ENROLLMENT FORM FOR COVERAGE UNDER GROUP POLICY GA-23111

INSTRUCTIONS

1. Please print all entries in ink. **SOCIAL SECURITY NUMBER IS REQUIRED.**
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, you must send us a copy of your Railroad Retirement Board BA-6 and Receipt for Your Claims form or your Application will not be processed.**
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
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		HOME TELEPHONE NUMBER (AREA CODE)
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:

- ☐ DISMISSED
- ☐ DISABLED
- ☐ SUSPENDED
- ☐ FURLOUGHED
- ☐ RESIGNED
- ☐ LEAVE OF ABSENCE
- ☐ PREGNANCY LEAVE
- ☐ DEATH ________ (DATE OF DEATH)
- ☐ OTHER ________ (GIVE REASON)
- ☐ **RETIRED**
  - DATE APPLIED FOR RAILROAD RETIREMENT ANNUITY MO. DAY YR.
  - EFFECTIVE DATE OF ANNUITY
  - AGE ANNUITY ☐
  - DISABILITY ANNUITY ☐ 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) **I WISH TO BE BILLED:** ☐ MONTHLY ☐ QUARTERLY	PLAN F NO PRESCRIPTION COVERAGE	PLAN E	PLAN M	PLAN A	PLAN B	PLAN C
EMPLOYEE	☐ $180.00	☐ $200.00	☐ $200.00	☐ $335.00	☐ $460.00	☐ $590.00
DEPENDENTS – SPOUSE, WIDOW/WIDOWER	☐ $180.00					
DEPENDENTS – SPOUSE, WIDOW/WIDOWER, CHILDREN UNDER AGE 19, STUDENTS (AGE 19 TO 25), INCAPACITATED CHILD (AGE 19 AND OVER)		☐ $200.00	☐ $200.00	☐ $335.00	☐ $460.00	☐ $590.00
EACH PARENT – ELIGIBLE UNDER MEDICARE	☐ $180.00					
EACH INCAPACITATED CHILD – ELIGIBLE UNDER MEDICARE	☐ $180.00					

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. SOCIAL SECURITY NUMBER IS REQUIRED.

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