This form is used to activate claim reimbursements for participants who have satisfied the eligibility provision of their employer’s retirement healthcare plan. Participants requesting reimbursement for special circumstances should call 877 554-1004 or contact your benefits office for more information.

IMPORTANT: Claim reimbursements can only be paid from the TIAA-CREF Money Market Mutual Fund. You may need to transfer funds to the Money Market Mutual Fund from other funds prior to submitting claims.

Note: If you are submitting this form as an eligible survivor, please complete all sections of the form including participant information in Section 1. For additional instructions please refer to the retirement healthcare plan survivor benefits kit.

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).

1. PARTICIPANT INFORMATION

Participant First Name

Middle Initial

Last Name

Street Address

City

State

Zip Code

Social Security Number/Taxpayer Identification Number

Date of Birth (mm/dd/yyyy)

Telephone Number

Ext

Marital Status

Gender

E-mail Address

Employer Name

Participant Account #

2. FAMILY INFORMATION (SPOUSE AND ELIGIBLE DEPENDENTS)

1. First Name

Middle Initial

Last Name

Relationship* (Spouse, Domestic Partner, Dependent)

Date of Birth (mm/dd/yyyy)

Social Security Number/Taxpayer Identification Number

Gender

F

M

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### 2. FAMILY INFORMATION (CONTINUED)

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### 3. SIGN AND DATE FORM

Relationship to Participant
- [ ] Self
- [ ] Spouse
- [ ] Eligible Dependent
- [ ] Other

Signature

Date (mm/dd/yyyy)

Print Name

Daytime Telephone Number