UAW RETIREE Medical Benefits Trust

Member Inquiry Form

Updated: May 2018

Please complete all areas of the form below -- do not leave any blanks.
If something is not applicable, write "NA" where possible.

Date

UBR/Counselor Name

Contact Phone

Contact Email

Would you prefer a response by phone or email?

Auto

Contract Holder

Member Name

Member Date of Birth

Full Social Security Number

Home Address

Member Phone

Member Email

Spouse's Name

Spouse Date of Birth

Dependent Name (s)

Check all that apply and provide details in the section below.

Dependent Eligibility

- ☐ Retirement
- ☐ Surviving Spouse
- ☐ Dependent
- ☐ Death Reporting

	Detail
◯ Current Health Plan	
◯ Medical Claim - Provide patient's name, date of service, doctor/hospital name, claim amount, a copy of the doctor/ hospital bill, and a copy of the explanation of benefits (required)	
◯ Drug - Provide patient's name, date of fill, place of service/mail order, and drug name.	
◯ Other - Dental, Vision, Physical Therapy, Hospice, etc.	
◯ Customer Service Issue - Plan/ Vendor	

Inquiry Detail

Please save and submit the completed form along with any supporting documentation to: memberexperience@rhac.com

If you cannot email this document, please print and complete the form, submitting along with copies of any supporting documentation as follows:

Fax: **313-324-5950**
Attn: Member Experience

U.S. Mail: **UAW Retiree Medical Benefits Trust**
Attn: Member Experience
P.O. Box 14309
Detroit, MI 48207