TRICARE Supplement Insurance Plan
ENROLLMENT FORM

Underwritten by Hartford Life and Accident Insurance Company
and Hartford Life Insurance Company, Hartford, CT 06155

MARINE CORPS
ASSOCIATION & FOUNDATION
EST 1913
GROUP BENEFITS PROGRAM

Complete and Return to:
MCA&F Group Benefits Program
PO BOX 26610
Phoenix, AZ 85068

PLEASE SEND NO MONEY NOW

Group Policyholder Marine Corps Association

1 Please tell us about yourself.

MCA Official Member No: _____ Date of Birth: ___ / ___ / _____
MONTH DAY YEAR

Member Name: _____
FIRST, M.I., LAST

Daytime Phone: (___) ___ – ____ Email: _____
(Internal use only for important updates & time-sensitive bulletins.)

Service Status:

◯ Active duty ◯ Retired ◯ Reservist ◯ Disabled

Are you retired from the military? ◯ Yes ◯ No

Date of Retirement (or eligibility for TRICARE benefits): ___ / ___ / _____
MONTH DAY YEAR

2 Please choose your MarineCARE coverage option.

RETIRED PLANS

◯ No Deductible Inpatient Only
◯ $75 Deductible In/Outpatient
◯ $150 Deductible In/Outpatient
◯ $250 Deductible In/Outpatient
◯ TRICARE Prime Supplement (not available in FL)

Who you want covered:
◯ Member ◯ Spouse ◯ Child(ren)

ACTIVE DUTY PLANS

◯ Inpatient Only
◯ In/Outpatient

Who you want covered:
◯ Spouse
◯ Child(ren)

3 Please provide names of family members to be covered:

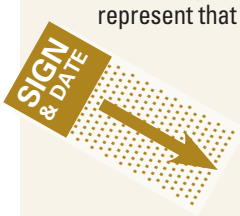
Name of Family Member Enrolling	Date of Birth
SPOUSE NAME (First, M.I., Last)	MONTH – DAY – YEAR
CHILD NAME (First, M.I., Last)	MONTH – DAY – YEAR
CHILD NAME (First, M.I., Last)	MONTH – DAY – YEAR

To cover additional children, please enclose a separate sheet with names, and dates of birth.

Please continue on Page 2

4 Please read, sign and date.

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 the Hartford Life and Accident Insurance Company. I understand that my coverage will become effective the first of the month following your receipt of my enrollment form and first premium payment. I further understand that this policy will not cover pre-existing conditions, i.e., injury or sickness for which medical advice or treatment has been received during the 12 months immediately preceding the effective date of this coverage, until I have been treatment-free for such condition for 12 consecutive months or this coverage has been in effect for 24 months, whichever is earlier. (For members residing in California, a pre-existing condition is any condition that required medical treatment, consultation, or expense during the 6 months immediately before your effective date of insurance. This exclusion will end on the date you have been insured under the group policy for 6 consecutive months. California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance.) For residents in all states except FL, PA, NJ and WA: Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person submits an insurance application or statement of claim containing any materially false, incomplete, or misleading information may be committing a crime and may be subject to civil or criminal penalties, depending upon state law. For 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 materially false, incomplete or misleading information is guilty of a felony of the third degree. For 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. I further understand that if any person to be covered under this policy is hospitalconfined on the date this insurance goes into effect, such effective date of coverage will be deferred until the first day of the month following a period of 30 consecutive days after final discharge from the hospital. I represent that to the best of my knowledge and belief, all statements and answers recorded on this form are true and complete.



MCA&F Member's Signature (required)

X

Date: (required)

MONTH / DAY / YEAR

Spouse's Signature (required if enrolling)

Date: (required if enrolling)

MONTH / DAY / YEAR

Please send no money now!

Premiums will be billed quarterly.

Return completed form today to:

MCA&F Group Benefits Program
P.O. Box 26610, Phoenix, AZ 85068

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Policy # AGP-5516
TRICARE Form Series includes SRP-1269, or state equivalent.