ENROLLMENT CHANGE FORM
ELECTION

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

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

Retiree Name_____ Medicare Eligible: YES____ NO_____
SSN_____ Medicare ID # (if yes above) _____
Date of Birth_____ Medicare Part A effective date _____

COVERAGE WILL GO INTO EFFECT THE FIRST OF THE MONTH FOLLOWING ERIC'S RECEIPT OF THE FULLY COMPLETED FORM.

PLEASE CHECK ONE:

☐ I Elect Retiree Healthcare Coverage- Medical Plan 1 (Non-Medicare)

☐ I Elect Retiree Healthcare Coverage- Medical Plan 2 (Medicare)

Name of Person to Add	Social Security Number	Date of Birth	Relationship (Spouse, Child)	Gender	Medicare Eligible (Circle One)	Medicare ID Number (Attach copy of Medicare card)
					Yes No	
					Yes No	

I request (for newly-elected retiree coverage only, check one):

☐ Pension Payment Deduction and I know that this request will not apply when the net pension payment is less than the amount of the premium. I may terminate any future pension payment deductions by giving written notice to the Company. It is my responsibility to pay any premium which is not deducted from my pension.

☐ Payflex to bill me for my required premium and I understand that my coverage will terminate upon failure to pay required premiums.

I understand that misstatements, misrepresentations or omissions may result in my coverage being voided as of its effective date with no benefits payable. I agree to inform Navistar, Inc. of any changes in eligibility of my dependents or other information relevant to this form. I recognize that I may terminate any future pension payment deductions by giving written notice to the Company. My signature below affirms that all information and statements provided on this form are full, complete and true to the best of my knowledge.

Signature_____ Date_____