



TRICARE SUPPLEMENT INSURANCE PROGRAM



- Initial Application
- Change of Information

**YOUR INFORMATION**

Policyholder Name (Your Association)		Member Number
Name	Rank and Service	Social Security Number
Address	Date of Birth (MM, DD, YYYY)	Daytime Phone
Service <input type="checkbox"/> Reservists <input type="checkbox"/> Widow/er    Date of Retirement _____ <input type="checkbox"/> Active Duty <input type="checkbox"/> Retired	Email Address	

**COVERAGE DESIRED**

1. <input type="checkbox"/> Active Duty Family Supplement	<input type="checkbox"/> Retired Supplement (Choose One)
	2. <input type="checkbox"/> Inpatient Coverage w/ \$250/\$500 Deductible
	3. <input type="checkbox"/> Inpatient and Outpatient Coverage w/ \$250/\$500 Deductible
	4. <input type="checkbox"/> Tricare Prime Supplement

**BILLING FREQUENCY**

<input type="checkbox"/> Monthly (via Checkomatic)	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Semi-Annually	<input type="checkbox"/> Annually
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**NAME OF EACH PERSON FOR WHOM COVERAGE IS DESIRED**

Name	Social Security Number	Date of Birth (MM, DD, YYYY)
Member _____	_____	_____
Spouse _____	_____	_____
Child _____	_____	_____
Child _____	_____	_____
Child _____	_____	_____

**AUTHORIZATION (PLEASE READ, SIGN AND DATE)**

**I hereby enroll** myself and/or my dependents with Hartford Life Insurance Company for coverage under the Association's TRICARE Supplement insurance plan. I certify that I am a member of the Association. I understand that my coverage will become effective on the first day of the month following approval of my completed enrollment form and payment of my initial 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 the 12 months (6 months in California, Indiana and Montana) immediately preceding their effective date will not be covered: (a) until that person (except in California, Indiana & Montana) has not received medical treatment or care for that condition during a period of 12 consecutive months ending on or after his or her effective date; or (b) until the end of a 6 month period from the person's effective date in California or the end of a 12 month period from the person's effective date in Indiana and Montana. After 2 years (1 year in Indiana, Montana, North Carolina & South Carolina; 6 months in California) from that person's effective date, he or she will become covered regardless of any pre-existing conditions he or she may have. I further understand that new conditions will be covered immediately.

**California residents only: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.**

**Florida residents only: 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.**

Signature of Member \_\_\_\_\_ Date \_\_\_\_\_