

**Prime Medicare Plans
ENROLLMENT FORM**

Union Pacific Railroad Employes Health Systems
PO Box 161020 Salt Lake City, UT 84116-1020

I wish to enroll in the UPREHS Medicare HCPP, Prime Medicare Secondary Plan and Prime 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 UPREHS Medicare Plans, I authorize the Centers for Medicare and Medicaid (CMS) to:

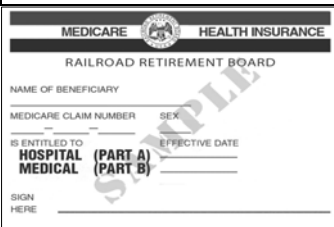
- Furnish information to UPREHS regarding my eligibility, enrollment and/or entitlement to Medicare Part A (Hospital), and/or Part B (Medical), and/or Part D (Prescription Drug); and
- I authorize UPREHS participating providers and pharmacies or any other holder of medical or other relevant information 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 Union Pacific Railroad, Southern Pacific Railroad, Western Pacific Railroad, 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: <input type="checkbox"/> M <input type="checkbox"/> F	Email Address: <i>(By supplying your email address, you agree to allow UPREHS to communicate with you about plan business by email):</i>	
Permanent Residence Street Address:			
City:		State:	ZIP Code:
Mailing Address (only if different from your Permanent Residence Address):			
Street Address:		City:	State: ZIP Code:
Please check ONE: <input type="checkbox"/> I am a Retired railroader <input type="checkbox"/> 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 CLAIM 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 UPREHS 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. _____

• **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 UPREHS Medicare HCPP, Prime Medicare Secondary Plan and Prime 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 UPREHS Medicare Plans.

(Your Signature)

(Date)