AMS TRICARE Prime Supplement Plan
ENROLLMENT FORM

Underwritten by: Monumental Life Insurance Company, Cedar Rapids, IA, an AEGON Company.

AWEBP

Policyholder: American Military Society

Group Policy Number: MZ0926079H0000A

1. PLEASE FILL IN AS REQUIRED

First Name:	Last Name:	Branch of Service:
Street Address:		City:
State:	Zip:	County:
Member Number: (If Applicable)	Sex: M F	Date of Birth: / /
Telephone Number: Work ( ) –	Telephone Number: Home ( ) –	

2. PLEASE FILL OUT THIS SECTION ONLY IF YOU WANT COVERAGE FOR YOUR SPOUSE AND/OR CHILDREN

Spouse's Full Name:	Sex: M F	Date of Birth: / /
Child's Name:	Sex: M F	Date of Birth: / /
Child's Name:	Sex: M F	Date of Birth: / /

3. YOUR ECONOMICAL QUARTERLY PREMIUM RATES*

Check the appropriate premium for yourself and each person you want covered:

Retiree and Their Family Dependents

Age	Male	Female
Under 40	$48.00	$50.00
40-44	$49.00	$51.00
45-49	$58.00	$60.00
50-54	$69.00	$74.00
55-59	$84.00	$88.00
60-64	$94.00	$99.00
All Children	$44.00	

Figure Your Premium in the Space Below:
Write premium for each covered person from the rate chart at left and add total

Covered Persons	Premium
Member	$_____
Spouse	$_____
Children (All)	$_____
Administrative Fee*	$ 3.00
TOTAL	$_____

NOTE: The $3.00 administrative fee applies to each premium invoice, whether quarterly, semi-annually, or annually.
*Not applicable to residents of New Jersey.

*All premiums and benefits are based on the attained age of the insured and change on the first premium due date after the attainment of ages, 40, 45, 50, 55 and 60. Premiums may increase if premiums are increased for the Master Policy.

4. PLEASE SELECT THE MODE OF PAYMENT MOST CONVENIENT FOR YOUR BUDGET.

DESIRED MODE OF PAYMENT: 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 on the reverse side to ensure convenient, uninterrupted protection.

If you choose to make payment by EFT, please include two (2) months's 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 THE OTHER SIDE OF THIS AUTHORIZATION

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 TRICARE Supplement program, underwritten by Monumental Life Insurance Company, Cedar Rapids, IA. 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.

AR, CO, KY, LA, ME, NM, OH, OK, TN and WA Residents: 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. **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 or confinement in prison. **FL Residents**: 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 felony of the third degree. **MD Residents**: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss of benefits or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. FRD1000A.MD. **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 person to criminal and civil penalties.

10/11

Signature	Date
Signature of Spouse (if applying for coverage)	Date

PAYOR'S AUTHORIZATION TO FINANCIAL INSTITUTION

I hearby 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

I hereby authorize AmWINS Group Benefits, Inc. to electronically debit my banking institution checking account to make payment on my policy(ies).

It is understood that credit for the payment is conditioned upon the order's being honored when presented and that this Authorization may be terminated (1) at the option of AmWINS Group Benefits, if any debit is not honored when presented for payment or, (2) upon thirty (30) days prior written notice given by AmWINS Group Benefits, the Bank, or the undersigned.

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):		
Payor's Signature:		

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

AMS TRICARE Prime Supplement Plan
ENROLLMENT FORM (MONTANA RESIDENTS)

Underwritten by: Monumental Life Insurance Company, Cedar Rapids, IA, an AEGON Company.

AWEBP

Policyholder: American Military Society

Group Policy Number: MZ0926079H0000A

1. PLEASE FILL IN AS REQUIRED

First Name:	Last Name:	Branch of Service:
Street Address:		City:
State:	Zip:	County:
Member Number: (If Applicable)	Sex: M F	Date of Birth: / /
Telephone Number: Work ( ) –	Telephone Number: Home ( ) –	

2. PLEASE FILL OUT THIS SECTION ONLY IF YOU WANT COVERAGE FOR YOUR SPOUSE AND/OR CHILDREN

Spouse's Full Name:	Sex: M F	Date of Birth: / /
Child's Name:	Sex: M F	Date of Birth: / /
Child's Name:	Sex: M F	Date of Birth: / /

3. YOUR ECONOMICAL QUARTERLY PREMIUM RATES*

Check the appropriate premium for yourself and each person you want covered:

Retiree and Their Family Dependents

Age	Member	Spouse
Under 40	$48.75	$50.13
40-44	$49.92	$51.30
45-49	$59.10	$60.48
50-54	$71.07	$73.83
55-59	$85.80	$87.87
60-64	$95.46	$98.91
All Children	$44.85	

Figure Your Premium in the Space Below:
Write premium for each covered person from the rate chart at left and add total

Covered Persons	Premium
Member	$_____
Spouse	$_____
Children (All)	$_____
Administrative Fee*	$ 3.00
TOTAL	$_____

NOTE: The $3.00 administrative fee applies to each premium invoice, whether quarterly, semi-annually, or annually.
*Not applicable to residents of New Jersey.

*All premiums and benefits are based on the attained age of the insured and change on the first premium due date after the attainment of ages, 40, 45, 50, 55 and 60. Premiums may increase if premiums are increased for the Master Policy.

4. PLEASE SELECT THE MODE OF PAYMENT MOST CONVENIENT FOR YOUR BUDGET.

DESIRED MODE OF PAYMENT: 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 on the reverse side to ensure convenient, uninterrupted protection.

If you choose to make payment by EFT, please include two (2) months's 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 THE OTHER SIDE OF THIS AUTHORIZATION

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 TRICARE Supplement program, underwritten by Monumental Life Insurance Company, Cedar Rapids, IA. 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.

10/11

Signature	Date
Signature of Spouse (if applying for coverage)	Date

PAYOR'S AUTHORIZATION TO FINANCIAL INSTITUTION

I hearby request and authorize you to pay and charge to my account electronic premium debits by NEBCO, 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

I hereby authorize National Employee Benefit Companies, Inc. (NEBCO) to electronically debit my banking institution checking account to make payment on my policy(ies).

It is understood that credit for the payment is conditioned upon the order's being honored when presented and that this Authorization may be terminated (1) at the option of NEBCO, if any debit is not honored when presented for payment or, (2) upon thirty (30) days prior written notice given by NEBCO, the Bank, or the undersigned.

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):		
Payor's Signature:		

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