

**AUTHORIZATION TO DEFER ENTRY INTO THE AA RETIREE MEDICAL COVERAGE**

Voluntary Deferral of Premium-based AA Retiree Medical Coverage in Favor of being covered under another medical plan.

Retiree / Personnel # \_\_\_\_\_ Retiree Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
Please print

Social Security # \_\_\_\_\_ Retirement Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex M F Martial Status S M  
Circle one Circle one

**Retiree Acknowledgement to Defer Entry into the  
AA Retiree Medical Coverage**

I hereby request that my existing AA Retiree Medical coverage be deferred for myself and eligible dependents. I/we are currently covered under another medical plan. I understand that once this medical coverage ends I must notify American Airlines HR Services to activate my AA Retiree Medical.

**Consent of Spouse / Domestic Partner**

I have reviewed the statement made by my spouse/domestic partner to defer entry into the AA Retiree Medical coverage. I acknowledge that my spouse / dependents are covered under another medical plan.

EFFECTIVE DATE \_\_\_\_\_

DATE \_\_\_\_\_ Signature of Retiree \_\_\_\_\_

DATE \_\_\_\_\_

Signature of Spouse / Domestic Partner \_\_\_\_\_

Return this signed and dated form to American Airlines HR Services P.O. Box 9741, Providence, RI 02940-9741  
Make and keep a copy of this form for your records.



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