BUILDING AMERICA®

REQUEST TO CANCEL OR CHANGE
UNION PACIFIC RETIREE MEDICAL ELECTION

Retiree/Plan Member Name: _____

Employee ID Number OR Last 4 of SSN _____

Mailing/Street Address: _____

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 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.

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

Special Consideration: If requesting to change coverage during the annual Open Enrollment period for active employees, please check below if you wish for your change in coverage to be effective November 1st or January 1st. *If not specified, change request will follow guidelines mentioned above and will be processed effective November 1st.*

☐ November 1st (of current year)
☐ January 1st (of upcoming year)

Please sign and date this form, and return by mail, fax, or email. If this form is not signed the processing of your request will be delayed.

Retiree's/Plan Member's Signature: _____

Date: _____

Form must be returned to:
Union Pacific Employee Benefits
1400 Douglas Street, Stop 0350
Omaha, NE 68179
Fax: (402) 233-2736
Email: HRSC@up.com