AFTEA TRICARE Supplement Plan

Enrollment Form

Underwritten by: Monumental Life Insurance Company, Cedar Rapids, IA, a Transamerica Company.

Policyholder: Armed Forces Top Enlisted Association

Group Policy Number:

1. Please fill in as required

First Name	Last Name	Branch of Service:
Address		Member Number (if applicable):
		Rank/Grade:
City		Date of Birth: / / Sex: ☐ M ☐ F
		Home Phone: ( ) -
State	Zip	Work Phone: ( ) -
County of Residence:		MWEBP

2. Please complete this section ONLY if you want coverage for your Spouse and/or Children.

Spouse's Full Name: (if coverage is selected):	Spouse's Date of Birth: / /	
Child's Name: (if coverage is selected):	Child's Sex: ☐ M ☐ F	Child's Date of Birth: / /
Child's Name: (if coverage is selected - if additional space is needed, attach a separate piece of paper):	Child's Sex: ☐ M ☐ F	Child's Date of Birth: / /

3. Are you currently enrolled in CHAMPVA? ☐ Yes ☐ No

4. Check the appropriate boxes to indicate the coverages you want for yourself and each person you want covered.

YOUR MONTHLY PREMIUM RATES *

RETIREE AND FAMILY

$150/$300 Plan Deductible

Age	Male	Female
Under 40	☐ $26.73	☐ $28.43
40 - 44	☐ $27.80	☐ $29.37
45 - 49	☐ $31.75	☐ $32.12
50 - 54	☐ $39.55	☐ $40.52
55 - 59	☐ $49.02	☐ $51.06
60 - 64	☐ $54.91	☐ $57.29
All Children	☐ $24.70	

$300/$600 Plan Deductible

Age	Male	Female
Under 40	☐ $17.38	☐ $18.48
40 - 44	☐ $18.08	☐ $19.09
45 - 49	☐ $20.65	☐ $20.89
50 - 54	☐ $25.71	☐ $26.35
55 - 59	☐ $31.86	☐ $33.19
60 - 64	☐ $35.70	☐ $37.24
All Children	☐ $16.06	

ACTIVE DUTY DEPENDENTS: Spouse: ☐ $10.48 Each Child ☐ $9.63 There is no Plan Deductible.(Billed Semi-Annually)

* Rates and/or benefits may be changed on a class basis. Rates are based on the attained age of the Insured Person and increase as you enter each new age category.

5. Please select the mode of payment most convenient for your budget.

☐ EFT** - Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually

** Electronic Funds Transfer: For your personal convenience, you can -- if you wish -- pay your premiums automatically by Electronic Funds Transfer. Use the EFT Authorization Form on the reverse side to ensure convenient, uninterrupted protection.

If you choose to make payment by EFT, please include two (2) months' premium as your initial payment. This is necessary to allow sufficient time for your banking institution to arrange automatic deduction monthly, according to your instructions on the EFT Authorization Form.

—IF PAYING PREMIUMS BY EFT, PLEASE FILL OUT AND SIGN OTHER SIDE OF THIS AUTHORIZATION—

TRICARE Prime User?	☐ Member ☐ Spouse	Check the box(es) at left if you and/or your Spouse use TRICARE Prime. We'll rush you full details about AFTEA TRICARE Prime Supplement Insurance Plan.

6. Please read carefully; then sign and return your completed Form to us with your initial premium payment.

I hereby certify that the above statements are complete and true to the best of my knowledge. I hereby elect to apply for insurance indicated under the TRICARE Supplement program, underwritten by Monumental Life Insurance Company, Cedar Rapids, IA. I understand that my coverage will become effective the first of the month following your receipt of my acceptance certificate and first premium payment.

I understand that any injury or sickness, whether diagnosed or undiagnosed, for which any person proposed for coverage has received medical treatment or care within the 6 months immediately preceding their effective date will not be covered until the coverage has been in effect for 6 months. I further understand that new conditions will be covered immediately.

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 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 information in an application for insurance is guilty of a crime and may be subject to fines or 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 felony of the third degree. **MD Residents**: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss of benefits 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 person to criminal and civil penalties.

Signature ⇨ Date / /

Signature of Spouse ⇨ Date / /
(If applying for coverage.)

10/11

Complete the following section, if you wish to pay your premiums via automatic Electronic Funds Transfer (EFT) From your Checking account:

PAYOR'S AUTHORIZATION TO FINANCIAL INSTITUTION

I hereby request and authorize you to pay and charge to my account electronic premium debits by AmWINS Group Benefits, Inc., Irving, Texas, provided there are sufficient collected funds in my account. I agree that this electronic debit shall be regarded in the same respect as if this were a check drawn on my account and signed by myself. This authority is to remain in effect until revoked by me in writing.

PAYOR'S AUTHORIZATION TO PLAN ADMINISTRATOR

BANK INFORMATION

PLEASE PRINT ALL INFORMATION EXCEPT SIGNATURE

Banking Institution:	Branch	
Address of Branch:		
City:	State:	Zip Code:
Account Number:		
Name of Account (Payor's Name):		

Signature ⇨ Date / /

PLEASE ATTACH A BLANK CHECK MARKED "VOID" TO THIS FORM.