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 Advantage PPO 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:

- Furnish information to SFEHACL regarding my eligibility, enrollment and/or entitlement to Medicare Part A (Hospital), and/or Part B (Medical), and/or Part D (Prescription Drug); and
- I authorize SFEHACL participating providers and pharmacies or any other holder of medical or other relevant information about me to release to the CMS or its claims agencies any information needed to administer the Medicare programs.

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: _____

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

_____

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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).

- Have you been diagnosed with ESRD (End Stage Renal Disease)? ☐ Yes ☐ No
- If yes, please provide your 30-month coordination period start and/or end dates.

  Start Date: _____
  End Date: _____

☐ I give consent for United Healthcare and its affiliates to call the phone number(s) I have provided using an auto dialer and/or prerecorded voice technology

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, Mexican, Mexican American, Chicano/a
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, another Hispanic, Latino/a, or Spanish origin
- ☐ **I choose not to answer.**

What's your race? Select all that apply.

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

What is your gender identity? Select one

- ☐ Woman
- ☐ Man
- ☐ Non-Binary
- ☐ I use a different term: _____
- ☐ **I choose not to answer.**

Which of the following Best represents yourself? Select One

- ☐ Lesbian or Gay
- ☐ Straight, that is not gay or lesbian
- ☐ Bisexual
- ☐ I use a different term _____
- ☐ I don't know
- ☐ **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 Advantage PPO 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**