

MEDIPLUS® TRICARE Reserve Select Supplement Insurance

Enrollment Form

04049-Q
085739020909
AGP-1134

1. Complete the following information:

NOTE: Name must be identical to how it appears on your military ID card.

Member Name: _____

Address: _____

City: _____

State: _____ ZIP: _____

Rank/Service: _____

Date of Birth: _____
mo / day / yr

Initial Service Entry Date: _____ MOAA Member #: _____
mo / day / yr

Date TRICARE Reserve Select coverage begins: _____ Daytime Phone: _____

Social Security #: _____ Existing Coverage Certificate #: 04049- _____

Email Address: _____
(MOAA will not rent or sell your email address.)

**SEND
NO
MONEY
NOW.**



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.

2. Choose your coverage:

Member (TS_1) Spouse (TS_5) Child (TSN7) NOTE: Member must enroll in order for spouse or child to have coverage.

Please complete if choosing family coverage† (Name(s) must be identical to how they appear on military ID card).

Full Name (Including Last Name)	Gender (M/F)	Date of Birth (mo/day/yr)
Spouse		
Child		
Child		
Child		

†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.

3. Answer these questions (even if only requesting child coverage).

	Member		Spouse	
	Yes	No	Yes	No
1. 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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Are you enrolling within 30 days of the date your TRICARE Reserve Select coverage begins?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4. Read, sign and date below.

I represent that to the best of my knowledge and belief, all statements and answers recorded on this form are true and complete. I hereby enroll myself and/or 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 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 MEDIPLUS Supplement is dependent upon my purchase of TRICARE Reserve Select. California residents: 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: 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.

Member's signature **X** _____ Date **X** _____

Questions? Call 1-800-247-2192 or email moaa.service@mercerc.com

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

Send no money now. Send completed Enrollment Form to:
MOAA Insurance Plans, P.O. Box 14464, Des Moines, IA 50306

TRICARE Policy Form Series includes
SRP-1269, or state equivalent
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