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PLAN #5100

REPLACEMENT PLAN FOR DEPENDENTS LOSING COVERAGE UNDER THE NATIONAL HEALTH & WELFARE PLAN (INCLUDING PLANS GA23000 AND/OR GA46000)

This is a replacement plan for those dependents not wishing to continue GA23000 and/or GA46000 COBRA coverage. This plan has its own Schedule of Benefits and pays benefits at 80%. The lifetime maximum for this plan is \$150,000.

ELIGIBLE DEPENDENTS:

- ▶ Dependents of railway employees who have exhausted benefits under the National Health and Welfare Plan (GA23000) due to disability.
- ▶ Dependents of early retirees who retired at 60 and/or 61 years of age with 30 or more years of service who have exhausted their GA46000 COBRA coverage due to the early retiree reaching 65 years of age.

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

	Monthly	Quarterly
<input type="checkbox"/> Spouse	\$ 574.00	\$1722.00
<input type="checkbox"/> Dependent Child	\$ 574.00	\$1722.00

COMPLETE THE FOLLOWING INFORMATION

Name of Retiree	SS#	Dob	Union
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Address	City, State	Zip Code	Phone #
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Dependent Full Name	SS#	Dob	Sex
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Dependent Full Name	SS#	Dob	Sex
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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