



Opt-Out (waiver) of Medical Coverage Form

I am currently covered under Amtrak's medical plan for agreement covered employees. My union agreement allows me to opt-out of the medical plan if I have medical coverage elsewhere. By opting out of the medical plan, I will not be required to contribute monthly payments to the Plan. Also, I will continue to be covered under Amtrak's dental and vision plans so long as I satisfy eligibility requirements of those plans.

Therefore I am requesting to opt-out of Amtrak's medical plan as I have medical coverage under the following medical plan:

_____ (insurance company name)

_____ (policy or group #)

_____ (name of primary subscriber under this plan)

My signature below indicates my authorization to cancel medical benefits for me and eligible family members. I understand that I can only re-enroll in the Amtrak health plan within 31 days after loss of coverage through the insurance company named above or during Amtrak's annual benefits open enrollment.

Employee Name: _____ **Employee I.D. #** _____
(please print)

Signature

Date

Please fax the completed form to the Amtrak Benefits Service Center, (515) 875-0599 or mail to Amtrak Benefits Service Center, P.O. Box 9183, Des Moines, IA 50306