Recurring Expense Reimbursement Request Form

UnitedHealthcare®
Healing health care. Together.℠

_____(Participant) takes part in the_____

(Print Participant Name) (Print Company Name)

Retiree Reimbursement Account Plan (Plan), administered by OptumHealth Financial Services, an affiliate of UnitedHealthcare. The Plan allows Participant to be reimbursed on a tax-qualified basis for medical expenses that are normally not reimbursed.

By signing below, the Participant or other Designated Representative (attach evidence of signer's authority to sign for Participant) directs the Plan to deduct the premium amount shown below from Participant's Retiree Reimbursement Account each month until one or more of the following happens:

- Participant's available funds are used up.
- Participant drops/adds/changes existing coverage.
- End of Plan year.
- Participant requests OptumHealth in writing to stop monthly payments.

Participant also requests the Plan to make regular monthly reimbursement payments directly to Participant.

Participant Information

I have read this document and understand and confirm that as a Participant in the Plan, a premium or premiums totaling $_____ will be deducted from my RRA account and reimbursed to me directly every month beginning _____/_____/_____ (Mo/Day/Yr).

Policy/Carrier Name #1	
Policy/Carrier Name #2 (if applicable)	SSN/TIN Number – –
Policy Account Number	Transit ABA Routing #

I understand the Plan will reimburse me based on the expenses I submit and my available funds. I understand it is my sole responsibility to inform the Plan administrator if my coverage ends or my monthly premium amount changes from the amount shown above. I accept full liability for timely notification of any changes.

Please note: If you choose the Automatic Recurring Reimbursement feature, it may take up to 10 business days for it to be added to your account. A new Recurring Expense Reimbursement Form must be submitted at the beginning of each plan year.

_____ _____

Participant Signature Date

Please return completed form to:

UnitedHealthcare, PO Box 728, Anoka, MN 55303-0728
Fax: 763-767-4700 ▪ Toll-free: 1-866-931-0070