

**HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY**

One Hartford Plaza  
Hartford, Connecticut 06155  
(A stock insurance company)



**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
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>

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.

## 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
<b>Member</b>	<input type="checkbox"/> Nonsmoker (CL41) <input type="checkbox"/> Smoker (CS41)	<input type="checkbox"/> Nonsmoker (CL21) <input type="checkbox"/> Smoker (CS21)	N/A	
<b>Spouse</b>	<input type="checkbox"/> Nonsmoker (CL45) <input type="checkbox"/> Smoker (CS45)	<input type="checkbox"/> Nonsmoker (CL25) <input type="checkbox"/> Smoker (CS25)	<input type="checkbox"/> Nonsmoker (AIT5) <input type="checkbox"/> Smoker (AIS5)	
<b>Dependent Child(ren)</b>	<input type="checkbox"/> Under age 25 (CL47) <input type="checkbox"/> Enrolled in TRICARE Young Adult (04089-CC47)	<input type="checkbox"/> Under age 25 (CL27) <input type="checkbox"/> Enrolled in TRICARE Young Adult (04089-CC27)	<input type="checkbox"/> Under age 25 (AIT7) <input type="checkbox"/> Enrolled in TRICARE Young Adult (04089-ACT7)	

RETIRED WITH \$300 PER PERSON DEDUCTIBLE		RETIRED WITH \$150 PER PERSON DEDUCTIBLE	
<b>Member</b>	<input type="checkbox"/> Nonsmoker (CL31) <input type="checkbox"/> Smoker (CS31)	<input type="checkbox"/> Nonsmoker (CL11) <input type="checkbox"/> Smoker (CS11)	
<b>Spouse</b>	<input type="checkbox"/> Nonsmoker (CL35) <input type="checkbox"/> Smoker (CS35)	<input type="checkbox"/> Nonsmoker (CL15) <input type="checkbox"/> Smoker (CS15)	
<b>Dependent Child(ren)</b>	<input type="checkbox"/> Under age 25 (CL37) <input type="checkbox"/> Enrolled in TRICARE Young Adult (04089-CC37)	<input type="checkbox"/> Under age 25 (CL17) <input type="checkbox"/> Enrolled in TRICARE Young Adult (04089-CC17)	

### INPATIENT ONLY PLANS For TRICARE Select

RETIRED WITH NO DEDUCTIBLE		RETIRED WITH \$200 PER PERSON DEDUCTIBLE	
<b>Member</b>	<input type="checkbox"/> Nonsmoker (CHN1) <input type="checkbox"/> Smoker (CNS1)	<input type="checkbox"/> Nonsmoker (CLN1) <input type="checkbox"/> Smoker (CLS1)	
<b>Spouse</b>	<input type="checkbox"/> Nonsmoker (CHN5) <input type="checkbox"/> Smoker (CNS5)	<input type="checkbox"/> Nonsmoker (CLN5) <input type="checkbox"/> Smoker (CLS5)	
<b>Dependent Child(ren)</b>	<input type="checkbox"/> Under age 25 (CHN7) <input type="checkbox"/> Enrolled in TRICARE Young Adult (04089-CCH7)	<input type="checkbox"/> Under age 25 (CLN7) <input type="checkbox"/> Enrolled in TRICARE Young Adult (04089-CCL7)	

### TRICARE PRIME PLAN

RETIRED PLAN		If enrolling in the TRICARE Prime Supplement (or USFHP), please tell us the date your TRICARE Prime (or USFHP) protection started.  ____ / ____ / ____ mo    day    yr
<b>Member</b>	<input type="checkbox"/> Nonsmoker (PHT1) <input type="checkbox"/> Smoker (PTS1)	
<b>Spouse</b>	<input type="checkbox"/> Nonsmoker (PHT5) <input type="checkbox"/> Smoker (PTS5)	
<b>Dependent Child(ren)</b>	<input type="checkbox"/> Under age 25 (PHT7) <input type="checkbox"/> Enrolled in TRICARE Young Adult (04089-PCT7)	

## 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
C. Are you enrolling within 60 days of termination of Active Duty service or within 30 days of initial eligibility for TRICARE benefits?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
F. Are you changing from our TRICARE Select Supplement to our TRICARE Select Prime Supplement on your Select Anniversary Date?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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:** \_\_\_\_\_