BUILDING AMERICA®

REQUEST TO CANCEL OR CHANGE
UNION PACIFIC RETIREE MEDICAL ELECTION

(PLEASE PRINT)

Retiree/Plan Member Name: _____

Employee ID Number: _____

Social Security Number (only if Employee ID is unknown): _____

Mailing/Street Address: _____

City/State/Zip Code: _____

Telephone Number: _____

Spouse's Name (if applicable): _____

If you wish to cancel your Union Pacific coverage, check the applicable box(es) below.

❑ I wish to cancel my participation in the Union Pacific Retiree Medical Program. I understand that I may not re-enroll unless I meet one of the criteria under the "Special Enrollment Periods" section of the Retiree Medical Guide. I am currently enrolled in:

- ❑ Retiree Only Coverage
- ❑ Family Coverage

I understand that, if I have family coverage, by canceling my participation in the Union Pacific Retiree Medical Program, my spouse's coverage, as well as that of any other covered dependents, will also be terminated.

❑ I wish to drop my spouse from participation in the Union Pacific Retiree Medical Program. I understand that he/she may not re-enroll unless he/she meets one of the criteria under the "Special Enrollment Periods" section of the Retiree Medical Guide.

Please sign and date this form. If this form is not signed, it will be returned to you, and processing of your request will be delayed.

NOTE: Requests for change of coverage will be effective the first of the month after the Union Pacific Workforce Shared Services receives your signed request (i.e., if the request is received in June, the change will be effective July 1st).

_____
(Retiree's/Plan Member's Signature)

_____
(Date)

Please return form to:

Union Pacific
Workforce Shared Services
1400 Douglas Street, Stop 0320
Omaha, NE 68179
Fax: (402) 233-2736