UnitedHealthcare

Retiree Claim for Reimbursement

*TIME SAVING TIP: Did you know you can file your claim online at **UHCRetireeAccounts.com** instead of completing this form? Simply log in to your account and click "File A Claim" under the "I Want To," section on the home page.*

Customer service professionals can be reached by calling 1-877-298-2305 (Monday - Friday from 8 a.m. to 8 p.m. Eastern time) if you have any questions.

1012 RRA UHC

1 About you

First Name, Last Name:	Last 4 of SSN:	Employer/Plan Sponsor Name:
Participant Address:	City, State ZIP:	

2 About your expenses

You may use one line on the claim form to enter expenses which are identical in nature even if the expenses have been incurred on different dates (i.e. office visit co-pays. RX co-pays). Please make sure to attach documentation verifying each individual expense. If you have more than 5 expenses, please complete a second form.

	Date of service MM/DD/YY *Example* *1/1/15 thru 1/31/15*	Expense Amount Claimed *Example* *$125.00*	Name of Person Receiving product or service *Example* *John Doe*	Name of Service Provider *Example* *ABC Insurance Co.*	Type of Expense (Medical, Vision, Premium, etc.) *Example* *Insurance Premium*
EXPENSE ❶					
EXPENSE ❷					
EXPENSE ❸					
EXPENSE ❹					
EXPENSE ❺					

3 Agreement and Signature

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.

✗ _____ _____

Participant's Signature Date

STOP

Don't forget to attach **legible supporting documentation** before mailing your form to the address below. Your documentation must clearly identify:

1. Total expense amount
2. Description of expense
3. Date expense was incurred
4. Name of person receiving service
5. Name of person/entity providing service
6. Signature and date of claim submission

Thank you for allowing us to serve you.

Where to return your form and documentation?

By Mail: UnitedHealthcare, P.O. Box 30516, Salt Lake City, UT 84130

By Email: optumclaims@prod.sourcehov.com

By Fax: 1-855-244-5016

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