



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 More Than 138 Years of Excellence

**A. PLEASE INDICATE WHICH PLAN YOU WISH TO ENROLL IN:**

<input type="checkbox"/> <b>Plan #4000 - Supplement to Medicare Parts A &amp; B with Navitus MedicareRx - Prescription Drug Plan **</b> \$325.00 monthly (\$975.00 quarterly).	<b>Please check box that pertains to you:</b> <input type="checkbox"/> Retired or Disabled Employee (ATSF / BNSF) <input type="checkbox"/> Spouse or Disabled Spouse of Retired Employee <input type="checkbox"/> Surviving or Disabled Spouse of Deceased Employee
<input type="checkbox"/> <b>Plan #4100 - Supplement to Medicare Parts A &amp; B NO Prescription Drug Benefit</b> \$174.00 monthly (\$522.00 quarterly)	

**B. 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.**



\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**\*\* IF YOU ARE ENROLLING IN PLAN #4000 AND HAVE HAD 63 OR MORE DAYS IN A ROW WHEN YOU DID NOT HAVE PART D OR OTHER CREDITABLE PRESCRIPTION DRUG COVERAGE, MEDICARE MAY CHARGE A LATE ENROLLMENT PENALTY IF YOU JOIN A PART D PLAN LATER.**

**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**. I also hereby authorize **CARE Railroad Healthcare** and/or **Navitus MedicareRx (PDP)** to release information, including my prescription drug event data, to CMS, who may release it for research and other purposes which follow all applicable Federal statutes and regulations.

**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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**Who Referred You or How Did You Hear about CARE:**

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