MEDIPLUS® TRICARE Reserve Select Supplement Insurance Plan

Enrollment Form

04089-Q
096342020909
AGP-5889

1. Complete the following information:

NOTE: Name must be identical to how it appears on your military ID card.

Member Name: _____

Address: _____

City: _____

State: _____ ZIP: _____

Rank/Service: _____

SEND NO MONEY NOW.

Endorsed by:

THE HARTFORD

MOAA Military Officers Association of America

Policies are underwritten by Hartford Life and Accident Insurance Company, Home Office Hartford, CT, 06155. The Hartford Financial Services Group, Inc., (NYSE: HIG) operates through its subsidiaries, including Hartford Life and Accident Insurance Company under the brand name, The Hartford®, and is headquartered at One Hartford Plaza, Hartford, CT 06155. For additional details, please read The Hartford's legal notice at www.thehartford.com.

Date of Birth: _____ MOAA Member #: _____
mo / day / yr

Initial Service Entry Date: _____
mo / day / yr

Date TRICARE Reserve Select coverage begins: _____ Daytime Phone: _____

Social Security #: _____ Existing Coverage Certificate #:040_ _-_____

Email Address: _____

(If you are already enrolled in MEDIPLUS and this enrollment form is for additional coverage or a change in coverage, insert your current insurance number here.)

2. Choose your coverage:

☐ Member (TS_1) ☐ Spouse (TS_5) ☐ Child under age 21 (TSN7) (23 if a full-time student) ☐ Child age 21–25 (TCN7) (if enrolled in TRICARE Young Adult)

NOTE: Member must enroll in order for spouse or child to have coverage.

Please complete if choosing family coverage† (Name(s) must be identical to how they appear on military ID card).

Full Name (Including Last Name)	Gender (M/F)	Date of Birth (mo/day/yr)
Spouse		
Child		
Child		
Child		

†Children must be under age 21 (23 if a full-time student or 26 if enrolled in TRICARE Young Adult). Please include proof of full-time status or proof of enrollment in TRICARE Young Adult with your form.
If you would like to enroll more than 3 children, please attach a separate sheet that includes the information requested.

3. Answer these questions.

	Member Yes	Member No	Spouse Yes	Spouse No
1. Have you or anyone enrolling for coverage smoked cigarettes, cigars, or used a pipe or chewing tobacco, nicotine product or snuff within the past 12 months?	☐	☐	☐	☐
2. Are you enrolling within 30 days of the date your TRICARE Reserve Select coverage begins?	☐	☐	☐	☐

4. Read, sign and date below.

I represent that to the best of my knowledge and belief, all statements and answers recorded on this form are true and complete. I hereby enroll myself and/or my dependents with Hartford Life and Accident Insurance Company for coverage under the Military Officers Association of America Group Health Insurance Program (MEDIPLUS). 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 and understand that I must retain membership to be eligible for MEDIPLUS. I understand this program will not cover pre-existing conditions (conditions [including pregnancy] for which medical advice or treatment was rendered or recommended by a physician for those being enrolled within six months of this new coverage) unless six months have passed from the effective date of this new coverage. 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 this MEDIPLUS Supplement is dependent upon my purchase of TRICARE Reserve Select. California residents: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage. Florida residents: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony in the third degree. Maryland residents only: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Member's signature **X** _____ Date **X** _____

Questions? Call 1-800-247-2192 or email moaa.service@mercer.com

(Hearing-impaired or voice-impaired members may call the Relay Line at 711-800-247-2192.)

Send no money now. Send completed Enrollment Form to:
MOAA Insurance Plans, P.O. Box 14464, Des Moines, IA 50306

TRICARE Policy Form Series includes GBD-3000, GBD-3100, or state equivalent.