HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY
One Hartford Plaza
Hartford, Connecticut 06155
(A stock insurance company)

TRICARE SUPPLEMENT INSURANCE PLAN ENROLLMENT FORM
MARINE CORPS ASSOCIATION

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 _____ MCA 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 ❍ Association Auxiliary 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	TRICARE Young Adult
		❍	❍
		❍	❍
		❍	❍
		❍	❍

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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)

❍ Under age 26 (if enrolled in TRICARE Young Adult)

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	TRICARE Young Adult
		❍	❍
		❍	❍
		❍	❍
		❍	❍

Note: Dependent Children must be under age 21 (23 if a full-time student or 26 if enrolled in TRICARE Young Adult); please include proof of enrollment in TRICARE Young Adult with your Enrollment Form.

PLEASE ANSWER QUESTIONS (EVEN IF ONLY REQUESTING CHILD COVERAGE), READ, SIGN AND DATE.	MEMBER	SPOUSE
A. 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?	❍ Y ❍ N	❍ Y ❍ N
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?	❍ Y ❍ N	❍ Y ❍ N
C. Are you enrolling within 60 days of termination of Active Duty service or within 30 days of initial eligibility for TRICARE benefits?	❍ Y ❍ N	❍ Y ❍ N
D. 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?	❍ Y ❍ N	❍ Y ❍ N
E. Have you enrolled in the TRICARE Reserve Select within the past 30 days?	❍ Y ❍ N	❍ Y ❍ N
F. 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?	❍ Y ❍ N	❍ Y ❍ N
G. Are you changing from our TRICARE Select Supplement to our TRICARE Select Prime Supplement on your Select Anniversary Date?	❍ Y ❍ N	❍ Y ❍ 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 _____

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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):

Payment Type:

Card Number:

Expiration Date:

Payment/Billing Frequency:

Automatic Bank Withdrawal (Electronic Funds Transfer):

Name:

Banking Institution:

Routing Number:

Account Number:

Bank Account Type: Checking Savings

TO ENROLL MAIL YOUR COMPLETED ENROLLMENT FORM TO:

Please mail within 10 days

MCA GROUP INSURANCE PROGRAM ADMINISTRATOR
1200 E. GLEN AVE.
PEORIA HEIGHTS, IL 61616-5384

QUESTIONS?
CALL 800.845.4685 OR
CUSTOMERSERVICE@INSUREMCA.COM

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