

# MEDIPLUS® TRICARE SUPPLEMENTAL INSURANCE ACTIVATION FORM

Complete all information in ink.

# 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.

Member Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Member Social Security Number: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Rank/Service:\* \_\_\_\_\_



Endorsed by:



Underwritten by:  
Hartford Life and Accident  
Insurance Company  
Simsbury, CT 06089

Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
mo day yr

Sex:  Male  Female

Daytime Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

Are you retired from the military?\*  Yes  No Date of retirement (or initial eligibility for TRICARE Benefits): \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
mo day yr

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

MOAA Member Number: \_\_\_\_\_

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

(If you are already enrolled in MEDIPLUS and this form is for additional coverage or a change in coverage)

# 2

## Please select the MEDIPLUS TRICARE Supplement you want.

(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 For TRICARE Standard & Extra

	RETIRED WITH \$400 PER PERSON DEDUCTIBLE	RETIRED WITH \$250 PER PERSON DEDUCTIBLE	ACTIVE DUTY WITH NO DEDUCTIBLE	
<b>Member</b>	<input type="checkbox"/> Nonsmoker (CL41) <input type="checkbox"/> Smoker (CS41)	<input type="checkbox"/> Nonsmoker (CL21) <input type="checkbox"/> Smoker (CS21)	N/A	N/A
<b>Spouse</b>	<input type="checkbox"/> Nonsmoker (CL45) <input type="checkbox"/> Smoker (CS45)	<input type="checkbox"/> Nonsmoker (CL25) <input type="checkbox"/> Smoker (CS25)	<input type="checkbox"/> Nonsmoker (AIT5) <input type="checkbox"/> Smoker (AIS5)	
<b>Child(ren)</b>	<input type="checkbox"/> (CL47)	<input type="checkbox"/> (CL27)	<input type="checkbox"/> (AIT7)	

	RETIRED WITH \$300 PER PERSON DEDUCTIBLE	RETIRED WITH \$150 PER PERSON DEDUCTIBLE
<b>Member</b>	<input type="checkbox"/> Nonsmoker (CL31) <input type="checkbox"/> Smoker (CS31)	<input type="checkbox"/> Nonsmoker (CL11) <input type="checkbox"/> Smoker (CS11)
<b>Spouse</b>	<input type="checkbox"/> Nonsmoker (CL35) <input type="checkbox"/> Smoker (CS35)	<input type="checkbox"/> Nonsmoker (CL15) <input type="checkbox"/> Smoker (CS15)
<b>Child(ren)</b>	<input type="checkbox"/> (CL37)	<input type="checkbox"/> (CL17)

### INPATIENT ONLY PLANS For TRICARE Standard & Extra

	RETIRED WITH NO DEDUCTIBLE	RETIRED WITH \$200 PER PERSON DEDUCTIBLE
<b>Member</b>	<input type="checkbox"/> Nonsmoker (CHN1) <input type="checkbox"/> Smoker (CNS1)	<input type="checkbox"/> Nonsmoker (CLN1) <input type="checkbox"/> Smoker (CLS1)
<b>Spouse</b>	<input type="checkbox"/> Nonsmoker (CHN5) <input type="checkbox"/> Smoker (CNS5)	<input type="checkbox"/> Nonsmoker (CLN5) <input type="checkbox"/> Smoker (CLS5)
<b>Child(ren)</b>	<input type="checkbox"/> (CHN7)	<input type="checkbox"/> (CLN7)

**2****Please select the *MEDIPLUS TRICARE Supplement* you want. (Continued).**

(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.)

**TRICARE PRIME PLAN**

RETIRED PLAN		If enrolling in the TRICARE Prime Supplement (or USFHP), please tell us the date your TRICARE Prime (or USFHP) protection started.  _____ / _____ / _____ mo / day / yr
<b>Member</b>	<input type="checkbox"/> Nonsmoker (PHT1) <input type="checkbox"/> Smoker (PTS1)	
<b>Spouse</b>	<input type="checkbox"/> Nonsmoker (PHT5) <input type="checkbox"/> Smoker (PTS5)	
<b>Child(ren)</b>	<input type="checkbox"/> (PHT7)	

**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: <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth: _____ / _____ / _____ mo day yr
Child Name: _____	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth: _____ / _____ / _____ mo day yr
Child Name: _____	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth: _____ / _____ / _____ mo day yr
Child Name: _____	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth: _____ / _____ / _____ mo day yr

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.

**4****Please complete these questions. Then read, sign and date.**

	Member		Spouse (if applying)	
	YES	NO	YES	NO
A. Have you or your spouse smoked cigarettes, cigars, or used a pipe or chewing tobacco, nicotine product or snuff in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Are you enrolling within 30 days of the date your employer health insurance ends because you are no longer an eligible participant in that program?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Are you enrolling within 30 days of termination of active duty service or initial eligibility for TRICARE benefits?*	<input type="checkbox"/>	<input type="checkbox"/>		

**5****Please read, sign and date:**

I hereby enroll myself and/or my dependents with Hartford Life and Accident Insurance Company 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 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. If I increase my coverage, the amount of the increase will be subject to the pre-existing condition limitation. I understand that the MEDIPLUS TRICARE Prime Supplement does not provide a waiver of premium provision for my surviving insured spouse and/or children. 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 have read the MEDIPLUS Acknowledgement and the "Important Notice About This Coverage" section of the MOAA MEDIPLUS Web site and agree to accept these terms. I understand that once my enrollment form has been processed, a MEDIPLUS certificate will be mailed to me. My MEDIPLUS protection will begin on the first of the month after the Plan Administrator receives this enrollment form and my first premium payment.

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.

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 1-800-855-2881.)

Or, e-mail [moaa@marshpm.com](mailto:moaa@marshpm.com)