# MEDIPLUS® TRICARE RETIRED RESERVE SUPPLEMENT INSURANCE ACTIVATION FORM

Complete all information in ink.

AGP-1134
085739021010 04049-Q

## 1 *Please complete the following information.*

NOTE: Name must be identical to how it appears on your military ID card.
*Widow(er)s do not need to complete these items.

Endorsed by:

**Underwritten by:**
Hartford Life Insurance Company in ME, MN and MT, and by Hartford Life and Accident Insurance Company in all other states. Home Office of both companies is Hartford, CT 06155.

**The Hartford® is The Hartford Financial Services Group, Inc., and its subsidiaries, including issuing company Hartford Life and Accident Insurance Company and Hartford Life Insurance Company.

Member Name: ______________________________

Address: ______________________________

City: ______________________________

State: ____________________ ZIP: ____________

Social Security Number: ______________________________

Email Address: ______________________________

Date of Birth: ____________ mo / day / yr

Rank/Service:* ______________________________

Sex: ☐ Male ☐ Female

Date TRICARE Retired Reserve Coverage begins: ____________ mo / day / yr

Daytime Phone: ______________________________

Membership Type: (Check one) ☐ MOAA Member ☐ MOAA Auxiliary Member

MOAA Member Number: ____________________

Initial Service Entry Date: ____________ mo / day / yr

Certificate Number: 040_ _-_ _ _ _ _ _ _

(If you are already enrolled in MEDIPLUS and this form is for additional coverage or a change in coverage, insert your current certificate number here.)

## 2 *Please select the MEDIPLUS TRICARE Retired Reserve Supplement you want.*

Member must enroll in order for spouse or child(ren) to have coverage. Children must be under age 21 (23 if a full-time student). Please include proof of full-time status with your activation form.

(NOTE: You're classified as a "nonsmoker" if you haven't smoked a cigarette, cigars, or used a pipe or chewing tobacco, nicotine product or snuff within the past 12 months.)

| IN- and OUTPATIENT PLANS | RETIRED WITH $400 PER PERSON DEDUCTIBLE | RETIRED WITH $250 PER PERSON DEDUCTIBLE |
|---|---|---|
| **Member** | ☐ Nonsmoker (CL61)<br>☐ Smoker (CS61) | ☐ Nonsmoker (CL51)<br>☐ Smoker (CS51) |
| **Spouse** | ☐ Nonsmoker (CL65)<br>☐ Smoker (CS65) | ☐ Nonsmoker (CL55)<br>☐ Smoker (CS55) |
| **Child(ren)** | ☐ CL67) | ☐ (CL57) |

## 3 *Please complete if your family is enrolling.*

(NOTE: Name(s) must be identical to how they appear on military ID card.)

Spouse Name: ______________________ Sex: ☐ M ☐ F Date of Birth: ____________ mo / day / yr

Child Name: ______________________ Sex: ☐ M ☐ F Date of Birth: ____________ mo / day / yr

Child Name: ______________________ Sex: ☐ M ☐ F Date of Birth: ____________ mo / day / yr

Child Name: ______________________ Sex: ☐ M ☐ F Date of Birth: ____________ mo / day / yr

Children must be under age 21 (23 if a full-time student or 26 if enrolled in TRICARE Young Adult). Please include proof of full-time status or proof of enrollment in TRICARE Young Adult with your form. If you would like to enroll more than 3 children, please attach a separate sheet that includes the information requested.

(Over, please)

## 4 Please complete these questions.

(NOTE: The MOAA member should answer questions even if only requesting child coverage.)

| | Member YES | Member NO | Spouse (if enrolling) YES | Spouse (if enrolling) NO |
|---|---|---|---|---|
| A. Have you or anyone enrolling for coverage smoked cigarettes, cigars, or used a pipe or chewing tobacco, nicotine product or snuff within the past 12 months? | ☐ | ☐ | ☐ | ☐ |
| B. Are you enrolling within 30 days of the date your TRICARE Retired Reserve coverage begins? | ☐ | ☐ | ☐ | ☐ |
| C. Are you enrolling within 60 days of termination of active duty service or initial eligibility for TRICARE benefits? | ☐ | ☐ | ☐ | ☐ |

## 5 Please read, sign and date.

I hereby enroll myself or myself and my dependents with The Hartford** for coverage under the Military Officers Association of America Group Health Insurance Program (MEDIPLUS). I certify that I am a current member of MOAA or plan to enroll/accept membership in MOAA and acknowledge that I will receive e-communications from MOAA and understand that I must retain membership to be eligible for MEDIPLUS. I understand that this program will not cover pre-existing conditions (conditions [including pregnancy] for which medical advice or treatment was rendered or recommended by a physician for those being enrolled within six months of this new coverage) unless six months have passed from the effective date of this new coverage. 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 this TRICARE Retiree Supplement is dependent on my (or my deceased spouse's) purchase of TRICARE Retired Reserve. 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 in the third degree.

**STATE NOTICE**

Any person who includes any false or misleading information on an application or filing a claim for an insurance policy is subject to criminal and civil penalties. It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. In certain states, penalties may include imprisonment, fines, denial of insurance and civil damages.

Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the State Insurance Regulatory Agency and/or Division of Insurance. If while in the state of Florida, a person 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, the person is guilty of a felony in the third degree. 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, misleading or deceptive 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 be subject to substantial civil and/or criminal penalty where and to the extent allowed by state law.

**Member's Signature X** ______________________________ **Date X** ________________

## Don't send money now! You'll be billed later.

Mail your completed Activation Form to:

MOAA Insurance Plans • P.O. Box 14464 • Des Moines, IA 50306

**Questions?** Call Toll-Free **1-800-247-2192**

(Hearing-impaired or voice-impaired members may call the Relay Line at 711-800-247-2192.)

Or, email moaa.service@mercer.com

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