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Railroad Maintenance

and Industrial
Health and Welfare Fund

Executive Administrator
Dora L. Crenshaw

December 1, 2025

TO: Participants in the Railroad Maintenance and Industrial Health and Welfare Fund

RE: **2026 Annual Medical Claim Statement (Claim Form)**

Dear Participant:

As you may be aware, the Plan of Benefits of the Railroad Maintenance and Industrial Health and Welfare Fund requires the completion of an annual Medical Claim Statement ("claim form"). This form must be completed for each patient at the beginning of each calendar year before any claims can be processed for that patient.

Enclosed please find two (2) Medical Claim Statements. *One (1) of these forms must be completed for each patient in their entirety. Claim forms completed with more than one patient per form or without all applicable sections completed will not be accepted.* Should you require additional forms, these forms may be copied, or you may contact the Fund office at (800)-258-6534 to request additional forms be mailed to you. These forms are also available on the Fund's website at www.rrfunds.org under the "Forms" tab.

Please see the reverse side of this letter for step-by-step instructions as to the proper completion of the form. Should you prefer, you may contact the Fund office at (800)-258-6534 for assistance in completing the form.

Si necesita este formulario en español, por favor llame a la Oficina del Fondo al (800)258-6534 y se lo enviaremos por correo, o puede descargarlo del sitio web del Fondo en www.rrfunds.org.

Also, please be aware that no benefits can be processed for any claim incurred in the new 2026 calendar year without this form being fully completed and returned for each patient. Please return the completed forms to **Railroad Maintenance and Industrial Health and Welfare Fund 2725 West Monroe Street, Springfield, IL 62704**. A self-addressed envelope is enclosed for your convenience in returning the forms. The forms will be kept on file for any claims incurred in the year 2026. An additional form may be required should a claim be caused by an accidental injury or illness or for coordination of benefits purposes.

If you have any questions regarding this matter, you may contact the Fund office at (800)-258-6534 between the hours of 7:30 AM and 5:00 PM Monday through Friday. Thank you in advance for your cooperation.

Very truly yours,



Dora L. Crenshaw
Executive Administrator

INSTRUCTIONS FOR COMPLETING THE MEDICAL CLAIM STATEMENT

- 1. Member/Participant/Employee Information:** This would be the name of the person who is employed by a contractor who is signatory to a collective bargaining agreement requiring health and welfare contributions to be paid to this Plan. Please complete each section. If you have any other insurance, even if it is through Medicaid or Medicare, the Fund requires this information. Please attach a copy of the ID card from the other insurance. If you do not have the ability to copy the ID card, please handwrite the information on the form.
- 2. If you are not married, and have no Dependents, please turn the form over, sign and date the back of the form and return to the Fund Office in the envelope you were provided with the forms.**
- 3. If you are married: Please take the second form and complete both the top section (Member/Participant/Employee Information) as well as the second section, Spouse Information.** Please enter your spouse's name and other information in the second box. Please make sure to complete each area. If your spouse is employed, please mark the box indicating whether it's full time or part time. If your spouse is not employed, please mark that box. If your spouse has any other insurance, even if it is Medicaid or Medicare, please complete that section. Again, please attach a copy of the ID card from the other insurance. If you do not have the ability to copy the ID card, please handwrite the information on the form.
- 4. If you and your Spouse have no covered Dependents: We will need both your signatures and the date on the reverse side of the form. Please return both forms to the Fund Office in the envelope you were provided with the forms.**
- 5. If you have covered Dependents (children which include adult children under age 26): Each Dependent will need their own form. Please complete the top section (Member/Participant/Employee Information) as well as the third section Dependent Information.** If that Dependent is covered by any other insurance, even if that coverage is through Medicaid or Medicare, please indicate that on the form. Again, please attach a copy of the ID card from the other insurance. If you do not have the ability to copy the ID card, please handwrite the information on the form.
- 6.** Please turn the form over, sign, date and return to the Fund Office. The Dependent Information form needs only the signature of the Member/Participant/Employee if the Dependent is a minor. If the Dependent is over age 18, please have the Dependent sign the form as well.
- 7. We will need a separate form for each Dependent.** You may feel free to photocopy both sides of the form. If you have a printer and access to the internet, these forms may be downloaded and printed from the Fund's website: www.rrfunds.org under the Forms tab. You may also call the Fund Office to request additional forms be mailed to you.

The Fund Office does not accept these forms via fax or email. We must have the form(s) returned to the Fund office with original signatures.

We would also like you to be aware that the Fund may require additional information throughout the Plan year. If a claim is received that contains any indication of an accident or injury, the Claims Department staff may send an Accident or Injury Report form to be completed that describes how the accident or injury occurred. Even though you may not consider the injury an accident, the Fund is still required to investigate. If you should receive one of these forms and have questions. Please do not hesitate to contact the Fund Office. We are here to help you and will be glad to walk you through the completion of the form.

The Fund office phone number is (800)-258-6534 and the Fund office hours are 7:00 AM to 5:00 PM Central Time except for Federal Holidays. The mailing address is 2725 West Monroe Street, Springfield, IL 62704.