JPMorgan Chase & Co.

UnitedHealthcare®

MRA and/or Health Care Spending Account Claim Form

Use this form to request payment from your
Medical Reimbursement Account (MRA) Policy No.: 742678
and/or Health Care Spending Account (HCSA) Policy No.: 742677

MAIL CLAIM FORM TO:
Health Care Account Service Center
P.O. Box 981506
El Paso, TX 79998-1506
Fax: 915-231-1709 Toll-Free Fax: 866-262-6354
Customer Service: 800-272-8970

Complete Part 1 entirely and legibly. If you do not know your Member ID, refer to your ID card or contact UnitedHealthcare. To change your address with JPMorgan Chase, access the JPMorgan Chase intranet > Me@JPMC > My Profile > My Personal Profile > Home Information.

Complete Part 2 if you are claiming medical, dental, vision, prescription or over-the-counter (OTC) medication expenses (must have a prescription for eligible OTC drugs or medicines; medical supplies do not require a prescription — including insulin).

DO

- Separate expense types by individual name.
- Complete the total requested amount.
- Include provider name, address and Tax ID (if available).
- Send original copies on white paper. Carbon copies and colored paper are not legible when scanned.
- Circle names and dollar amounts on receipts.
- Tape small receipts to a standard 8.5" x 11" sheet of blank paper. Ensure print is legible.
- Attach itemized receipts/documentation to the form.
- Read Certification for Reimbursement, sign and date form.
- Make a copy of form and documentation for your personal records.

DO NOT

- Do not submit canceled checks or credit card receipts alone. These are not adequate documentation without supporting itemization.
- Do not highlight names, prices or dates on receipts. They are not legible when scanned.
- Do not handwrite item names on receipts. These are not acceptable.
- Do not submit handwritten receipts for Rx.
- Do not submit pre-treatment estimates or estimated insurance statements.

MRA must be used first for eligible medical and prescription drug expenses.

For **medical, dental, vision and hearing expenses**, submit your insurance carrier's explanation of benefits (EOB) statement with your completed form. When applicable, your insurance claim must be finalized prior to submitting a request for reimbursement.

For expenses not covered by your medical, dental or vision insurance plan and for copayments, you must submit documentation, which includes the following information:

• Name and address of provider • Dollar amount charged • Date of service • Patient's name • Type of service
• Reason for non-coverage (Insurance carrier EOB, if applicable)

Prescription documentation must contain the following:

• Patient name • Out-of-pocket cost of the drug • Date the prescription was filled • Prescription name or NDC# or the word copay must be printed on the receipt (information usually can be found on prescription tags provided by pharmacies)

For **eligible over-the-counter (OTC) drugs or medicines** (requires a prescription to be reimbursable — other than insulin) or **eligible OTC medical care supplies** (does not require prescription), you must check the OTC box on the claim form.

Documentation must contain the following:

• Printed receipt • Name of over-the-counter item • Price • Date of purchase • OTC prescription (only if OTC drug or medicine)

Mail (or fax) the form and required documentation to the address (or fax number) provided on this form. All reimbursement requests for a plan year must be postmarked prior to the filing deadlines in your plan documents. Please refer to your plan document for health-related services that may not be covered under your MRA/HCSA. A list of eligible/non-eligible items along with frequently asked questions are available online at **myuhc.com®** through My Health.

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Part 1 Employee/Subscriber Information (Please Print) Please read the instructions in their entirety before completing form.

Employee/Subscriber Name (Last and First)	Member ID	Date of Birth	Daytime Telephone No
Mailing Address, City, State, Zip Code — Please also notify JPMorgan Chase of any address changes.		Employer Name: JPMorgan Chase	

Part 2 Health Care Expenses (Please Print). Itemize **each** expense using separate entries below. Use additional forms as necessary.

Date of Service From:	Patient Name/Relationship	Date of Birth	Description of Services	Amount
Date of Service To:	Name of Provider	Provider Phone #	Provider Address	
Type of Service[1] (Please check): MD / RX / OTC / VIS / DN / HR		Provider Tax ID # (optional)		

Date of Service From:	Patient Name/Relationship	Date of Birth	Description of Services	Amount
Date of Service To:	Name of Provider	Provider Phone #	Provider Address	
Type of Service[1] (Please check): MD / RX / OTC / VIS / DN / HR		Provider Tax ID # (optional)		

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Date of Service From:	Patient Name/Relationship	Date of Birth	Description of Services	Amount
Date of Service To:	Name of Provider	Provider Phone #	Provider Address	
Type of Service[1] (Please check): MD / RX / OTC / VIS / DN / HR		Provider Tax ID # (optional)		

[1]Please check one box for each expense type: MD=Medical, RX=Prescription, OTC=Over-the-Counter, VS=Vision, DN=Dental, HR=Hearing

Total Request for Reimbursement: $

Certification for Reimbursement

I certify that any expenses for which I am requesting reimbursement from my health care accounts, as itemized above, were incurred by me (and/or my covered spouse and/or covered dependents) for health care as permitted under the health care accounts and have not been reimbursed, and I will not seek reimbursement under any other plan. I understand that expenses reimbursed through the health care account programs cannot be used to claim any federal income tax deduction or credit. To the best of my knowledge and belief, my statements are complete and true. I agree that by submitting this claim for reimbursement, I am agreeing to these certification terms.

EMPLOYEE/SUBSCRIBER SIGNATURE: ______________________ **DATE:** ______________