The Railroad Employees National Early Retirement Major Medical Benefit Plan (Group Health Plan GA-46000)
Application for Coverage

If you believe you currently are, or will soon be, eligible for coverage under the Railroad Employees National Early Retirement Major Medical Benefit Plan (GA-46000), complete this form as soon as possible and mail to the address on the back of the form. UnitedHealthcare will confirm your eligibility and send you identification cards, or advise you why you are not eligible.

Part 1 – Employee/Retiree Information

Last Name_____ First Name_____ MI___ SSN_____

Street Address_____City_____ State___ Zip Code_____

Telephone Number_____ Former Employer_____ Union_____

Date you last worked_____ Date you applied for annuity_____ Annuity effective date_____

Number of service months_____ Date of Birth_____

If you received vacation pay after you stopped working, give date(s)_____

Type of Annuity (Check One)
- ☐ Full Age (60/30)
- ☐ Occupational Disability
- ☐ Total and Permanent Disability
- ☐ Other (describe) _____

Part 2 – Family Information

If an enrollment is being submitted for a spouse, dependent children under age 19, a student child aged 19-25, or an incapacitated child, you must complete the following for each person. If you need additional space to list dependents, please attach an additional sheet of paper and include all items listed below. A Social Security Number is required for every individual and a Health Insurance Claim number is required if the individual is eligible for Medicare.

Complete for each of your Eligible Dependents

	First Name	MI	Date of Birth	Sex	Social Security Number (Required)	Eligible for Medicare? Y/N	Health Insurance Claim Number (From Red/White/Blue Medicare Card) (Required if Medicare Eligible)
Spouse							
Child 1							
Child 2							

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Children are not covered after attaining age 19 except as indicated in the definition of an Eligible Dependent as stated in the booklet describing the Railroad Employees National Early Retirement Major Medical Benefit Plan. **IF YOU LISTED CHILDREN, AGE 19 OR OVER, COMPLETE THE SECTION BELOW.**

	First Name	MI	Disabled (Yes/No)	Student (Yes/No)	If student, give name, address and telephone number of the school
Child 1	_____	____	_____	_____	_____
Child 2	_____	____	_____	_____	_____

Part 3 – Employee Verification

Group Health Plan GA-46000 does not cover persons eligible under Medicare. Persons approved for disability Part A must enroll for additional Medicare Benefits. The member is responsible to notify UnitedHealthcare immediately when any person becomes eligible for Medicare. The member will become responsible for any medical bills that are paid without knowledge of Medicare. See the section in the booklet entitled “Additional Information” for more information regarding Medicare.

This information will be used in connection with all claims for benefits under the Plan. I understand it is the member’s obligation to keep this information up to date by calling UnitedHealthcare at 1-800-842-5252 with any changes. Failure to do so may affect benefits under the Plan.

All information on this form is true and correct to the best of my knowledge.

Signature _____ **Date**_____

Important Note: Additional documents are required for processing your application for Group Health Plan GA-46000. Please send copies of the following completed documents along with this application (do not send in a separate envelope). These forms are provided by your Railroad Retirement Board.

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☐ Your last BA-6 FORM

☐ Form AA-1 – RECEIPT FOR YOUR CLAIM

You may be asked to supply your Award Notice

When completed, mail all information to:
UnitedHealthcare
Railroad Administration
PO Box 30791
Salt Lake City, UT 84130-0791