TRICARE SUPPLEMENT INSURANCE PLAN ENROLLMENT FORM

FOR EXISTING AND NEW EMPLOYEES

ADMINISTERED BY: SELMAN & COMPANY
SPONSORED BY: GOVERNMENT EMPLOYEES ASSOCIATION (GEA)
UNDERWRITTEN BY: Hartford Life and Accident Insurance Company, Hartford, CT 06155
(A stock insurance company)

Fields with an asterisk are required. Application processing will be delayed if these fields are missing.

*Please indicate request type below.

❑ New Enrollment ❑ Terminate Member Only	❑ Add Dependent(s) ❑ Terminate Dependent(s) Only	❑ Terminate Coverage ❑ Change Address

If making changes to existing coverage, please include current insured ID:_____

***CHECK THE BOX BELOW IF YOU ARE:**	***SELECT YOUR TRICARE SUPPLEMENT OPTION BELOW:**	***Group Name:**	
❑ Retired Military ❑ Retired Military Spouse/Surviving Spouse ❑ Retired Reservist ❑ Retired Reservist Spouse/Surviving Spouse	❑ Select ❑ Retired Reserve ❑ Prime *Your Supplement Insurance choice will match your primary TRICARE plan type. Medicare beneficiaries are not eligible to enroll.*	*Group Code: Policy Number:	
		*E-Mail Address:	
		*Coverage Effective Date:	
Employee Full SSN:	*Enroll Employee: ❑ Yes ❑ No	*Employee Date of Birth:	
*Employee First Name:	*Employee Last Name:	Middle Initial:	Gender: ❑ M ❑ F
*Home Address:	*City:	*State:	*Zip Code:
Primary Phone:		Enlistment Date:	

LIST ALL DEPENDENTS *(IF ENROLLING IN THE PLAN)

Relationship Codes	*First Name	*Last Name	*Date of Birth MM/DD/YYYY	Gender		If Disabled and under age 26 Check **Yes**
S-Spouse				❑ M	❑ F	
C-Child				❑ M	❑ F	❑ Yes
C-Child				❑ M	❑ F	❑ Yes
C-Child				❑ M	❑ F	❑ Yes
C-Child				❑ M	❑ F	❑ Yes

Note: Dependent Children must be under age 26 and enrolled in a primary TRICARE plan to be eligible. Additional children may be listed on a separate sheet of paper and attached to/submitted with this form.

Confirmation Please read, sign and date:

I hereby enroll myself and/or my dependents with the Hartford Life and Accident Insurance Company for coverage under the Government Employees Association (GEA) sponsored TRICARE Supplement Plan. I understand that I must be a member of GEA to be eligible for coverage and that my coverage will become effective on the receipt of this enrollment form and premium.

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.

By signing below, I authorize my employer to deduct the monthly premiums from my paycheck on a pre-tax basis. I hereby authorize my employer to reduce my gross salary before taxes are calculated according to the benefit elected.

SIGN HERE ➢	*EMPLOYEE SIGNATURE:	DATE:

Fraud Notice(s)

For Residents of Florida:

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 of the third degree.

For Residents of Kentucky:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

For Residents of Louisiana:

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

For Residents of Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or 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.

For residents of New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. Any person who includes any false or misleading information on an application for insurance is subject to criminal and civil penalties.

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.

For Residents of Ohio: Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

For Residents of Tennessee: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines and denial of insurance benefits.

For Residents of Virginia: Any person who, with the intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.

For Residents of Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, and denial of insurance benefits.