ENROLLMENT CHANGE FORM
WAIVER

To disenroll yourself and dependents or remove a dependent only, please fill out this form and return it (by mail, fax, or email) to the Employee/Retiree Information Center (ERIC).

Fax: 1-630-753-7100.
Email to: **Retireehotline@navistar.com**
US mail to: Navistar, Inc- ERIC, P O Box 4080, Lisle, IL 60532

Retiree Name_____ Address _____
City_____
SSN_____ State _____
Zip_____

COVERAGE WILL BE WAIVED EFFECTIVE THE FIRST OF THE MONTH FOLLOWING ERIC'S RECEIPT OF THE FULLY COMPLETED FORM.

NOTE: Waiving health coverage in the Navistar Retiree Health Plan includes waiving the medical and prescription drug benefits. Dental, vision, hearing benefits, if applicable, are also waived.

I waive coverage for:

☐ Myself (including any covered dependents)

☐ Spouse

☐ Dependent Child(ren)

Name of Person to Remove	Social Security Number	Date of Birth	Relationship (Spouse, Child)	Gender

I understand that, by waiving coverage, any member removed from coverage or I will not be eligible for Medical, Prescription Drug, Dental, Vision and Hearing coverage through the Navistar, Inc. Retiree Health Benefit Program. I understand that I may re-enroll myself or my eligible dependents at a later date (if re-enrollment is an option under my plan) by completing the appropriate forms. A certificate of prior coverage may be required. If I am unable to provide a certificate of prior coverage, I understand that the pre-existing condition provision may apply.

Signature_____ Date_____