



TRICARE RETIRED RESERVE 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.)

IN and OUTPATIENT PLANS For TRICARE Retired Reserve

RETIRED WITH \$400 PER PERSON DEDUCTIBLE Member <input type="checkbox"/> Nonsmoker (CL61) <input type="checkbox"/> Smoker (CS61)	Spouse <input type="checkbox"/> Nonsmoker (CL65) <input type="checkbox"/> Smoker (CS65)	Dependent Child(ren) <input type="checkbox"/> Under age 25 (CL67) <input type="checkbox"/> Enrolled in TRICARE Young Adult (CC67)
RETIRED WITH \$250 PER PERSON DEDUCTIBLE Member <input type="checkbox"/> Nonsmoker (CL51) <input type="checkbox"/> Smoker (CS51)	Spouse <input type="checkbox"/> Nonsmoker (CL55) <input type="checkbox"/> Smoker (CS55)	Dependent Child(ren) <input type="checkbox"/> Under age 25 (CL57) <input type="checkbox"/> Enrolled in TRICARE Young Adult (CC57)

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 TRICARE Retired Reserve coverage begins?	<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

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:** _____