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

www.carehealthplan.com

Plan #5100 - Replacement Plan for dependents who have exhausted benefits under United Healthcare GA46000 and/or the National Health and Welfare Plan (GA23000)

Select the membership type that pertains to you and place a ☑ in the box.

		Monthly	Quarterly
☐	Spouse	$ 471.00	$ 1413.00
☐	Dependent Child	$ 471.00	$ 1413.00

COMPLETE THE FOLLOWING INFORMATION

Name of Retiree — SS# — Dob — Union

Address — City, State — Zip Code — Phone #

Dependent Full Name — SS# — Dob — Sex

Dependent Full Name — SS# — Dob — Sex

A medical history form must be completed as this plan has a 12-month preexisting condition clause. A certificate of prior health coverage from your former group health plan will be required in order to obtain coverage without a preexisting condition exclusion.

I would like my membership to become effective the first day of ____________________

Signature: ______________________ Date: ______________________

MEDICAL HISTORY FORM

Give details of "Yes" answers. (Identify question number, circle applicable items; including diagnosis, dates, duration, names and addresses of all attending physicians and medical facilities if consulted within 5 years.) If additional room is necessary attach a separate page.

A. DURING THE PAST 10 YEARS HAVE YOU EVER BEEN TREATED FOR:	YES	NO
1. Fainting spells, nervous or mental disorder, paralysis, seizure, disorder, dizziness, or any disease or abnormality of your brain or nervous system?	○	○
2. Chest pain, heart attack, heart murmur, high blood pressure, rheumatic fever, or any disorder of your heart or blood vessels?	○	○
3. Asthma, chronic cough, emphysema, shortness of breath, or any disorder of your lungs or respiratory system?	○	○
4. Frequent or recurrent abdominal pain, indigestion, ulcers, diarrhea, colitis, or any bleeding from or disease of your stomach, intestines, gallbladder or liver?	○	○
5. Sugar, protein, or blood in your urine, kidney stones, or any disorder of your kidneys, bladder, prostate, ovaries, uterus or complication of pregnancy?	○	○
6. Diabetes, thyroid, or other glandular disorder?	○	○
7. Arthritis, bursitis, sciatica, gout, recurrent back pain, or any disorder of your back, spine, muscles, bones or joints?	○	○
8. Disorder of your eyes, ears, nose or throat?	○	○
9. Blood disorder, cancer, cyst, or tumor?	○	○
10. Disorder of your breast, lymph nodes or skin?	○	○
11. Any physical defect or deformity?	○	○
B. DURING THE PAST 5 YEARS HAVE YOU:		
1. Had a checkup, consultation, illness or surgery?	○	○
2. Been treated or evaluated at a hospital, clinic, or other facility?	○	○
3. Had an electrocardiogram (EKG), x-rays or other diagnostic tests?	○	○
4. Been advised to have any diagnostic test, hospitalization or surgery which was not done?	○	○
5. Do you smoke cigarettes or have you smoked in the past twelve months?	○	○
6. Are you taking any prescribed medications?	○	○
7. Have you ever been advised to limit your use of alcohol or other addictive substances?	○	○
8. Have you ever been treated or told to seek treatment for alcohol abuse or chemical dependency, or been a member of Alcoholics Anonymous?	○	○

I understand that ***CARE*** may require a medical examination at my own expense, and reserves the right to decline an application based on answers to the health questions. I have read the above statements and answers of the Medical History. I believe the answers are true, complete and correct. I agree to allow them to become part of my application. I understand that if I have knowingly attempted to defraud ***CARE***, coverage will be rescinded and a full refund will be given me with no payment of claims. If claims have been paid, I will be responsible for reimbursing ***CARE*** the full amount paid.

I also understand in certain membership categories ***CARE*** is not required to pay benefits for any pre-existing medical condition for twelve (12) months from the date membership becomes effective.

AUTHORIZATION: I authorize any physician, health professional, hospital or medical facility to provide ***CARE*** with any information about my health in order to determine eligibility for this plan.

____

Signature of Applicant or Legal Guardian　　　　　　Date