AMTRAK

Opt-Out (waiver) of Medical Coverage Form

I am currently covered under Amtrak's medical plan for agreement covered employees. My union agreement allows me to opt-out of the medical plan if I have medical coverage elsewhere. By opting out of the medical plan, I will not be required to contribute monthly payments to the Plan. Also, I will continue to be covered under Amtrak's dental and vision plans so long as I satisfy eligibility requirements of those plans.

Therefore I am requesting to opt-out of Amtrak's medical plan as I have medical coverage under the following medical plan:

_____ (insurance company name)

_____ (policy or group #)

_____ (name of primary subscriber under this plan)

My signature below indicates my authorization to cancel medical benefits for me and eligible family members. I understand that I can only re-enroll in the Amtrak health plan within 31 days after loss of coverage through the insurance company named above or during Amtrak's annual benefits open enrollment.

Employee Name: _____ **Employee I.D. #** _____
(please print)

_____ _____
Signature **Date**

Please fax the completed form to the Amtrak Benefits Service Center, (515) 875-0599 or mail to Amtrak Benefits Service Center, P.O. Box 9183, Des Moines, IA 50306

If you wish to opt-out of the Amtrak medical plan, please complete the enclosed Opt-Out of Medical Coverage Form and fax it to the Amtrak Benefits Service Center at 515-875-0599. Please return the form by April 15, 2008 to ensure your request is processed before the first May paycheck. Opt-out forms will not be accepted after April 30, 2008.

If you have any questions about the changes to your benefits, please contact the Amtrak Benefits Service Center at 800-481-4887.

Amtrak Benefits Department