



800.334.1330
254.773.1330
fax 254.774.7652

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

www.carehealthplan.com

A. PLEASE INDICATE WHICH PLAN YOU CHOOSE TO ENROLL IN:

<input type="checkbox"/> PLAN #4000: Supplement to Medicare Parts A & B with Medicare (Part D) Prescription Drug Coverage** \$267.00 monthly (\$801.00 quarterly).	Please check box that pertains to you: <input type="checkbox"/> Retired Employee (ATSF / BNSF) <input type="checkbox"/> Spouse of Retired Employee <input type="checkbox"/> Surviving Spouse of Deceased Employee
<input type="checkbox"/> PLAN #4100: Supplement to Medicare Parts A & B ONLY \$142.00 monthly (\$426.00 quarterly)	

B. COMPLETE THE FOLLOWING INFORMATION:

First Name _____ Middle Initial _____ Last Name _____
 Home Address _____ Date of Birth _____
 City _____ State _____ Zip _____
 Home Telephone (_____) _____ E-mail _____ Sex: Male Female

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

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 the Consolidated Associations of Railroad Employees (CARE) 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 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. I also hereby authorize CARE and/or informedRx® 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.*

****If you are a new enrollee in Plan #4000 and have had a period of 63 or more days in a row when you did not have Part D or other creditable prescription drug coverage, you may incur a late enrollment penalty.**

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

PLEASE INCLUDE A COPY OF YOUR MEDICARE CARD

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) (include relationship to applicant):

