

Retiree Medical Program Application

NATIONAL EMPLOYEES
HEALTH PLAN

Participant Information

Last Name _____ First _____ Initial _____
Participant ID No. _____ Date of Birth _____
Address _____ City _____ State ____ Zip _____
Home Phone _____
Date of Retirement (mm/dd/yy) _____ Date Last Worked (mm/dd/yy) _____
Are you eligible for coverage as an employee or as a dependent of a covered employee? Yes _____ No _____
Are you eligible for a Teamster pension benefit or an Employer sponsored pension plan? Yes _____ No _____
Please submit proof of pension benefit eligibility

Spouse Information

Last Name _____ First _____ Initial _____
Date of Birth _____
Address _____ City _____ State ____ Zip _____
Home Phone _____ Is spouse a NEHP Plan Participant? Yes _____ No _____

Employment Information

Please list below all the National Employees Health Plan participating employers for whom you were employed. Please attach a supplemental list for additional employers, and include any name changes for previous employers.

| Name of Employer | Location (City, State) | From (mm/yy) | To (mm/yy) |
|------------------|---------------------------|-----------------|---------------|
| 1. _____ | _____ | _____ | _____ |
| 2. _____ | _____ | _____ | _____ |
| 3. _____ | _____ | _____ | _____ |
| 4. _____ | _____ | _____ | _____ |
| 5. _____ | _____ | _____ | _____ |
| 6. _____ | _____ | _____ | _____ |

Authorization

Please investigate my eligibility for the Retiree Medical Program.

Printed name of applicant

Signature of applicant / Date

Please sign and mail your retiree application form to:
National Employees Health Plan • P.O. Box 430 • Sterling Heights, MI 48311
Phone 800-648-8200 • Fax 586-693-4760