Mail to:
PayFlex Systems USA, Inc.
P.O. Box 3039
Omaha, NE 68103-3039
1-800-284-4885

HEALTH REIMBURSEMENT ARRANGEMENT
TRANSITION HRA CLAIM FORM

FAX TO:
PayFlex Systems USA, Inc.
(402) 231-4310
(No Cover Page Required)
Page 1 of _____

Employee Name _____ **Employee ID**_____

Employer Name _____

Note: If you need to make an address change, please contact your employer HR/Benefits office to notify us immediately.

TRANSITION HRA (T-HRA) Claims *(For you or your dependents)*
The expenses for which you are requesting reimbursement from your T-HRA must not be reimbursed from any other source. This means if you have medical, dental or vision insurance, all expenses must be submitted to your insurance company before submitting for reimbursement from your T-HRA. When you receive the **Explanation of Benefits Statement (EOB)** from your insurance company, submit a copy to us along with this completed claim form. If you are enrolled in a High Deductible Health Plan Option ("HDHP Option") and requesting reimbursement for medical expenses other than dental and/or vision care expenses, you must submit a copy of the EOB from the HDHP Option and the EOB must reflect that the individual incurring the medical expense has met the annual HDHP Deductible.

Balance forward statements, cancelled checks, credit card receipts or received on account statements are not acceptable. Prescription drug claims must include the drug name and require the pharmacy receipt (not the cash register receipt) or a printout of prescriptions from your pharmacy. Orthodontia claims require an itemized statement/payment receipt, the orthodontist's contract/payment agreement or monthly payment coupons.

In addition, Union Pacific employees enrolled in an HDHP Option and Medicare eligible LTD participants enrolled in a UHC PPO Option requesting reimbursement of an expense incurred by a Dependent must provide proof that such Dependent is enrolled as a Dependent under the Plan. Such proof may be provided by going to www.myuhc.com, printing a copy of the page entitled **"View Account Balances"** showing your covered Dependents, and submitting such page with this claim form.

****** Information below must be completed -- "See Attached" is not acceptable. ******

Exact Date of Service MM/DD/YY	Patient Name	Relation To You	Name of Provider/Address	Description of Service	Amount Requested
				Total	**$**

I certify that I or my Dependent(s) have actually incurred these eligible expenses. I understand that expense incurred means the service has been provided that gave rise to the expense, regardless of when I am billed or charged for, or pay for the service. The expenses have not been reimbursed or are not reimbursable from any other insurance or benefit plan or health flexible spending account plan. I understand that any amounts reimbursed may not be claimed on my or my spouse's income tax returns. If requesting reimbursement of an expense incurred by my Dependent, I certify that my Dependent incurred such expense while enrolled as a Dependent under the Group Health Plan. I have received and read the printed material regarding the T-HRA plan and understand all of the provisions. For a description of other information, if any, you must submit with your claim, please consult the claim procedures in your Group Health Plan's Summary Plan Description.

Employee Signature _____ ***Date***_____

******Make copies for yourself, since these documents will not be returned. If you fax your claim, keep the original.******