SFEHACL Medicare Plans
ENROLLMENT FORM

Santa Fe Employes hospital Association – Coast Lines
551 East San Bernardino Rd, Covina CA 91723

Section 1– All fields are required

I **wish to enroll in the Santa Fe Employes Hospital Association - Coast Lines (SFEHACL) Medicare HCPP, Medicare Secondary Plan and Medicare Part D Prescription Drug Plans and agree to abide by those rules and regulations and any other applicable Federal or State laws, together with any amendments that may be made thereto. By enrolling in the SFEHACL Medicare Plans,** I **authorize the Centers for Medicare and Medicaid (CMS) to:**

Note, to join this plan you must:

- Be enrolled in both Medicare Part A and Part B.
- Be a former employee of Santa Fe Railway, BNSF Railway, Amtrak, LAJ Railway, or other subsidiaries or other merged railways, and collecting an annuity from the Railroad Retirement Board.
- If you meet these qualifications, YOU AND YOUR Medicare SPOUSE MAY BE ELIGIBLE!

Please Provide the Following Information (please print clearly)

Last Name: First Name: Middle Initial:		Home Phone Number: ( )
Birth Date: (_____/ _____/_____) (M M/D D/Y Y Y Y)	Sex: ☐ M ☐ F	Email Address: *(By supplying your email address, you agree to allow SFEHACL to communicate with you about plan business by email):*
Permanent Residence Street Address:		
City:	State:	ZIP Code:

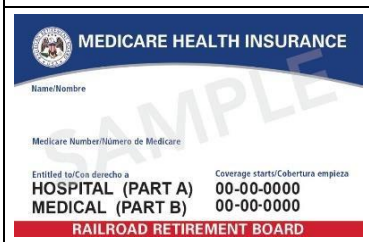
Mailing Address *(Only if different from your permanent address)*

Street Address: City: State: Zip:

☐ I am a Retired ☐ I am the Spouse (or Widow/Widower) of a Retired railroader

From which railroad did you (or your spouse) retire, and what was your/their date of retirement?

Railroad: _____ Retirement Date: _____



Please take out your red, white, and blue Medicare ID card to complete this section:

Medicare Number: _____

Hospital (Part A) Effective Date: _____

Medical (Part B) Effective Date: _____

Please Circle Yes or No and Complete as Requested - and Sign

- I am currently enrolled in another Medicare MA-PD OR PDP Plan. Yes or No. If you answer yes, you will automatically cancel your membership in the other plan(s). You cannot be a member of the SFEHACL Medicare Plans and another Medicare plan at the same time. If yes, print the name of other Medicare Plan(s). _____

- I have other Health Insurance. Yes or No. If yes, print Insurance Company Name, Address and Policy Number

_____

Section 2 – All fields are optional

Answering the following questions is your choice. You can't be denied coverage because you don't fill them out.

Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.

- ☐ No, not of Hispanic, Latino/a, or Spanish origin
- ☐ Yes, Puerto Rican
- ☐ Yes, another Hispanic, Latino/a, or Spanish origin
- ☐ **I choose not to answer.**
- ☐ Yes, Mexican, Mexican American, Chicano/a
- ☐ Yes, Cuban

What's your race? Select all that apply.

- ☐ American Indian or Alaska Native
- ☐ Chinese
- ☐ Japanese
- ☐ Other Asian
- ☐ Vietnamese
- ☐ Asian Indian
- ☐ Filipino
- ☐ Korean
- ☐ Other Pacific Islander
- ☐ White
- ☐ Black or African American
- ☐ Guamanian or Chamorro
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ **I choose not to answer.**

I understand that my signature on this form certifies that I have read and understand its contents.

Completion of this form is my request to become a member of the SFEHACL Medicare HCPP, Medicare Secondary Plan and Medicare Part D Prescription Drug Plans. I understand that I must continue to pay my Medicare Part B premiums to remain an eligible member of the SFEHACL Medicare Plans.

(Your Signature) **Date**