CLEVELAND CLIFFS RETIREE HEALTHCARE ELECTION FORM

Retiree Healthcare Buy-In Eligible

Full Cost of the MAPD plan is paid by the retiree

2024 Rate Per Enrollee Per Month: $104.09

RETIREE INFORMATION

NAME: _____ PHONE: (____) _____

PHYSICAL ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

SOCIAL SECURITY #: _____ DATE OF BIRTH: ____/____/____
MONTH DAY YEAR

ENROLLED IN MEDICARE?: YES ☐ NO ☐ MEDICARE ID #_____

MEDICARE EFFECTIVE DATES: PART A:_____ PART B:_____

□ ***I elect to enroll in the Cleveland Cliffs Retiree Healthcare program effective _____.***
- □ **Retiree Restricted Healthcare Account (RRHA) Eligible**
- □ **Voluntary Enrollment without RRHA Eligibility**

SPOUSE INFORMATION

NAME: _____ PHONE: (____) _____

PHYSICAL ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

SOCIAL SECURITY #: _____ DATE OF BIRTH: ____/____/____
MONTH DAY YEAR

DATE OF MARRIAGE:_____

ENROLLED IN MEDICARE?: YES ☐ NO ☐ MEDICARE ID #_____

MEDICARE EFFECTIVE DATES: PART A:_____ PART B:_____

□ ***I elect to enroll in the Cleveland Cliffs Retiree Healthcare program effective _____.***

Retiree Signature	**Date**

Return Address: Cleveland Cliffs Benefit Administrator
Retiree Benefit Selection
4853 Galaxy Parkway, Suite K
Cleveland, OH 44128
Toll Free: (800) 379-6899