MEDIPLUS® TRICARE SUPPLEMENT INSURANCE PLAN ACTIVATION FORM

Complete all information in ink.

096342020303 AGP-5889
Group A: 04079-Q, Group B: 04089-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.

Member Name: _____

Address: _____

City: _____

State: _____ ZIP: _____

Member Social Security Number: _____

Email Address: _____

Rank/Service:* _____

THE HARTFORD

Endorsed by: MOAA Military Officers Association of America

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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 Surviving Spouse Member

MOAA Member Number: _____

Initial Service Entry Date (MO/DAY/YR): _____
(For administrator use: 04079 if date is prior to 1/1/2018, otherwise 04089. All TRICARE Young Adult coverage will be 04089.)

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 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 prior to enrollment.)

IN- and OUTPATIENT PLANS For TRICARE Select

	RETIRED WITH $400 PER PERSON DEDUCTIBLE	RETIRED WITH $250 PER PERSON DEDUCTIBLE	ACTIVE DUTY WITH NO DEDUCTIBLE
Member	☐ Nonsmoker (CL41) ☐ Smoker (CS41)	☐ Nonsmoker (CL21) ☐ Smoker (CS21)	N/A
Spouse	☐ Nonsmoker (CL45) ☐ Smoker (CS45)	☐ Nonsmoker (CL25) ☐ Smoker (CS25)	☐ Nonsmoker (AIT5) ☐ Smoker (AIS5)
Child(ren)	☐ Under age 21 (CL47) (23 if a full-time student) ☐ Age 21-25 (04089-CC47) (if enrolled in TRICARE Young Adult)	☐ Under age 21 (CL27) (23 if a full-time student) ☐ Age 21-25 (04089-CC27) (if enrolled in TRICARE Young Adult)	☐ Under age 21 (AIT7) (23 if a full-time student) ☐ Age 21-25 (04089-ACT7) (if enrolled in TRICARE Young Adult)

	RETIRED WITH $300 PER PERSON DEDUCTIBLE	RETIRED WITH $150 PER PERSON DEDUCTIBLE
Member	☐ Nonsmoker (CL31) ☐ Smoker (CS31)	☐ Nonsmoker (CL11) ☐ Smoker (CS11)
Spouse	☐ Nonsmoker (CL35) ☐ Smoker (CS35)	☐ Nonsmoker (CL15) ☐ Smoker (CS15)
Child(ren)	☐ Under age 21 (CL37) (23 if a full-time student) ☐ Age 21-25 (04089-CC37) (if enrolled in TRICARE Young Adult)	☐ Under age 21 (CL17) (23 if a full-time student) ☐ Age 21-25 (04089-CC17) (if enrolled in TRICARE Young Adult)

INPATIENT ONLY PLANS For TRICARE Select

	RETIRED WITH NO DEDUCTIBLE	RETIRED WITH $200 PER PERSON DEDUCTIBLE
Member	☐ Nonsmoker (CHN1) ☐ Smoker (CNS1)	☐ Nonsmoker (CLN1) ☐ Smoker (CLS1)
Spouse	☐ Nonsmoker (CHN5) ☐ Smoker (CNS5)	☐ Nonsmoker (CLN5) ☐ Smoker (CLS5)
Child(ren)	☐ Under age 21 (CHN7) (23 if a full-time student) ☐ Age 21-25 (04089-CCH7) (if enrolled in TRICARE Young Adult)	☐ Under age 21 (CLN7) (23 if a full-time student) ☐ Age 21-25 (04089-CCL7) (if enrolled in TRICARE Young Adult)

TRICARE Policy Form Series includes GBD-3000, GBD-3100, or state equivalent.

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 prior to enrollment.)

TRICARE PRIME PLAN

	RETIRED PLAN
Member	☐ Nonsmoker (PHT1) ☐ Smoker (PTS1)
Spouse	☐ Nonsmoker (PHT5) ☐ Smoker (PTS5)
Child(ren)	☐ Under age 21 (PHT7) (23 if a full-time student) ☐ Age 21-25 (04089-PCT7) (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.

_____
mo / day / yr

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.

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 employer health insurance ends because you are no longer an eligible participant in that program?	☐	☐	☐	☐
C. Are you enrolling within 60 days of termination of active duty service or initial eligibility for TRICARE benefits?*	☐	☐	☐	☐
D. Are you making changes to your MEDIPLUS Supplement Plan due to a Qualifying Life Event?	☐	☐	☐	☐

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 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. 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 website 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 day 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. Maryland residents only: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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.)

email moaa.service@mercer.com