

MEDIPLUS® TRICARE Reserve Select Supplement Insurance

Enrollment Form

04009-Q
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AGP-1134

1. Complete the following information:

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

Name: _____
Address: _____
City: _____
State: _____ ZIP: _____

Rank/Service: _____ Date of Birth: ____/____/____ MOAA Member #: _____
mo day yr

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

Social Security #: _____ Existing Coverage Certificate #: 04009-_____

E-mail Address: _____ (Optional. MOAA will not rent or sell your e-mail address.)
(If you are already enrolled in MEDIPLUS and this enrollment form is for additional coverage or a change in coverage, insert your current insurance number here.)



SEND NO MONEY NOW.

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 it appears on your military ID card).

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

†Children must be under age 21, or 23 if a full-time student. Please include proof of full-time status with your application. If you would like to enroll more than 3 children, please attach a separate sheet that includes the information requested.

3. Answer these questions.

Member **Spouse**
Yes **No** **Yes** **No**

- Have you or your spouse smoked cigarettes, cigars, or used a pipe or chewing tobacco, nicotine product or snuff in the past 12 months?
- Are you enrolling within 30 days of the date your TRICARE Reserve Select coverage begins?

4. Read, sign and date below.

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 member of MOAA. 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 e-mail moaa@marshpm.com

(Hearing-impaired or voice-impaired members may call the Relay Line at 1-800-855-2881.)

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