



TRICARE SUPPLEMENT PLAN ENROLLMENT FORM FOR ACTIVE EMPLOYEES

Administered by: ASSOCIATION & SOCIETY INSURANCE CORPORATION

Sponsored by: American Military Retirees Association

Underwritten by: Monumental Life Insurance Company, Cedar Rapids, IA, an AEGON company

<input type="checkbox"/> New Enrollment	<input type="checkbox"/> Add Dependent(s)*	<input type="checkbox"/> Change Address
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Check the box below if you are:	Select your TRICARE option:	Policy #: MZ0925783H0000A
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<input type="checkbox"/> Retired Military		Group Code: C914-B PD
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<input type="checkbox"/> Retired Military Spouse	<input type="checkbox"/> Standard	Employee ID #:
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<input type="checkbox"/> Surviving Spouse of Retired Military personnel	<input type="checkbox"/> Prime	DEERS #:
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<input type="checkbox"/> Retired Reservist	<input type="checkbox"/> Retired Reserve	
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Employee Last Name:	First Name:	Middle Initial:	Gender <input type="checkbox"/> M <input type="checkbox"/> F
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Home Address:	City:	State:	Zip Code:
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Home Phone:	Work Phone:	Date of Birth:
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More than (4) dependents, please add an extra sheet with their information

Relationship Codes	Last Name	First Name	Middle Initial	Date of Birth MM/DD/YYYY	Social Security Number	If Child disabled Check Y
Spouse						
Children						<input type="checkbox"/> Y
						<input type="checkbox"/> Y
						<input type="checkbox"/> Y
						<input type="checkbox"/> Y
						<input type="checkbox"/> Y

Relationship Codes: H=husband W=wife S=son D=daughter SS=stepson SD=stepdaughter OF=other female child OM=other male child

Coverage Level and Monthly Premium Amounts:

<input type="checkbox"/> Employee Only	\$ 60.00	<input type="checkbox"/>
<input type="checkbox"/> Employee plus One	\$119.00	<input type="checkbox"/>
<input type="checkbox"/> Employee plus Two/More	\$160.00	<input type="checkbox"/>

I hereby enroll myself and/or my dependents with the Monumental Life Insurance Company for Coverage under the American Military Retirees Association (AMRA) sponsored TRICARE Supplement Plan. I understand that I must be a member of AMRA to be eligible for coverage and that my coverage will become effective on the receipt of this enrollment form and premium.

AR, CO, KY, LA, ME, NM, OH, OK, TN and WA Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of a claim or an application containing any false, incomplete or misleading information is guilty of a crime and may be subject to fines or confinement in prison.

DC and RI Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false or fraudulent claim 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.

FL 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 crime and may be subject to fines and confinement in prison.

MD Residents: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. FRD1000A.MD

NJ Residents: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

PA Residents: 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 subjects such a person to criminal and civil penalties.

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: _____
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*Documentation of eligibility is required for all dependents. See the Eligibility Rules and Definitions chart at www.dhrm.virginia.gov.