

ENROLLMENT FORM FOR COVERAGE UNDER GROUP POLICY GA-23111

INSTRUCTIONS

1. Please print all entries in ink.
2. If the employee or any dependent is covered under **Medicare due to disability**, please attach a copy of the **red, white and blue Medicare Card**.
3. If eligible for **Medicare due to age**, be sure to provide your **Health Insurance Claim Number** from your Medicare Card in the space provided below.
4. If you are applying for **Plan E**, please send a copy of your **Railroad Retirement Board BA-6 and Receipt For Your Claims forms**.
5. If you are applying for **Plan M**, please send a copy of your **MBCR Early Retirement ID card or other proof showing you have coverage**.

6. Please mail this form with the required payment to:
UnitedHealthcare
RAILROAD ADMINISTRATION
450 COLUMBUS BLVD.
P.O. BOX 150453
HARTFORD, CT 06115-0453
NEED ADDITIONAL INFORMATION?
SEE OUR WEBSITE AT:
www.myuhc.com/groups/railroadinfo

NAME OF EMPLOYEE (LAST) (FIRST) (M.I.)			EMPLOYEE SOCIAL SECURITY NUMBER	DATE OF BIRTH MO. DAY YR.	HEALTH INSURANCE CLAIM NUMBER (From your red, white and blue Medicare Card.)
BILLING ADDRESS NO. AND STREET CITY STATE ZIP (AREA CODE)					HOME TELEPHONE NUMBER
NAME OF EMPLOYER		NAME OF UNION WHICH REPRESENTED YOU		DATE OF HIRE MO. DAY YR.	DATE LAST WORKED MO. DAY YR.
ENTER NUMBER OF MONTHS OF RAILROAD SERVICE		IF YOU RECEIVED VACATION PAY AFTER YOU STOPPED WORKING ENTER MONTH AND YEAR MO. YR.			
PLEASE CHECK THE REASON THE EMPLOYEE LEFT WORK:					
<input type="checkbox"/> DISMISSED <input type="checkbox"/> DISABLED <input type="checkbox"/> SUSPENDED <input type="checkbox"/> FURLOUGHED		<input type="checkbox"/> RESIGNED <input type="checkbox"/> LEAVE OF ABSENCE <input type="checkbox"/> PREGNANCY LEAVE		<input type="checkbox"/> DEATH (DATE OF DEATH) _____ <input type="checkbox"/> OTHER (GIVE REASON) _____ <input type="checkbox"/> RETIRED DATE APPLIED FOR RAILROAD RETIREMENT ANNUITY MO. DAY YR. _____ EFFECTIVE DATE OF ANNUITY AGE ANNUITY <input type="checkbox"/> DISABILITY ANNUITY <input type="checkbox"/> MO. DAY YR. _____	

Note: Each June 1st of that calendar year, and only at that time, adjustments to the premium for all plans under GA-23111 may occur. Additionally, if you are enrolled in either Plan A, B, or C under GA-23111, and a change in the premium amount you pay does occur, you will be allowed, at that time, to switch your plan to a different plan (A, B, or C) if available.

RATES SUBJECT TO CHANGE JUNE 1	REQUIRED MONTHLY PAYMENT					
	PERSONS ELIGIBLE UNDER MEDICARE	PERSONS ELIGIBLE UNDER EARLY RETIREMENT MAJOR MEDICAL PLAN	PERSONS ELIGIBLE UNDER MBCR EARLY RETIREMENT PLAN	PERSONS NOT ELIGIBLE UNDER MEDICARE OR EARLY RETIREMENT MAJOR MEDICAL PLAN		
PERSONS TO BE INSURED (PLEASE CHECK THE APPROPRIATE BOXES)	<input type="checkbox"/> PLAN F <small>NO PRESCRIPTION COVERAGE</small>	<input type="checkbox"/> PLAN E	<input type="checkbox"/> PLAN M	<input type="checkbox"/> PLAN A	<input type="checkbox"/> PLAN B	<input type="checkbox"/> PLAN C
I WISH TO BE BILLED: <input type="checkbox"/> MONTHLY <input type="checkbox"/> QUARTERLY						
EMPLOYEE	<input type="checkbox"/> \$155.00	<input type="checkbox"/> \$160.00	<input type="checkbox"/> \$160.00	<input type="checkbox"/> \$265.00	<input type="checkbox"/> \$350.00	<input type="checkbox"/> \$440.00
DEPENDENTS – SPOUSE, WIDOW/WIDOWER	<input type="checkbox"/> \$155.00					
DEPENDENTS – SPOUSE, WIDOW/WIDOWER, CHILDREN UNDER AGE 19, STUDENTS (AGE 19 TO 25), INCAPACITATED CHILD (AGE 19 AND OVER)		<input type="checkbox"/> \$160.00	<input type="checkbox"/> \$160.00	<input type="checkbox"/> \$265.00	<input type="checkbox"/> \$350.00	<input type="checkbox"/> \$440.00
EACH PARENT – ELIGIBLE UNDER MEDICARE	<input type="checkbox"/> \$155.00					
EACH INCAPACITATED CHILD – ELIGIBLE UNDER MEDICARE	<input type="checkbox"/> \$155.00					

If an enrollment is being submitted for a spouse, dependent children under age 19, parents, parents-in-law, a student child or an incapacitated child, you must complete the following for each person. If you need more space to list dependents, please attach an additional sheet of paper and include all items listed below. Health insurance claim number is required if the individual is eligible for Medicare.

NAME (LAST) (FIRST) (M.I.)	RELATIONSHIP	SOCIAL SECURITY NUMBER	DATE OF BIRTH MO. DAY YR.	HEALTH INSURANCE CLAIM NUMBER (From your red, white and blue Medicare Card.)
NAME (LAST) (FIRST) (M.I.)	RELATIONSHIP	SOCIAL SECURITY NUMBER	DATE OF BIRTH MO. DAY YR.	HEALTH INSURANCE CLAIM NUMBER (From your red, white and blue Medicare Card.)
NAME (LAST) (FIRST) (M.I.)	RELATIONSHIP	SOCIAL SECURITY NUMBER	DATE OF BIRTH MO. DAY YR.	HEALTH INSURANCE CLAIM NUMBER (From your red, white and blue Medicare Card.)
NAME (LAST) (FIRST) (M.I.)	RELATIONSHIP	SOCIAL SECURITY NUMBER	DATE OF BIRTH MO. DAY YR.	HEALTH INSURANCE CLAIM NUMBER (From your red, white and blue Medicare Card.)

I understand that the benefits to which I am subscribing are those indicated by the required monthly payment check hereon for the plan or plans as described in the booklet furnished to me in connection with Group Policy GA-23111. I also understand that I will be notified in writing by UnitedHealthcare if I am not accepted or will receive a bill for the next payment if I am accepted.

SIGNATURE OF EMPLOYEE

DATE