AFTEA TRICARE Prime Supplement Plan
ENROLLMENT FORM

Underwritten by: Transamerica Financial Life Insurance Company Home Office: 440 Mamaroneck Avenue, Harrison, New York, 10528, a Transamerica Company AWEBP

Policyholder: Armed Forces Top Enlisted Association Group Policy Number: MZ0932721H0002A

1. PLEASE FILL IN AS REQUIRED

First Name:	Last Name:	Branch of Service:
Street Address:		City:
State:	Zip:	County:
Member Number: (If Applicable)	Sex: ☐ M ☐ F	Date of Birth: / /
Telephone Number: Work ( ) –	Telephone Number: Home ( ) –	

2. PLEASE FILL OUT THIS SECTION ONLY IF YOU WANT COVERAGE FOR YOUR SPOUSE AND/OR CHILDREN

Spouse's Full Name:	Sex: ☐ M ☐ F	Date of Birth: / /
Child's Name:	Sex: ☐ M ☐ F	Date of Birth: / /
Child's Name:	Sex: ☐ M ☐ F	Date of Birth: / /

3. YOUR ECONOMICAL QUARTERLY PREMIUM RATES*

Check the appropriate premium for yourself and each person you want covered:

Retiree and Their Family Dependents

Age	Member	Spouse
Under 40	☐ $48.75	☐ $50.13
40-44	☐ $49.92	☐ $51.30
45-49	☐ $59.10	☐ $60.48
50-54	☐ $71.07	☐ $73.83
55-59	☐ $85.80	☐ $87.87
60-64	☐ $95.46	☐ $98.91
All Children	☐ $44.85	

Figure Your Premium in the Space Below:
Write premium for each covered person from the rate chart at left and add total

Covered Persons	**Premium**
Member	$_____
Spouse	$_____
Children (All)	$_____
Administrative Fee*	$ 3.00
TOTAL	$_____

NOTE: The $3.00 administrative fee applies to each premium invoice, whether quarterly, semi-annually, or annually.
*Not applicable to residents of New Jersey.

*All premiums and benefits are based on the attained age of the insured and change on the first premium due date after the attainment of ages, 40, 45, 50, 55 and 60. Premiums may increase if premiums are increased for the Master Policy.

4. PLEASE SELECT THE MODE OF PAYMENT MOST CONVENIENT FOR YOUR BUDGET.

DESIRED MODE OF PAYMENT: ☐ 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 on the reverse side to ensure convenient, uninterrupted protection.

If you choose to make payment by EFT, please include two (2) months's 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 THE OTHER SIDE OF THIS AUTHORIZATION—

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.

10/11

Signature	Date
Signature of Spouse (if applying for coverage)	Date

PAYOR'S AUTHORIZATION TO FINANCIAL INSTITUTION

I hearby request and authorize you to pay and charge to my account electronic premium debits by NEBCO, 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

I hereby authorize National Employee Benefit Companies, Inc. (NEBCO) to electronically debit my banking institution checking account to make payment on my policy(ies).

It is understood that credit for the payment is conditioned upon the order's being honored when presented and that this Authorization may be terminated (1) at the option of NEBCO, if any debit is not honored when presented for payment or, (2) upon thirty (30) days prior written notice given by NEBCO, the Bank, or the undersigned.

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):		
Payor's Signature:		

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