UnitedHealthcare

Recurring Premium Expense Reimbursement Request

Please complete this form to establish a recurring premium expense reimbursement. 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 while completing this form.

1005 RRA UHC

1 Participant Information

Participant Name:	Last 4 of SSN:
Home Address:	City/ST/ZIP:
Employer/Plan Sponsor Name:	

2 Recurring Premium Expense Information

Please provide the information below about your recurring reimbursement request:

1. Which months would you like to be reimbursed? _____ through _____
   (Month/Year – Example: Jan 2017) (Month/Year – Example: Dec 2017)
2. What is the amount you would like to be reimbursed each month? $ _____

Important Note: The amount you request each month to be reimbursed cannot exceed your monthly contribution, if applicable, and the amount you request each month will be deducted from your RRA until one or more of the following happen:

- Your available funds are used up
- The calendar year ends
- You drop/add/change your existing coverage
- You notify UnitedHealthcare in writing to stop the monthly recurring reimbursements

3 Required Premium Expense Documentation

Please provide copies of documentation for the premiums that are eligible for reimbursement. If we are unable to read the documents due to the quality of the copy, we may need to request additional information. Here are some examples of acceptable supporting documentation for plan premiums:

- Insurance premium confirmation letter
- Monthly or quarterly billing statement
- Insurance premium payment coupon
- Bank statement showing premium deduction (electronic withdrawal)
- Annual statement from Social Security Administration (if plan allows Medicare Part B and/or D reimbursement)

4 Participant Signature

By signing below, I (or my designated representative – attach evidence of authority to sign for Participant) direct UnitedHealthcare to deduct the premium reimbursement amount indicated in this request and make regular monthly payments directly to me, based on expenses submitted and available funds. I understand that it is my responsibility to inform UnitedHealthcare if there are changes in coverage or monthly premium amount, or if I wish to stop monthly reimbursements.

x _____ _____

Participant Signature Date

Thank you for allowing us to serve you.

Where to return your form?

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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