AMS TRICARE Supplement Plan

Enrollment Form (New York Resident)

Underwritten by: Transamerica Financial Life Insurance Company,
Home Office: 440 Mamaroneck Avenue, Harrison, New York 10528, a Transamerica Company.

Policyholder: American Military Society

Group Policy Number: MZ0926079H0000A

1. Please fill in as required

First Name	Last Name	Branch of Service:
Address		Member Number (if applicable):
		Rank/Grade:
City		Date of Birth: / / Sex: ☐ M ☐ F
		Home Phone: ( ) -
State	Zip	Work Phone: ( ) -

County of Residence:

MWEBP

2. Please complete this section ONLY if you want coverage for your Spouse and/or Children.

Spouse's Full Name: (if coverage is selected):	Spouse's Date of Birth: / /	
Child's Name: (if coverage is selected):	Child's Sex: ☐ M ☐ F	Child's Date of Birth: / /
Child's Name: (if coverage is selected - if additional space is needed, attach a separate piece of paper):	Child's Sex: ☐ M ☐ F	Child's Date of Birth: / /

3. Are you currently enrolled in CHAMPVA? ☐ Yes ☐ No

4. Check ☐ the appropriate boxes to indicate the coverages you want for yourself and each person you want covered.

YOUR MONTHLY PREMIUM RATES *

RETIREE AND FAMILY

$150/$300 Plan Deductible

Age	Male	Female
Under 40	☐ $26.73	☐ $28.43
40 - 44	☐ $27.80	☐ $29.37
45 - 49	☐ $31.75	☐ $32.12
50 - 54	☐ $39.55	☐ $40.52
55 - 59	☐ $49.02	☐ $51.06
60 - 64	☐ $54.91	☐ $57.29
All Children	☐ $24.70	

$300/$600 Plan Deductible

Age	Male	Female
Under 40	☐ $17.38	☐ $18.48
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	

ACTIVE DUTY DEPENDENTS: Spouse: ☐ $10.48 Each Child ☐ $9.63 There is no Plan Deductible.(Billed Semi-Annually)

* Rates and/or benefits may be changed on a class basis. Rates are based on the attained age of the Insured Person and increase as you enter each new age category.

5. Please select the mode of payment most convenient for your budget.

☐ EFT** - Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually

** Electronic Funds Transfer: For your personal convenience, you can -- if you wish -- pay your premiums automatically by Electronic Funds Transfer. Use the EFT Authorization Form on the reverse side to ensure convenient, uninterrupted protection.

If you choose to make payment by EFT, please include two (2) months' premium as your initial payment. This is necessary to allow sufficient time for your banking institution to arrange automatic deduction monthly, according to your instructions on the EFT Authorization Form.

▼ IF PAYING PREMIUMS BY EFT, PLEASE FILL OUT AND SIGN OTHER SIDE OF THIS AUTHORIZATION ▼

TRICARE Prime User?	☐ Member ☐ Spouse	Check ☐ the box(es) at left if you and/or your Spouse use TRICARE Prime. We'll rush you full details about AMS TRICARE Prime Supplement Insurance Plan.

6. Please read carefully; then sign and return your completed Form to us with your initial premium payment.

I hereby certify that the above statements are complete and true to the best of my knowledge. I hereby elect to apply for insurance indicated under the AMS TRICARE Supplement program, underwritten by Transamerica Financial Life Insurance Company. I understand that my coverage will become effective the first of the month following your receipt of my acceptance certificate and first premium payment.

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 the 6 months immediately preceding their effective date will not be covered until the coverage has been in effect for 6 months. I further understand that new conditions will be covered immediately.

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.

Signature ☐ Date / /

Signature of Spouse ☐ Date / /
(If applying for coverage.)

10/11

Complete the following section, if you wish to pay your premiums via automatic Electronic Funds Transfer (EFT) From your Checking account:

PAYOR'S AUTHORIZATION TO FINANCIAL INSTITUTION

I hereby request and authorize you to pay and charge to my account electronic premium debits by AmWINS Group Benefits, Inc., Irving, Texas, provided there are sufficient collected funds in my account. I agree that this electronic debit shall be regarded in the same respect as if this were a check drawn on my account and signed by myself. This authority is to remain in effect until revoked by me in writing.

PAYOR'S AUTHORIZATION TO PLAN ADMINISTRATOR

BANK INFORMATION

PLEASE PRINT ALL INFORMATION EXCEPT SIGNATURE

Banking Institution:	Branch	
Address of Branch:		
City:	State:	Zip Code:
Account Number:		
Name of Account (Payor's Name):		

Signature ☐ Date / /

PLEASE ATTACH A BLANK CHECK MARKED "VOID" TO THIS FORM.