HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY
One Hartford Plaza
Hartford, Connecticut 06155
(A stock insurance company)

MOAA INSURANCE PLANS

THE HARTFORD

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
		☐	☐
		☐	☐
		☐	☐
		☐	☐

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.

Form PA-10038 (2017) (NY)

TRICARE Form Series includes GBD-3000, GBD-3100, or state equivalent.
099780020909 Group B: 04089-Q
103195 A23297

OVER →

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	☐ Nonsmoker (TSN1)	**Spouse**	☐ Nonsmoker (TSN5)	**Child(ren)**	☐ Under age 21 (TSN7) (23 if a full-time student)
	☐ Smoker (TSS1)		☐ Smoker (TSS5)		☐ Age 21-25 (TCN7) (if enrolled in TRICARE Young Adult)

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?	☐ Yes ☐ No	☐ Yes ☐ No
B. Have you enrolled in the TRICARE Reserve Select within the past 30 days?	☐ Yes ☐ No	☐ Yes ☐ 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. Payment Options:

Option 1. Electronic Funds Transfer – Select Frequency: ☐ Monthly ☐ Quarterly ☐ Semiannually ☐ Annually

Routing Number: _____ Account Number: _____

I request that you pay and charge my account debits drawn from my account by the Plan Administrator to its order. This authorization will stay in effect until I revoke it in writing. Until you receive such notice, I agree that you shall be fully protected in honoring any such debits. I also agree that you may, at any time, end this agreement by giving 30 days advanced written notice to me and to the Plan Administrator. You are to treat such debit as if it were signed by me. If your dishonor such debit with or without cause, I will not hold you liable even if it results in loss of my insurance.

Signature of Premium Payer: _____ **Date:** _____

Option 2. Direct Bill – Select Frequency: ☐ Quarterly ☐ Semiannually ☐ Annually

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