ENROLLMENT FORM AMS TRICARE and CHAMPVA Supplement Insurance Underwritten by Transamerica Premier Life Insurance Company, Cedar Rapids, IA.

Transamerica Premier Life Insurance Company
A Stock Company
Home Office: Cedar Rapids, Iowa

Administrative Office: 6110 Parkland Blvd., Cleveland, OH 44124

ENROLLMENT FORM

PLEASE PRINT LEGIBLY

SECTION A

Name:	Branch of Service:	Date of Birth: (MM/DD/YY) ____/____/____	Sex: ☐ Male ☐ Female
Address:	Telephone No.: (_____) _____ – _____		

Please complete if your family is enrolling (First Name, Last Name).

Covered Dependent Information: If you're Retired military status and you are enrolling your spouse and children, you must also enroll. If you are Active Duty military status, only spouse and child coverage is available. If enrolling more than three children, please list on separate sheet, sign and date it.

SECTION B

Spouse Name:	Spouse Date of Birth: __/__/__	
Child Name:	Child's Date of Birth: __/__/__	Child's Sex:
Child Name:	Child's Date of Birth: __/__/__	Child's Sex:
Child Name:	Child's Date of Birth: __/__/__	Child's Sex:

Read your enrollment materials carefully to determine your benefit needs.

SECTION C: Select the coverage(s) you want:

1. TRICARE Standard Retiree/Extra Supplement Insurance Plan:	☐ Member	☐ Spouse	☐ Children
2. TRICARE Prime Retiree Supplement Insurance Plan:	☐ Member	☐ Spouse	☐ Children
3. TRICARE Active Duty Family Supplement Plan:	☐ Member	☐ Spouse	☐ Children
4. CHAMPVA Supplement Plan:	☐ Member	☐ Spouse	☐ Children

SECTION D: Mode of Payment:

☐ **EFT** ☐ **Monthly** ☐ **Quarterly** ☐ **Semi-Annual** ☐ **Annual**

PLEASE READ

SECTION E

I hereby enroll myself and/or my dependents with Transamerica Premier Life Insurance Company for coverage under the AMS TRICARE or CHAMPVA Supplement Insurance Plan. I understand that I must be a member of AMS to be eligible for coverage and that my coverage will become effective on the first day of the month following receipt of this Enrollment Form and premium.

I understand that any injury or sickness, whether diagnosed or undiagnosed, for which any person proposed for coverage has received medical treatment or care within 6 months immediately preceding their effective date will not be covered until that person has not received medical treatment or care for that condition during a period of 6 consecutive months ending on or after his or her effective date. After 6 months from that person's effective date, he or she will become covered regardless of any preexisting conditions he or she may have. I further understand that new conditions will be covered immediately.

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 crime and may be subject to fines or confinement in prison.

AR, CO, KY, ME, OH, OK, TN and WA Residents: Any person who knowingly and with intent to inquire, defraud, or deceive any insurer files a statement of a claim or an application containing any false, incomplete, or misleading information is guilty of a crime and may be subject to fines or confinement in prison. **DC and RI Residents:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **FL Residents:** Any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of a claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree. **MD Residents:** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefits 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. **NJ Residents:** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties. **PA Residents:** 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 subjects such a person to criminal and civil penalties.

SIGN AND DATE THIS ENROLLMENT FORM

Signature: X _____	**Date:** ____ / ____ / ____
Spouse Signature: X _____	**Date:** ____ / ____ / ____

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(Over, please)

SECTION F: Here's What You Pay

Retiree Rates per Individual

TRICARE Standard/Extra Monthly Premiums ($300 policy deductible for individual coverage and $600 for family)			TRICARE Prime Quarterly Premiums ($0 policy deductible)		
Attained Age	**Male**	**Female**	**Attained Age**	**Male**	**Female**
18-39	$17.38	$18.48	18-39	$48.00	$50.00
40-44	$18.08	$19.09	40-44	$49.00	$51.00
45-49	$20.65	$20.89	45-49	$58.00	$60.00
50-54	$25.71	$26.35	50-54	$69.00	$74.00
55-59	$31.86	$33.19	55-59	$84.00	$88.00
60-64	$35.70	$37.24	60-64	$94.00	$99.00
All Children	$16.06	$16.06	All Children	$44.00	$44.00

Monthly Rates per individual

CHAMPVA ($300 policy deductible for individual coverage and $600 for family)			Active Duty	
Attained Age	**Male**	**Female**	**Spouse**	**Each Child**
18-39	$17.38	$18.48	$10.48	$9.63
40-44	$18.08	$19.09		
45-49	$20.65	$20.89		
50-54	$25.71	$26.35		
55-59	$31.86	$33.19		
60-64	$35.70	$37.24		
All Children	$16.06	$16.06		

Covered Dependent Information: If you're Retired military status and you are enrolling your spouse and children, you must also enroll. If you are Active Duty military status, only spouse and child coverage is available. If enrolling more than three children, please list on separate sheet, sign and date it.

SECTION G: Choose Your Payment Method

Check or Money Order	Automatic Bank Withdrawal
Please bill me: ☐ **Monthly (First month to be paid by check or money order.)** ☐ Quarterly ☐ Semi-annually ☐ Annually $_____ is enclosed payable to Transamerica Premier Life.	☐ **Automatic Bank Withdrawal** (Please complete the form below.)

Complete this section if you selected Automatic Bank Withdrawal for payment:

Name:	
Address:	City:
State:	Zip:
Name of the Bank or Institution: My account is ☐ Checking ☐ Savings	Account Number: Routing Number:
I choose to be billed: ☐ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually Deduction date: ☐ 5th ☐ 15th ☐ 24th	Daytime Phone Number: (_____) _____ – _____

Pre-Authorized Payment Agreement

I HEREBY AUTHORIZE THE ADMINISTRATOR TO ELECTRONICALLY CHARGE MY ACCOUNT FOR MY PREMIUM PAYMENT. I understand that the premium payment for my selected plan, as shown in the rate chart above, will be deducted from my account at the frequency and day of the month I have chosen. My premium payment will reflect my current applicable rate. I agree that this electronic payment shall be regarded the same as if it were a check written by me and drawn on my account. This authorization is to remain in effect until revoked by me in writing. I understand that credit for the payment is conditioned upon the order being honored when presented. I understand that this authorization may be terminated 1) at the option of The Company if any debit is not honored when presented for payment, or 2) upon thirty (30) days written notice given by The Company, the bank or me. In the event the premium amount to be withdrawn changes, I will be notified in writing at least 10 days before the new premium amount is to be withdrawn.

Account Holder's Signature:	**Date:**
X_____	_____ / _____ / _____

IMPORTANT

Please include a voided blank check (write "VOID" across a blank check) or a deposit slip with this form and sign the Authorization Form. **For savings accounts only,** you must contact your financial institution to determine if your savings account can be used. Once you have received approval, obtain the ABA routing number and write it below.

ABA routing No. _____

Keep Your AMS TRICARE or CHAMPVA Supplement Wherever You Go

This TRICARE or CHAMPVA Supplement insurance plan is yours, even if you change jobs, become a consultant, start your own business or retire early. This plan is not tied to a particular state or region of the country. So the plan helps you more easily manage changes in your civilian career and allows you the freedom to make your changes in life without worrying about your insurance.