☐ Male ☐ Female

3. SIGN AND DATE FORM

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

Relationship to Participant

☐ Self ☐ Spouse ☐ Eligible Dependent ☐ Other

Your Signature

Today's Date (mm/dd/yyyy) ☐☐/☐☐/20☐☐

Name (please print)

Daytime Telephone Number

RETURN COMPLETED FORM(S) TO:

FAX:
800-914-8922 (within U.S.)
704-595-5795 (outside U.S.)

STANDARD MAIL:
TIAA
P.O. Box 1259
Charlotte, NC 28201-1259

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

SEND US YOUR FORM ONLINE:

- Log in to your account at **tiaa.org**. On the top most menu, next to "Profile & Settings," select "Messages."
- Within the "Shared Files" tab in "Message Center," select the "Upload Files" button.

MOBILE UPLOAD:

- Log in to your TIAA app, and click on "Upload documents" from the menu.
- Follow the instructions to take a picture and upload your completed form.