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).
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 #

* 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 (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

CONTINUED ON NEXT PAGE
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  F

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  F

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  F

3. SIGN AND DATE FORM

  Relationship to Participant
  [ ] Self  [ ] Spouse  [ ] Eligible Dependent  [ ] Other  
  Signature                                                                 Date (mm/dd/yyyy)
  Print Name                                                        
  Daytime Telephone Number                                        

PLEASE RETAIN A COPY FOR YOUR RECORDS