CARE
RAILROAD HEALTHCARE
Serving Current and Former BNSF Railroaders

800.334.1330
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4912 Midway Drive
Post Office Box 6130
Temple, TX 76503-6130

www.carehealthplan.com

"Celebrating 139 Years of Railroaders Serving Railroaders"

Plan #3000 - Secondary Coverage Application

Secondary Coverage for Active Employees and dependents covered by one of the following plans:
Comprehensive Health Care Benefit (CHCB) or **Managed Medical Care Programs (MMCP)**

Plan #3000 will reimburse you for up to **$350 of your deductible** in full for covered services, with the remainder of the deductible (if applicable) being reimbursed at 20%. **CARE** will reimburse you for the difference between the ***Amount Allowed**** and the Amount Paid by your primary carrier, not to exceed 20%. For members covered under a Managed Care Plan, **CARE** will reimburse you for any copayments charged by the Primary carrier. Should you receive medical services from an Out-of-Network provider through your Primary plan, **CARE** will reimburse you for the difference between the Amount Allowed and the Amount Paid by your Primary carrier, not to exceed 20%. The annual limit for this plan is **$3,350 (including the deductible)**.

Please select your 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 Only	$ 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 _____

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

How did you hear about us and/or who referred you: _____

Employee Signature: _____ Date: _____