

NAME _____

SSN _____

HOME PHONE () _____

NOTICE: To insure continued eligibility, payment must be received by the 15th of the month prior to the month of coverage. Send this coupon and your check to the address below.

Enclosed is my payment for _____, 200__.

MEDICAL \$ _____

DENTAL \$ _____ The Goodyear Tire & Rubber Co.
P O Box 403365

VISION \$ _____ Atlanta, GA 30384-3365

TOTAL \$ _____

LAYOFF BENEFIT PAYMENT COUPON

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