HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY
One Hartford Plaza
Hartford, Connecticut 06155
(A stock insurance company)

MOAA INSURANCE PLANS

THE HARTFORD

TRICARE SUPPLEMENT INSURANCE PLAN ENROLLMENT FORM

MEMBERS AGES 64 AND YOUNGER

Group Policyholder: Military Officers Association of America
Policy Number: AGP-5889

1. Member Information:

Member Name: _____ Rank: _____

Street: _____ City: _____ State: _____ Zip Code: _____

MOAA Membership Number: _____ Gender: ☐ Male ☐ Female Member Social Security Number: _____

Member Date of Birth: _____ Email Address: _____ Preferred Phone #: _____

Initial Service Entry Date: _____

2. Spouse Information:

Is Spouse coverage desired? ☐ Yes ☐ No Spouse Gender: ☐ Male ☐ Female

Spouse Full Name (if enrolling): _____ Spouse Date of Birth: _____

3.

☐ Are you a Member of the Association? ☐ A Spouse of a Member of the Association?

Check the box below if you and/or your Spouse are:

☐ Retired Military ☐ Active Duty Member ☐ Retired Military Spouse/Surviving Spouse
☐ National Guard or Reserve Member ☐ Retired Reservist ☐ Retired Reservist Spouse/Surviving Spouse

Medicare beneficiaries are not eligible to enroll.

4. Dependent Child(ren) Information (if enrolling):

If more than 4 child(ren), attach additional sheet.

Child Name	Date of Birth	Student	TRICARE Young Adult
		☐	☐
		☐	☐
		☐	☐
		☐	☐

Note: Dependent Children must be under age 25 or enrolled in TRICARE Young Adult; please include proof of enrollment in TRICARE Young Adult with your Enrollment Form. Additional children may be listed on separate paper and attached to/submitted with this form.

Form PA-10038 (2017) (MT)

TRICARE Form Series includes GBD-3000, GBD-3100, or state equivalent.
099780020303 Group A: 04079-Q, Group B: 04089-Q
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OVER →

5. Coverage Information:

Please select the TRICARE Supplement you want. Choose a plan for everyone you want to cover. Note: Your TRICARE Supplement Selection must match your TRICARE Health Plan.
(NOTE: You're classified as a "nonsmoker" if you haven't smoked a cigarette, cigars, or used a pipe or chewing tobacco, nicotine product or snuff within the past 12 months prior to enrollment.)
(For administrator use: 04079 if Initial Service Entry Date is prior to 1/1/2018, otherwise 04089. All TRICARE Young Adult coverage will be 04089.)

IN and OUTPATIENT PLANS For TRICARE Select

	RETIRED WITH $400 PER PERSON DEDUCTIBLE		RETIRED WITH $250 PER PERSON DEDUCTIBLE		ACTIVE DUTY WITH NO DEDUCTIBLE	
Member	☐ Nonsmoker (CL41)	☐ Smoker (CS41)	☐ Nonsmoker (CL21)	☐ Smoker (CS21)	N/A	
Spouse	☐ Nonsmoker (CL45)	☐ Smoker (CS45)	☐ Nonsmoker (CL25)	☐ Smoker (CS25)	☐ Nonsmoker (AIT5)	☐ Smoker (AIS5)
Dependent Child(ren)	☐ Under age 25 (CL47) ☐ Enrolled in TRICARE Young Adult (04089-CC47)		☐ Under age 25 (CL27) ☐ Enrolled in TRICARE Young Adult (04089-CC27)		☐ Under age 25 (AIT7) ☐ Enrolled in TRICARE Young Adult (04089-ACT7)	

	RETIRED WITH $300 PER PERSON DEDUCTIBLE		RETIRED WITH $150 PER PERSON DEDUCTIBLE	
Member	☐ Nonsmoker (CL31)	☐ Smoker (CS31)	☐ Nonsmoker (CL11)	☐ Smoker (CS11)
Spouse	☐ Nonsmoker (CL35)	☐ Smoker (CS35)	☐ Nonsmoker (CL15)	☐ Smoker (CS15)
Dependent Child(ren)	☐ Under age 25 (CL37) ☐ Enrolled in TRICARE Young Adult (04089-CC37)		☐ Under age 25 (CL17) ☐ Enrolled in TRICARE Young Adult (04089-CC17)	

INPATIENT ONLY PLANS For TRICARE Select

	RETIRED WITH NO DEDUCTIBLE		RETIRED WITH $200 PER PERSON DEDUCTIBLE	
Member	☐ Nonsmoker (CHN1)	☐ Smoker (CNS1)	☐ Nonsmoker (CLN1)	☐ Smoker (CLS1)
Spouse	☐ Nonsmoker (CHN5)	☐ Smoker (CNS5)	☐ Nonsmoker (CLN5)	☐ Smoker (CLS5)
Dependent Child(ren)	☐ Under age 25 (CHN7) ☐ Enrolled in TRICARE Young Adult (04089-CCH7)		☐ Under age 25 (CLN7) ☐ Enrolled in TRICARE Young Adult (04089-CCL7)	

TRICARE PRIME PLAN

	RETIRED PLAN	
Member	☐ Nonsmoker (PHT1)	☐ Smoker (PTS1)
Spouse	☐ Nonsmoker (PHT5)	☐ Smoker (PTS5)
Dependent Child(ren)	☐ Under age 25 (PHT7) ☐ Enrolled in TRICARE Young Adult (04089-PCT7)	

If enrolling in the TRICARE Prime Supplement (or USFHP), please tell us the date your TRICARE Prime (or USFHP) protection started.

____ / ____ / ____
mo day yr

6. Please answer questions (even if only requesting child coverage), read, sign and date.

	Member	Spouse
A. Have you, or anyone enrolling for coverage, smoked cigarettes, cigars, or used a pipe, chewing tobacco, nicotine product or snuff within the past 12 months?	☐ Yes ☐ No	☐ Yes ☐ No
B. Are you enrolling within 30 days of the date your employer health insurance ends because you are no longer an eligible participant in the program?	☐ Yes ☐ No	☐ Yes ☐ No
C. Are you enrolling within 60 days of termination of Active Duty service or within 30 days of initial eligibility for TRICARE benefits?	☐ Yes ☐ No	☐ Yes ☐ No
D. Are you enrolling within 30 days of Active Duty service and has your family been insured under the TRICARE Active Duty Supplement prior to your retirement?	☐ Yes ☐ No	☐ Yes ☐ No
E. Are you changing from our TRICARE Prime Supplement to our TRICARE Select Supplement on your Prime Anniversary Date or because you have moved outside of the Prime Network?	☐ Yes ☐ No	☐ Yes ☐ No
F. Are you changing from our TRICARE Select Supplement to our TRICARE Select Prime Supplement on your Select Anniversary Date?	☐ Yes ☐ No	☐ Yes ☐ No

7. Authorization - Please read, sign and date:

I acknowledge that I have been given the opportunity to enroll in the TRICARE Supplement Insurance Plan and that I am age 64 or younger, unless ineligible for Medicare, an MOAA Member and that the above information is true and complete to the best of my knowledge.

I understand that this program may not cover pre-existing conditions (conditions for which I received medical advice or treatment within 6 months prior to the effective date of coverage or until the coverage has been in effect for 6 months). This pre-existing condition limitation will not apply if waived in accordance with policy provisions.

I understand that my coverage will become effective on the first day of the month following receipt of my completed Enrollment Form and payment of my initial premium.

I understand that eligibility to receive benefits under the TRICARE Retiree Supplement is dependent on my (or my deceased spouse's) entitlement to uniformed services retired pay.

I understand and agree that insurance will go into effect upon receipt of my first premium payment and this Enrollment Form and remain in effect only in accordance with the provisions, terms and conditions of the insurance policy. I understand and agree that only the insurance policy issued to MOAA can fully describe the provisions, terms, conditions, limitations and exclusions of my insurance.

Member Signature: _____ **Date:** _____

Spouse Signature (if enrolling): _____ **Date:** _____

8. Payment Options:

Option 1. Electronic Funds Transfer – Select Frequency: ☐ Monthly ☐ Quarterly ☐ Semiannually ☐ Annually

Routing Number: _____ Account Number: _____

I request that you pay and charge my account debits drawn from my account by the Plan Administrator to its order. This authorization will stay in effect until I revoke it in writing. Until you receive such notice, I agree that you shall be fully protected in honoring any such debits. I also agree that you may, at any time, end this agreement by giving 30 days advanced written notice to me and to the Plan Administrator. You are to treat such debit as if it were signed by me. If your dishonor such debit with or without cause, I will not hold you liable even if it results in loss of my insurance.

Signature of Premium Payer: _____ **Date:** _____

Option 2. Direct Bill – Select Frequency: ☐ Quarterly ☐ Semiannually ☐ Annually

Mail your completed Enrollment Form to: **MOAA Insurance Plans** • P.O. Box 14536 • Des Moines, IA 50306
Call: 1-800-247-2192 with Questions or to Enroll over the Phone. **Email**: moaa.service@getamba.com

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Form PA-10038 (2017) (MT)

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For administrative purposes only:

Member Only (WR01)
Member & Child (WR04)
Member & Spouse (WR02)
Family (WR03)
Spouse Only (WR05)
Spouse & Child (WR06)

099780020303 Group A: 04079-Q, Group B: 04089-Q