APPLICATION FOR IRON ROAD HEALTHCARE DEPENDENT SUPPLEMENTAL PLAN (DSP)

Who can apply for the DSP?

The DSP is for dependents of active employees who are currently enrolled in the Iron Road Challenger Plan. The Plan is for dependents who are on the CHCB or MMCP.

What to do when the application is completed?

Once you have completed the application, you can mail it, fax it or email it back to us.

Iron Road Dependent Supplemental Plan
P.O. Box 161020
Salt Lake City, UT 84116-1020
Email: membership-helpdesk@ironroadhealthcare.com
Fax: 801-595-2003

What happens after I send in my application?

Once we receive your application and enroll your dependents in the DSP, you will receive a confirmation letter with a Member ID Number for each dependent you have enrolled in the Plan. You can use your dependent's Member ID online (www.ironroadhealthcare.com) to check the status of pending claims. *Please Note: A completed application does not guarantee eligibility.*

How do I pay my premium?

The DSP premium is paid monthly via payroll deduction. By signing this application, you agree to allow your employer to deduct your premium and forward it to Iron Road. The premium for the CHCB plan is $195 per month and $105 per month for the MMCP plan.

How do I file a claim?

The DSP covers allowable expenses, for your dependents, after all other insurance plans have paid, up to the plan limits.

- Once other plans have paid, you will receive an Explanation of Benefits (EOB).
- Submit all EOB's to Iron Road via fax, email or mail.
- Once your claim has been reviewed, Iron Road will pay you directly for the allowable expenses.
- Claims are usually paid within 30 days.
- You can check the status of a claim online at www.ironroadhealthcare.com using the dependent's Member ID number.
- Fax claims to 801-595-4399 or email them to help@ironroadhealthcare.com.

What if I have questions?

We are always happy to hear from you and to answer any questions you have. You can contact Iron Road Member Services at **800-547-0421**, Monday through Friday from 7:30 a.m. to 3:30 p.m., MST. You can also email us at **help@ironroadhealthcare.com**.

IRON ROAD
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1 STEP ONE: Select A Plan

Please tell us which insurance plan your dependent(s) is enrolled in.

☐ National CHCB Plan ☐ National MMCP Plan

2 STEP TWO: Current Iron Road Member Information

Please provide information about the current Iron Road (employee) Member.

Last name:	First name:	Middle initial:

Mailing address (that is on file with Iron Road):

City:	State:	ZIP:

Iron Road Member ID Number:	Date of Birth:	UPRR Employee ID Number:

Preferred Phone:	Email Address:

3 STEP THREE: Tell Us About Your Dependents

Please provide information about ***each*** of your dependents to be covered by the DSP.

Last name:	First name:	Middle initial:

Date of Birth:	Relationship to Member / Employee

Gender (M or F):	Is this dependent covered by insurance other than CHCB or MMCP? If yes, please list name of insurance company.

Last name:	First name:	Middle initial:

Date of Birth:	Relationship to Member / Employee

Gender (M or F):	Is this dependent covered by insurance other than CHCB or MMCP? If yes, please list name of insurance company.

Last name:	First name:	Middle initial:

Date of Birth:	Relationship to Member / Employee

Gender (M or F):	Is this dependent covered by insurance other than CHCB or MMCP? If yes, please list name of insurance company.

Last name:	First name:	Middle initial:

Date of Birth:	Relationship to Member / Employee

Gender (M or F):	Is this dependent covered by insurance other than CHCB or MMCP? If yes, please list name of insurance company.

Last name:	First name:	Middle initial:

Date of Birth:	Relationship to Member / Employee

Gender (M or F):	Is this dependent covered by insurance other than CHCB or MMCP? If yes, please list name of insurance company.

Last name:	First name:	Middle initial:

Date of Birth:	Relationship to Member / Employee

Gender (M or F):	Is this dependent covered by insurance other than CHCB or MMCP? If yes, please list name of insurance company.

If you have more than six dependents, please copy this page, provide their information and attach it to this application.

4 STEP FOUR: Your Agreement & Signature

By my signature below, I represent that the information given on this form is correct to the best of my knowledge and I agree to the following:

I hereby authorize my employer to deduct the required contributions for the (circle one) Iron Road Healthcare CHCB Dependent Supplemental Plan ($195 per month) or Iron Road MMCP Dependent Supplemental Plan ($105 per month) from my wages and to forward the contributions to Iron Road. I agree to comply with the rules and regulations of the supplemental plan I have chosen, and understand and agree that it is my responsibility to advise Iron Road if (1) my dependents' coverage under their health insurance or coverage is terminated or changes from the coverage listed in Step 1 of this form; (2) I have new dependents; and/or (3) persons previously reported as my dependents are no longer my dependents. If my dependents' primary coverage changes or terminates and Iron Road is not advised, I understand that Iron Road will not refund my contributions. If there are no payroll deductions, I understand that I must make the required contributions directly to Iron Road, and that if I do not do so, my coverage will be canceled. I understand that if this coverage is canceled, I must wait until the next open enrollment after three years have passed since such cancellation before I can re-enroll in the Plan. I understand that this Plan requires me to be enrolled (1) from my initial date of enrollment until the following December 31; and (2) in subsequent years, for a 12-month Plan Year, beginning January 1st and ending the following December 31. I also understand that I will automatically be re-enrolled for subsequent Plan Years, unless I notify Iron Road in writing prior to December 1st before the beginning of the Plan Year.

Iron Road Member Signature:	Date (MM/DD/YYYY):

This form should be signed by the current Iron Road Healthcare Member, as listed in Step Two of this application.