Instructions

Fidelity Retiree Health Reimbursement Plan
Reimbursement Request Form

How the Plan works:

The Fidelity Retiree Health Reimbursement Plan (the Plan) is designed to help eligible employees pay for eligible medical expenses during retirement.

You are eligible to submit requests for reimbursement from your accumulated credits if you are:

- Terminated from Fidelity employment with at least 10 years of service and are age 55 or older.
- The ex-spouse of a Plan participant who has continued Plan coverage under COBRA.
- The surviving spouse of an eligible employee with Plan credits.

1. Complete the "Plan Participant Information" section.

2. Complete the "Eligible Medical Expenses" section.
   You may request reimbursement for eligible medical expenses incurred after you became a Plan participant and are eligible to access your credits. Each expense must be listed separately. For example, you must list each medical, dental or other group health plan expense on a separate line. If you need more space, please make a copy of this form. For a list of eligible medical expenses, refer to IRS publication 502 or 969 that can be found at www.irs.gov.

3. Enclose the following documents. If submitting reimbursement for:
   - *A deductible, copayment, or out-of-pocket expense*, enclose a copy of the Explanation of Benefits (EOB) from your health plan, showing any balance not paid by the plan. If your plan does not issue EOBs, you must attach an itemized receipt(s) from your health care provider.
   - *A health plan, Medicare, or long-term care premium,* enclose a copy of the invoice provided by the health plan.
   - *Health care expenses not covered, or only partially covered, by insurance*, enclose an original itemized receipt indicating the provider's name, address, dates of service, and type of service. You must also include proof of payment (e.g., receipt from provider indicating amount paid).

4. Read the "Your Signature" section, then sign and date the form.

5. Make a copy of the form and all attachments for your records.

6. Return copies of the original form and original documents to (retain the originals for your records):

   Fax Number:
   1-813-830-7900

   Mailing Address:
   Acclaris Reimbursement Center
   P.O. Box 25171
   Lehigh Valley, PA 18002-5171

Fidelity Retiree Health Reimbursement Plan
Reimbursement Request Form (continued)

Plan Participant Information

Last name	First name	MI	SSN

Daytime Phone Number	Email Address

Your mailing address currently on file will be used. If you've had a change of address, please update your information on Fidelity NetBenefits®.

Eligible Medical Expenses

Date of Service							
From	To	Provider	Type of Service	Reimbursement Amount Requested	Total Expense Amount	Amount Paid by Insurance	Amount Paid by You

If you are filing a claim for your spouse, please fill out the following information:

Patient's Name	Relationship to Participant	Patient's Date of Birth

Signature

I certify that to the best of my knowledge the above information is accurate and that reimbursement is being requested only for expenses incurred by me and/or my spouse. I am requesting reimbursement only for eligible medical expenses as defined in IRS Publication 502 or 969. I authorize Acclaris, as the administrator for FMR LLC, to reimburse me for the amount requested from my Retiree Health Reimbursement Plan. I understand that any person who knowingly and with intent to defraud or deceive any claims reimbursement company, who files a statement of claim containing any materially false or misleading information, is guilty of a crime and may be liable for substantial civil penalties, and I will hold Acclaris harmless for payment of any ineligible expenses presented in such a manner.

Participant Signature

Date

Keep this original form for your records. Make a copy of this form and return it to:

Acclaris Reimbursement Center
P.O. Box 25171
Lehigh Valley, PA 18002-5171
Fax: 1-813-830-7900