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_____

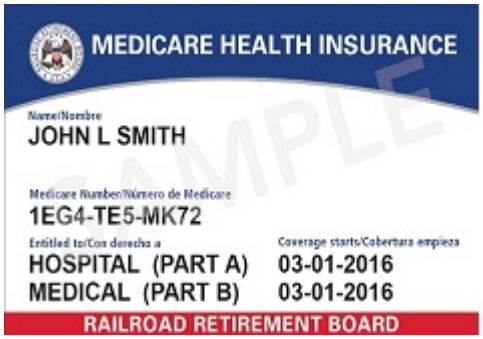
Home Address _____ City _____ State ____ Zip_____

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.



_____

_____

_____

**** 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.**

Please answer the following Questions:

1. Are you or your spouse currently employed? _____YES _____ NO

2. Some individuals may have other supplemental and/or drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs.

   Other than Medicare or **CARE**, do you have any health insurance, such as private insurance, Veteran's Administration, or insurance through your spouse? _____YES _____ NO

   If **YES**, please list your other coverage and identification (ID) number(s) for this coverage:

   Name of other coverage: ID# for this coverage:

   _____ _____

   Group # for this coverage: Phone Number:

   _____ _____

3. Are you a resident in a long-term care facility, such as a nursing home? _____ YES _____ NO

   If yes, please provide the following information:

   Name of Institution: _____

   Address of Institution (number and street): _____

   Phone Number: _____ Date of Admission: _____

4. Do you have End Stage Renal Disease (ESRD)? ESRD is a permanent kidney failure and requires regular kidney dialysis or a transplant to stay alive. _____YES _____NO

5. Do you have Diabetes? _____YES _____NO

6. Do you receive Medicaid benefits? _____YES _____ NO

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.

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: _____

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:

_____