TRICARE Supplement Insurance Plan

ENROLLMENT FORM

Underwritten by Hartford Life and Accident Insurance Company
and Hartford Life Insurance Company, Hartford, CT 06155

Complete and Return to:

AUSA MASTERCARE GROUP INSURANCE PLANS
P.O. Box 9947
Phoenix, AZ 85068

1 Please complete:

Member Name: (FIRST, M.I., LAST) Date of Birth: (MONTH – DAY – YEAR)

Address:

City, State, Zip: (CITY) (STATE) (ZIP CODE)

Phone Number: ( ) – Gender: ◯ M ◯ F

Rank/Service (Member Status):

◯ Active duty ◯ Retired ◯ Reservist ◯ Disabled ◯ Deceased

Are you retired from the military? ◯ Yes ◯ No

Are you currently receiving Medicare? ◯ Yes ◯ No

Date of Retirement (or eligibility for TRICARE benefits): (MONTH – DAY – YEAR)

Email Address:

2 Please select coverage:

Smoker Status: (Required)

Member: ◯ Non-Smoker ◯ Smoker **Spouse:** ◯ Non-Smoker ◯ Smoker

Family of Active Duty Members Plan Inpatient & Outpatient

◯ Spouse ◯ Child(ren)

Retired TRICARE Prime Supplement

◯ Member ◯ Spouse ◯ Child(ren)

Retired TRICARE Standard Supplement - Inpatient & Outpatient

Select Coverage Desired:

◯ $200 Deductible ◯ $350 Deductible

Select Person(s) you would like covered:

◯ Member ◯ Spouse ◯ Child(ren)

3 Please provide for family members to be covered:

Name of Family Member Enrolling	Date of Birth (MONTH – DAY – YEAR)
SPOUSE NAME (First, M.I., Last)	
CHILD NAME (First, M.I., Last)	
CHILD NAME (First, M.I., Last)	

Please continue on Page 2

AU21254 N44203 B1198
Policy # AGP-5329; AGP-5330
TRICARE Form Series includes SRP-1269, or state equivalent.

3 Please provide for family members to be covered:

Name of Family Member Enrolling **Date of Birth**

CHILD NAME (First, M.I., Last) MONTH – DAY – YEAR

CHILD NAME (First, M.I., Last) MONTH – DAY – YEAR

CHILD NAME (First, M.I., Last) MONTH – DAY – YEAR

To cover additional children, please enclose a separate sheet with names, and dates of birth.

4 Please sign and date:

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 AUSA Mastercare TRICARE Supplement program, underwritten by the Hartford Life and Accident Insurance Company and Hartford 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 further understand that this policy will not cover pre-existing conditions, i.e., injury or sickness for which medical advice or treatment has been received during the first 12 months of coverage (6 months for Retired Prime and Active Duty Standard/Extra) immediately preceding the effective date of this coverage, until I have been treatment-free for such condition for 12 consecutive months (6 months for Retired Prime and Active Duty Standard/Extra) or this coverage has been in effect for 24 months (12 months for Retired Prime and Active Duty Standard/Extra), whichever is earlier. (For members residing in California, a pre-existing condition is any condition that required medical treatment, consultation, or expense during the 6 months immediately before your effective date of insurance. This exclusion will end on the date you have been insured under the group policy for 6 consecutive months. California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance.) For residents in all states except FL, PA, NJ and WA: Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person submits an insurance application or statement of claim containing any materially false, incomplete, or misleading information may be committing a crime and may be subject to civil or criminal penalties, depending upon state law. For 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 materially false, incomplete or misleading information is guilty of a felony of the third degree. For 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. I further understand that if any person to be covered under this policy is hospital-confined on the date this insurance goes into effect, such effective date of coverage will be deferred until the first day of the month following a period of 30 consecutive days after final discharge from the hospital. I represent that to the best of my knowledge and belief, all statements and answers recorded on this form are true and complete.

SIGN & DATE

X

AUSA Member's Signature **Date:** MONTH – DAY – YEAR

Spouse's Signature (if enrolling) **Date:** MONTH – DAY – YEAR

Return completed form today to:

AUSA Mastercare Group Insurance Plans
P.O. Box 9947, Phoenix, AZ 85068

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