UnitedHealthcare

Recurring Premium Expense Reimbursement Request

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

Questions? Please call us at 1-877-298-2305 if you have any questions while completing this form.

1005 RRA UHC

1 Participant information

First name, last name:	Last 4 of SSN:	Employer/plan sponsor name:
Participant address:	City, State ZIP:	

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 are reimbursed each month cannot exceed your monthly contract payment amount. The amount you request each month will be deducted from your HRA or FSA 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 Agreement and participant 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. I understand that it is my responsibility to inform Optum Bank if there are changes in coverage or monthly premium amount, or if I wish to stop monthly reimbursements.

X _____ _____

Participant's signature Date

Where to return your form and documentation?
By mail: UnitedHealthcare, P.O. Box 30516, Salt Lake City, UT 84130
By email: optumclaims@optumbank.com
By fax: 1-844-822-2881
Note: Forms without a signature will not be processed.

HRAs and RRAs are administered by Optum Financial.