#### HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

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





# TRICARE RESERVE SELECT 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 Mer	mber Social Security N	umber:	
Member Date of Birth:	mber 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	f Birth:	
			,		
3.					
Are you a Member of the Association?	A Spouse of a Member of the A	ssociation?			
Check the box below if you and/or your Spous	e are:				
Retired Military	Active Duty Member	Retired Military Spouse/Su	ırviving Spouse		
National Guard or Reserve Member	Retired Reservist	Retired Reservist Spouse/S	Surviving Spouse		
Medicare beneficiaries are not eligible to enroll.					
4. Dependent Child(ren) Informa	tion (if enrolling):				
If more than 4 child(ren), attach additional s					
Child Name		of Birth	Student	TRICARE Young Adult	

Note: Dependent Children must be under age 21 (23 if a full-time student or 26 if 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.

TRICARE I	Reserve Select					
Member	□ Nonsmoker (TSN1)	Spouse	Nonsmoker (TSN5)	Child(ren)		age 21 (TSN7)
☐ Smoker (TSS1)	☐ Smoker (TSS1)		☐ Smoker (TSSS)		(23 if a full-time student)  Age 21-25 (TCN7)	
					(if enrol	
Plaasa	answer questions (even	if only reques	ting child coverage) rea	ad sian and da	ata	
rease	answer questions (even	ii oilly reques	ting tima toverage,, rea		nber	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?		co, Yes	s 🗌 No	Yes		
B. Have you enrolled in the TRICARE Reserve Select within the past 30 days?			☐ Yes	☐ Yes ☐ No		
Author	ization - Please read, sig	n and date.				
		II dila dadet				,
			CARE Complement Incomes as Plan and t	hat law and C4 announ		ali milala fan Madia
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## 9. Fraud Notice(s):

### For Residents of New York:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

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