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Railroad Maintenance and Industrial Health and Welfare Fund

Executive Administrator
Paige C. Koeppel

November 5, 2026

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

RE: **2027 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.

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.

This form has been revised for easier use and understanding. ***Please note: If you or any of your dependents have other insurance coverage, please provide a copy of that ID card when mailing the completed forms. Please also provide information as to who is insured and what family members are covered under the other plan.***

Also, please be aware that no benefits can be processed for any claim incurred in the new 2027 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 may also be retuned via facsimile (217)-787-2973 or via email to service@rrfunds.org. The forms will be kept on file for any claims incurred in the year 2027. An additional form may be required should a claim be caused by an accidental injury or illness or for coordination of benefits purposes. More detailed instructions for completion of the forms is enclosed.

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 Central Time. Thank you in advance for your cooperation.

Very truly yours,

Paige C. Koeppel

Paige C. Koeppel
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.**

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.

You may return the completed form(s) via email to service@rrfunds.org, via facsimile (217)-787-2973 or via mail in the self-addressed return envelope provided.

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.