CARE
RAILROAD HEALTHCARE
Serving Current and Former *BNSF* Railroaders

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Celebrating More Than 140 Years of Excellence

A. PLEASE INDICATE WHICH PLAN YOU WISH TO ENROLL IN PLAN YEAR 2024 / 2025:

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

B. COMPLETE THE FOLLOWING INFORMATION:

First Name _____ Middle Initial _____ Last Name_____

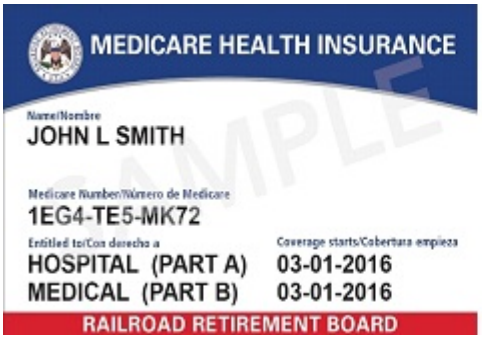
Home Address _____ City _____ State ____ Zip_____

Social Security Number _____ E-mail _____ Date of Birth _____

Sex: __ Male __ Female Home Telephone (_____) _____ Cell Phone (____) _____

Info requested by the Centers for Medicare & Medicaid Services (CMS)	
Ethnicity* ☐ Not of Hispanic, Latino or Spanish Origin ☐ Puerto Rican ☐ Mexican, Mexican American ☐ Cuban ☐ I choose not to answer ☐ Form left blank	**Race*** ☐ American Indian or Alaska Native ☐ Black or African American ☐ Asian / Pacific Islander ☐ White / Caucasian ☐ Other: _____ ☐ I choose not to answer ☐ Form left blank

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



_____

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_____

**** 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.

_____

_____

Who Referred You or How Did You Hear about CARE:

_____