HOSPITAL INDEMNITY AND SHORT TERM RECOVERY INSURANCE PLAN ENROLLMENT FORM

AGP-40008
092716020808 04025-Q

Complete all information in ink.

1 *Complete information:*

Member Name: _____

Address: _____

City: _____

State: _____ ZIP: _____

Rank/Service: _____

MOAA Member Number: _____

☐ Male ☐ Female

Date of Birth: _____
mo / day / yr

Telephone #: _____ Email Address: _____
(MOAA will not rent or sell your email address.)

THE HARTFORD

Underwritten by:
Hartford Life and Accident Insurance Company
Hartford, CT 06155.

The Hartford® is The Hartford Financial Services Group, Inc., and its subsidiaries, including issuing company Hartford Life and Accident Insurance Company.

Endorsed by: MOAA Military Officers Association of America

SEND NO MONEY NOW

2 *Please select who will be covered:*

☐ MOAA Member (S101)

☐ Member's Spouse (S105)

Spouse's Name: _____
(if enrolling)

Spouse's Date of Birth: _____ ☐ Male ☐ Female
mo / day / yr

3 *Sign and date below:*

I hereby confirm my enrollment in the MOAA Hospital Indemnity and Short Term Recovery Plan. I certify that I am a current member of MOAA or plan to enroll/accept membership in MOAA and acknowledge that I will receive e-communications from MOAA. I understand that this plan will not cover pre-existing conditions (conditions for which medical advice or treatment was rendered or recommended by a physician for those being enrolled within 6 months of this new coverage) unless 6 months have passed from the effective date of this new coverage. I understand that the above coverage will become effective on the first day of the month following receipt of my Enrollment Form and first premium payment. I attest that I am age 65 or older. (I hereby attest that I have major medical health insurance or Medicare that meets the requirements of minimum essential coverage as defined by the Affordable Care Act.)

Member's Signature X _____ **Date X** _____

Spouse's Signature X _____ **Date X** _____
(if enrolling)

THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.

MEDICARE AND TRICARE MEET THE MINIMUM ESSENTIAL COVERAGE REQUIREMENT OF THE AFFORDABLE CARE ACT.

Don't send money now! You'll be billed later.

Mail your completed Enrollment Form to:
MOAA Insurance Plans • P.O. Box 14464 • Des Moines, IA 50306

Questions? Call Toll-Free **1-800-247-2192**
(Hearing-impaired or voice-impaired members may call the Relay Line at 711-800-247-2192.)
Or, email moaa.service@mercer.com