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:
   
   **TIAA-CREF**  
   **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).
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 (CONTINUED)

2. First Name ___________________________ Middle Initial __________
   Last Name ___________________________
   Relationship* (Spouse, Domestic Partner, Dependent) ________________________ Date of Birth (mm/dd/yyyy) ______/_____/__________
   Social Security Number/Taxpayer Identification Number ______________________ Gender ______ M

3. First Name ___________________________ Middle Initial __________
   Last Name ___________________________
   Relationship* (Spouse, Domestic Partner, Dependent) ________________________ Date of Birth (mm/dd/yyyy) ______/_____/__________
   Social Security Number/Taxpayer Identification Number ______________________ Gender ______ M

4. First Name ___________________________ Middle Initial __________
   Last Name ___________________________
   Relationship* (Spouse, Domestic Partner, Dependent) ________________________ Date of Birth (mm/dd/yyyy) ______/_____/__________
   Social Security Number/Taxpayer Identification Number ______________________ Gender ______ M

3. SIGN AND DATE FORM

Relationship to Participant
   Self   ☐ Spouse   ☐ Eligible Dependent   ☐ Other ___________________________

Signature ___________________________ Date (mm/dd/yyyy) ______/_____/__________

Print Name ___________________________

Daytime Telephone Number ___________________________