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Celebrating More Than 140 Years of Excellence

A. PLEASE INDICATE WHICH PLAN YOU WISH TO ENROLL IN FOR PLAN YEAR 2026:

<input type="checkbox"/> 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: <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"/> Plan #4100 - Supplement to Medicare Parts A & B NO Prescription Drug Benefit \$174.00 monthly (\$522.00 quarterly)	

**** If you are enrolling in Plan #4000 and DID NOT have Part D or other creditable prescription drug coverage for 63 or more consecutive days, Medicare may charge a Late Enrollment Penalty (LEP).**

B. COMPLETE THE FOLLOWING INFORMATION:

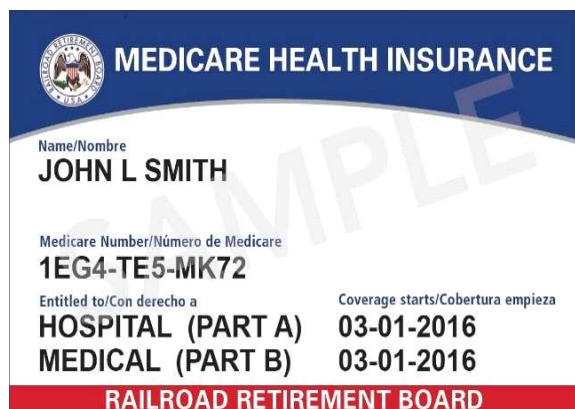
First Name _____ Middle Initial _____ Last Name _____

Home Address _____ City _____ State _____ Zip _____

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

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

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



Medicare Number: _____

Hospital (Part A) Effective Date: _____

Hospital (Part B) Effective Date: _____

Please answer the following Questions:

1. Will you have other **prescription drug coverage** (like VA, TRICARE) in addition to **CARE**?
_____ YES _____ NO

If YES, please list name of other coverage:

Member number for this coverage: _____

Group number for this coverage: _____

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

Will you have other Medicare supplemental coverage in addition to **CARE**? _____ 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:

4. 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: _____

5. 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
6. Do you have Diabetes? _____ YES _____ NO
7. Do you receive Medicaid benefits? _____ YES _____ NO
8. Who Referred You or How Did You Hear about **CARE**: _____

IMPORTANT: Read and sign below

- I must keep both Hospital (Part A) and Medical (Part B) to keep my **CARE** coverage.
- I understand that I can be enrolled in only one Medicare Supplement plan at a time – and that enrollment in this plan will automatically end my enrollment in another supplement/MA plan (exceptions apply for MA PFFS MA MSA plans).
- 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.
- The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form I will be disenrolled from the plan.
- I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (as described above) this signature certifies that:
 - 1) This person is authorized under State law to complete this enrollment and
 - 2) Documentation of this authority is available upon request by Medicare.

Applicant Signature: _____ **Date:** _____

If an authorized representative is signing this application on behalf of the applicant, please sign above and complete the fields below.

Print Name: _____ Address: _____

Phone Number: _____ Relationship to Enrollee: _____

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: _____

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

For individuals helping enrollee with completing this form only

Only complete this section if you're an individual (i.e. agents, brokers, SHIP counselors, family members or other third parties) helping the enrollee fill out this form.

Name: _____ Relationship to enrollee: _____

Signature: _____

National Producer Number (Agents/Brokers only): _____