ArcelorMittal USA
Pre-Medicare Retiree Health Care Coverage Enrollment Form

Enrollment (check box for your enrollment election)

[ ] **Enrollment With Proof of Termination of Other Employer Coverage** - I elect to enroll the individual(s) designated below in ArcelorMittal USA retiree health care coverage. Coverage will be effective on the first of the month following termination of the other employer's coverage, as long as receipt of the completed and signed enrollment form and all required documentation is received within 90 days following termination. I understand I must submit proof of termination of employer's coverage in order to enroll myself and/or my designated eligible dependent(s) at this time. I authorize that the required health care coverage contribution be taken from my monthly pension check (if applicable) or billed to me on a monthly basis (if applicable).

ENROLL THE FOLLOWING:

Only list the name(s) of the individual(s) that you want to enroll for health care coverage.

Name (print): _____

Name (print): _____

Name (print): _____

Name (print): _____

*Signature of the **Retiree/Surviving Spouse** (not the spouse or dependent) is required for enrollment.*

Retiree/Surviving Spouse Signature: _____

Date: _____

Retiree/Surviving Spouse Social Security Number: _____

Address: _____

_____

Phone Number with Area Code: _____

Return completed and signed form to:

ArcelorMittal USA MC7005
Attn. Retiree Termination and Enrollment
3220 Dickey Rd.
East Chicago, IN 46312

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