CARE
RAILROAD HEALTHCARE
Serving Current and Former BNSF Railroaders

800.334.1330
254.773.1330
fax 254.774.7652

4912 Midway Drive
Post Office Box 6130
Temple, TX 76503-6130

www.carehealthplan.com

"Celebrating 138 Years of Railroaders Serving Railroaders"

Plan #4100 - Supplement to Medicare Parts A & B Only - No Prescription Drug Benefit
$174.00 monthly ($522.00 quarterly)
Please check box that pertains to you:

☐ Retired Employee (BNSF) ☐ Disabled Retired Employee (BNSF)

☐ Spouse or Disabled Spouse of Retired Employee

☐ Surviving Spouse or Disabled spouse of Deceased Employee

A. COMPLETE THE FOLLOWING INFORMATION:

First Name _____ Middle Initial _____ Last Name _____

Home Address _____

City _____ State _____ Zip _____

E-mail _____ Date of Birth _____ Sex: __ Male __ Female

Home Telephone (_____) _____ Cell Phone (_____) _____

Please provide us with the following information located on your Medicare card or a copy of your card.

_____

_____

_____

Your application must be received at least 30 days prior to your requested effective date. The effective date of enrollment must be the first day of a month.

I wish my Medicare supplemental plan to become effective: _____

Please list any other health insurance policies that provide benefits which this Medicare supplement would duplicate:

_____

_____

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Release of information: By joining this plan, I allow the Centers for Medicare & Medicaid Services (CMS) to give information to the plan. I hereby authorize the Social Security Administration and/or the Railroad Retirement Board to furnish information to **CARE Railroad Healthcare** regarding Hospital Insurance benefits (Part A) and Medical Insurance benefits (Part B) under Title XVIII of the Social Security Act. I hereby authorize the Social Security Administration and/or the Railroad Retirement Board to furnish **CARE Railroad Healthcare** information as to Part B benefits received and information regarding Part B termination and the effective month of such termination, for its use in connection with the operation of **CARE Railroad Healthcare**.

CARE Railroad Healthcare does not exclude or limit membership based on your health condition.

I understand that my signature on this application means that I have read and understand the contents of this application.

Applicant's Signature: _____ Date:_____

Name of person or persons authorized to receive my protected health information (PHI).
Please include relationship to applicant and contact phone number.

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