C AND O EMPLOYEES' HOSPITAL ASSOCIATION

511 MAIN STREET, 2nd FLOOR
CLIFTON FORGE, VIRGINIA 24422-1166
TELEPHONE (540) 862-5728/5729 (800) 679-9135 FAX (540) 862-3552/4958

1897-2015 MORE THAN 100 YEARS OF EXCELLENCE

Employee Name_____
Employee ID Number _____
COEHA ID Number: COF0000_____

Dear Member:

We have received word that you are planning to retire from CSX Transportation and would like to retain your membership with the C & O Employees' Hospital Association. Before we can process your insurance, it will be necessary that you furnish us with the following information in order that we may determine your eligibility for membership. PLEASE COMPLETE ALL INFORMATION:

Social Security No. _____ Telephone No. (____)_____

Date of Birth _____ Last Day Worked _____Occupation_____

Division _____ Location _____ No. Years of Railroad Service _____

Name, Title, Address & Phone No. of Employing Officer:_____

_____

_____

Members retiring at age 60 or older, but not yet age 65, with 30 or more years of service with the Railroad Retirement Board are entitled to benefit plan (Plan 5).
Please send us a copy of your Railroad Retirement Award Notice Letter. This information is required in order to properly process your membership in a retired status. We will need a copy of your last BA-6 Form which shows your years of service under the Railroad Retirement Board if you qualify for Plan 5.

___ Plan 5: Premium is $250 monthly. $750 annual deductible, $25 copay on office visit. In-network Benefits paid at 95%, also has 60/30 major medical benefits.

____ I do not qualify for Plan 5, please enroll me in appropriate plan, Early Retirement or COBRA.

Our Rules and Regulations require that members enroll in both Parts A and B of Medicare when they are eligible. PLEASE ENCLOSE A COPY OF YOUR MEDICARE CARD, if eligible.

PAYMENT OPTION

I wish to select the following payment option: (check only one)

A._____I have enclosed the first dues payment and wish to pay on a quarterly, semi-annually or annual basis.

(OVER)

B. _____I authorize COEHA to have my dues premium withdrawn from my checking account monthly. My current rate is $_____. I understand that this premium may increase and I may cancel at any time. Enclosed is a voided blank check from my checking account. Dues will automatically be withdrawn from my account on the 5th of each month.

If you have health insurance coverage other than COEHA coverage, please fill out the Full Name & Address of Insurance Co.:

_____

_____

_____

Policy No. _____

Phone No. (_____)_____

Name of Spouse _____

Employer _____

Signed _____ Date _____