Re: Disability Letter

We are in receipt of information from your employer indicating that you stopped working because you are disabled. In order for your health coverage to continue, we must have the proof of your disability statement below completed by your attending physician.

The completed form should be mailed or faxed to Railroad Enrollment Services. The mailing address and fax number are:

Railroad Enrollment Services
PO Box 30775
Salt Lake City, UT 84130-0775
Fax #: (248) 733-6080

IF THIS PROOF OF DISABILITY IS NOT RECEIVED, YOUR COVERAGE WILL BE TERMINATED.

If you have questions, please call Railroad Enrollment Services at (800) 753-2692.

TO BE COMPLETED BY ATTENDING PHYSICIAN:

Please put ssn here:

I certify that _____ has been disabled from performing his/her regular occupation from _____ (Date) to _____ (Date) due to the following condition(s):

_____

_____

Is the employee permanently disabled from his/her regular occupation? **YES NO** (Please circle one.)

If no, please give us an estimated return to work date _____, or

the date of his/her next appointment with you _____.

_____

Physician's Signature Date

MD0896