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Post Office Box 6130
Temple, TX 76503-6130

www.carehealthplan.com

"Celebrating 138 Years of Railroaders Serving Railroaders"

Secondary Coverage Application
PLAN #3000

Secondary Membership for Active Employees and dependents and/or Retired Employees and dependents covered by one of the following **Comprehensive Health Care Benefit (CHCB)** plans; please select plan:

☐ Aetna US Healthcare
☐ Cigna
☐ Highmark Blue Cross/Blue Shield
☐ United Healthcare GA23000
☐ United Healthcare GA107300
☐ United Healthcare 0690100
☐ Other Plan
Please Specify ____________________

	Monthly	Quarterly
☐ Employee or Retired Employee	$ 58.00	$ 174.00
☐ Employee and One Dependent	$ 116.00	$ 348.00
☐ Employee and Two or More Dependents	$ 174.00	$ 522.00

Payroll deduction or bank draft is available upon request. If you will be using Payroll Deduction or bank draft you will need to remit dues for one month in order to give us time to set up the proper deduction.

COMPLETE THE FOLLOWING INFORMATION:

Employee Name ____ SS# ____ DOB ____ Union ____

Address ____ City, State ____ Zip Code ____ Phone # ____

Dependent Full Name ____ SS# ____ DOB ____ Relationship ____

Dependent Full Name ____ SS# ____ DOB ____ Relationship ____

Dependent Full Name ____ SS# ____ DOB ____ Relationship ____

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As a Secondary member under Plan #3000, I understand ***CARE*** *will reimburse me for up to $200 of my deductible in full for covered services with the remainder of the deductible (if applicable) being reimbursed at 20%. In addition,* ***CARE*** *will reimburse me for the difference between the Amount Allowed and Amount Paid by my primary carrier, not to exceed 20% up to the* ***CARE*** *annual limit of $2,200.*

For members covered under the United Healthcare GA23111-E, ***CARE*** *will reimburse up to $200 of the deductible in full for covered services with the remainder of the deductible (if applicable) being reimbursed at 20%. In addition,* ***CARE*** *will reimburse up to 20% of the Amount Allowed by the GA23111-E plan up to the* ***CARE*** *annual limit of $2,200.*

I wish my membership to become effective the first day of ______________________________

Employee Signature: ______________________________ Date: ______________