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**A. CHOOSE WHICH PLAN YOU WISH TO ENROLL IN:**

<input type="checkbox"/> <b>PLAN #4000: Supplement to Medicare Parts A &amp; B with Creditable Prescription Drug Coverage</b> \$261.00 monthly (\$783.00 quarterly). <b>Prescription Benefit:</b> \$200 deductible / \$3275 annual maximum	<p><b>Please check box that pertains to you</b></p> <input type="checkbox"/> Retired Employee (ATSF / BNSF) <input type="checkbox"/> Spouse of Retired Employee <input type="checkbox"/> Surviving Spouse of Deceased Retired Employee
<input type="checkbox"/> <b>PLAN #4100: Supplement to Medicare Parts A &amp; B ONLY</b> \$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 also 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.*

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

**PLEASE ENCLOSE A COPY OF YOUR MEDICARE CARD SHOWING EFFECTIVE DATE FOR BOTH PARTS A & B.**

I wish my membership to become effective the first day of \_\_\_\_\_

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):

\_\_\_\_\_

\_\_\_\_\_