



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 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 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.

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.)

TRICARE Reserve Select

Member <input type="checkbox"/> Nonsmoker (TSN1) <input type="checkbox"/> Smoker (TSS1)	Spouse <input type="checkbox"/> Nonsmoker (TSN5) <input type="checkbox"/> Smoker (TSS5)	Child(ren) <input type="checkbox"/> Under age 21 (TSN7) (23 if a full-time student) <input type="checkbox"/> Age 21-25 (TCN7) (if enrolled in TRICARE Young Adult)
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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. Have you enrolled in the TRICARE Reserve Select within the past 30 days?	<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 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 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.

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.

Member Signature: _____ **Date:** _____

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

8. 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.