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

THE HARTFORD

TRICARE Supplement Insurance Plan Enrollment Form
Member ages 64 or younger, unless ineligible for Medicare

Group Policyholder: American Military Society (AMS)
Policy Number: AGP-5963

SECTION 1

Member Information

Member's Name:		**Association Membership Number:**	
Street:	**City**	**State:**	**Zip Code:**
Member's Social Security Number:		**Member's Date of Birth:**	
Email Address:		**Daytime Phone Number:**	

SECTION 2

Is Spouse's coverage desired? ☐ Yes ☐ No

Spouse's Full Name (if enrolling):	**Spouse's Date of Birth:**

SECTION 3

☐ **Are you a Member of the Association?**	☐ **A Spouse of a Member of the Association?**
Rank:	**Date of enlistment** (or commission date):

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.

SECTION 4

Dependent Child(ren) Information (if enrolling):		**If more than 4 child(ren), attach additional sheet.**	
Child(ren) 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.

TRICARE Form Series includes GBD-3000, GBD-3100 or state equivalent

SECTION 5

Coverage Information

Please select the AMS TRICARE Supplement you want. Choose a plan for everyone you want to cover.

Family members can choose different plans. You do not need to take the same coverage.

Note: Your TRICARE Supplement Selection must match your TRICARE Health Plan.

☐ Active Duty Select Family Select Supplement Plan	☐ Retiree Select & Retired Reserve Supplement Plans Deductible Option: ☐ $150 ☐ $300
☐ Retiree Prime Supplement Plan with Point-of-Service (POS) Benefits	

I hereby enroll for the following coverage (check all that apply):

☐ Member	☐ Spouse
☐ Dependent Child(ren) Under age 21 (under 23 if full-time student)	☐ Under age 26 (if enrolled in TRICARE Young Adult)

If enrolling in the TRICARE Prime Supplement (or USFHP), please tell us the date your TRICARE Prime (or USFHP) protection started:

If you're Retired military status and you're enrolling your Dependent, you must also enroll. If you're Active Duty military status, only Dependent coverage is available.

SECTION 6

Please answer questions (even if only requesting child coverage), read, sign and date.	MEMBER	SPOUSE
Are you enrolling within 63 days of Active Duty service and has your family been insured under the TRICARE Active Duty Supplement prior to your retirement?	☐ Yes ☐ No	☐ Yes ☐ No

SECTION 7

Confirmation Please read, sign and date:

I acknowledge that I have been given the opportunity to enroll in the AMS TRICARE Supplement Insurance Plan and that I am age 64 or younger, unless ineligible for Medicare, an AMS Member and that the above information is true and complete to the best of my knowledge.

I understand that this program may not cover pre-existing conditions (conditions for which I received medical advice or treatment within 6 consecutive months prior to the effective date of coverage or until the coverage has been in effect for 6 consecutive months). This pre-existing condition limitation will not apply if waived in accordance with policy provisions.

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 that eligibility to receive benefits under the TRICARE Retiree Supplement is dependent on my (or my deceased spouse's) entitlement to uniformed services retired pay.

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 AMS can fully describe the provisions, terms, conditions, limitations and exclusions of my insurance.

Member Signature: _____ Date:_____

This signature applies only to that portion of the Enrollment Form completed by this individual.

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

This signature applies only to that portion of the Enrollment Form completed by this individual.

SECTION 8

Payment - Automatic Bank Withdrawal (Electronic Funds Transfer):

Name:	Banking Institution:	Routing Number:	
Account Number:	Bank Account Type:	☐ Checking	☐ Savings

I wish to pay my premiums: ☐ Monthly ☐ Quarterly ☐ Semi-annually ☐ Annually

I authorize the Administrator to initiate debit entries for my regular payment from the bank account provided above. I understand that payment will be processed on or after the due date and will continue to be deducted from my account unless I notify the Administrator otherwise in writing or my coverage ends. I also understand if corrections of the debit are necessary, this may involve an adjustment to my account.

Member Signature: _____ Date: _____

This signature applies only to that portion of the Enrollment Form completed by this individual.

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

This signature applies only to that portion of the Enrollment Form completed by this individual.

SECTION 9

Fraud Notice(s)

For Residents of Florida:
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.

For Residents of Kentucky:
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

For Residents of Louisiana:
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.

For Residents of Maryland:
Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or 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.

For Residents of New Jersey:
Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. Any person who includes any false or misleading information on an application for insurance is subject to criminal and civil penalties.

For Residents of Ohio:
Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

For Residents of Tennessee:
It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines and denial of insurance benefits.

For Residents of Virginia:
Any person who, with the intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.

For Residents of Washington:
It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, and denial of insurance benefits.