

# HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

One Hartford Plaza  
 Hartford, Connecticut 06155  
 (A stock insurance company)



**ASSOCIATION OF THE UNITED STATES ARMY**

## TRICARE SUPPLEMENT INSURANCE PLAN ENROLLMENT FORM ASSOCIATION OF THE UNITED STATES ARMY

**Please Print. Use Dark Ink. Do Not Erase. Initial All Changes.**

Verify preprinted information and complete as necessary: **(NOTE: Name must be identical to how it appears on your military ID card.)**

### MEMBER INFORMATION

New Enrollment

Member Name \_\_\_\_\_ AUSA Member Number \_\_\_\_\_

Member's Date of Birth \_\_\_\_\_ Gender:  Male  Female

Home Address (Street, City, State, Zip) \_\_\_\_\_ Member's Social Security Number \_\_\_\_\_

Daytime Phone Number \_\_\_\_\_ Work Phone Number \_\_\_\_\_ Cell Phone Number \_\_\_\_\_

Member Occupation \_\_\_\_\_ Email Address \_\_\_\_\_

Is Spouse's coverage desired?  Yes  No Spouse's Full Name (If Enrolling) \_\_\_\_\_

Spouse's Date of Birth \_\_\_\_\_ Gender:  Male  Female

Spouse's Occupation \_\_\_\_\_ Spouse's Social Security Number \_\_\_\_\_

**Membership Type:**  Association Member

**Rank / Status\*\* / Duty Status / Active / Retired:**  Active Duty  Retired  Reservist  Disabled **Are you retired from the military:**  Yes  No

\*\* Widow(er)s do not need to complete these items.

Date of enlistment (or commission date) \_\_\_\_\_ Date of retirement (or initial eligibility for TRICARE benefits) \_\_\_\_\_

**Are you a member of the association?**  Yes  No **A Spouse of a Member of the Association?**  Yes  No

**Check the box below if you and/or your Spouse are:**  Retired Military  Retired Military Spouse/Surviving Spouse  Retired Reservist

Retired Reservist Spouse/Surviving Spouse  National Guard or Reserve Member  Active Duty Member

(Medicare beneficiaries are not eligible to enroll.)

### DEPENDENT CHILD(REN) INFORMATION (IF ENROLLING) IF MORE THAN 4 CHILDREN, ATTACH ADDITIONAL SHEET.

Child(ren) Name	Date of Birth:	Student
		<input type="radio"/>
		<input type="radio"/>
		<input type="radio"/>
		<input type="radio"/>

**COVERAGE INFORMATION**

Please select the Association 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.

TRICARE Select Retiree In/Out  Retiree TRICARE Prime Supplement  TRICARE Select Active Duty Family Plans  TRICARE Reserve Select Supplement

**Deductible Option:**  In/Outpatient  Inpatient only  Individual  Family

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

Member  Spouse Name \_\_\_\_\_

Dependent Child(ren) Under age 21 (under 23 if a full-time student)

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. If Family coverage is desired, please complete the following:

Name	Date of Birth:	Student
		<input type="radio"/>
		<input type="radio"/>
		<input type="radio"/>
		<input type="radio"/>

**Note:** Dependent Children must be under age 21 (23 if a full-time student).

**PLEASE ANSWER QUESTIONS (EVEN IF ONLY REQUESTING CHILD COVERAGE), READ, SIGN AND DATE.**

MEMBER

SPOUSE

<b>A.</b> 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?	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N
<b>B.</b> Are you enrolling within 30 days of the date your employer health insurance ends because you are no longer an eligible participant in the program?	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N
<b>C.</b> Are you enrolling within 60 days of termination of Active Duty service or within 30 days of initial eligibility for TRICARE benefits?	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N
<b>D.</b> Are you enrolling within 30 days of Active Duty service and has your family been insured under the TRICARE Active Duty Supplement prior to your retirement?	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N
<b>E.</b> Have you enrolled in the TRICARE Reserve Select within the past 30 days?	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N
<b>F.</b> Are you changing from our TRICARE Prime Supplement to our TRICARE Select Supplement on your Prime Anniversary Date or because you have moved outside of the Prime Network?	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N
<b>G.</b> Are you changing from our TRICARE Select Supplement to our TRICARE Select Prime Supplement on your Select Anniversary Date?	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N

**CONFIRMATION PLEASE READ, SIGN AND DATE:**

I acknowledge that I have been given the opportunity to enroll in the AUSA TRICARE Supplement Insurance Plan and that I am age 64 or younger, unless ineligible for Medicare, an AUSA 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 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.

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

Do you wish to receive your Certificate of Insurance by secure email?  Yes  No

If the "Yes" checkbox is selected, please provide your email address \_\_\_\_\_

Member's Signature X

Date (MM/DD/YY)

Spouse's Signature (If enrolling) X

Date (MM/DD/YY)

**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.

**I authorize the Administrator to initiate credit card payments or debit entries for my regular payment from the credit card or bank account provided above. I understand that payment will be processed on or after the due date and will continue to be charged or 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: \_\_\_\_\_

Spouse Signature (if enrolling): \_\_\_\_\_ Date: \_\_\_\_\_

**PAYMENT OPTIONS**

Credit Card (Automatic Withdrawal):

Name:

Payment Type:

Banking Institution:

Card Number:

Routing Number:

Expiration Date:

Account Number:

Payment/Billing Frequency:

Bank Account Type:   Checking   Savings

Automatic Bank Withdrawal (Electronic Funds Transfer):

**TO ENROLL MAIL YOUR COMPLETED ENROLLMENT FORM TO:**

**PLEASE MAIL WITHIN 10 DAYS**

**MAIL YOUR COMPLETED APPLICATION TO:**

AUSA GROUP INSURANCE PROGRAM  
1200 E. GLEN AVE. PEORIA HEIGHTS, IL 61616-5348

**QUESTIONS?**

CALL 1.800.882.5707 OR  
EMAIL CUSTOMERSERVICE@AUSACOVERAGE.COM