

Retiree Medical Program Application



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