NCOA TRICARE Supplement Insurance Enrollment Form

To enroll, please complete the Enrollment Form below and return with first month's premium payment (or indicate and authorize the automatic payment method you prefer on the form).

Mail to: **The Hartford**
P.O. Box 1197
Minneapolis, MN 55440-9546

Hartford Life and Accident Insurance Company
Simsbury, CT 06089

1. Complete information:

Member's Name: ______________________

Address: ______________________

City: ______________ ST: ______ ZIP: ______

NCOA Mbr. No.

☐ Active Duty ☐ Retired

Date of Birth ____/____/____ (month/day/year)

Daytime Phone (______)______________

☐ Male ☐ Female

Email Address ______________________

2. Tell us who you'd like to enroll:

RETIREE

(0119) ☐ TRICARE Standard/Extra Retiree In/Out
(0120) ☐ Retiree TRICARE Prime Supplement Plan

☐ Member ☐ Spouse ☐ Child(ren)

ACTIVE DUTY

(0117) ☐ TRICARE Standard/Extra Active Duty Family Plans
(0118) ☐ TRICARE Reserve Select Supplement

☐ Spouse ☐ Child(ren)

If you're Retired military status and you're enrolling your spouse and children, you must also enroll. If you're Active Duty military status, only spouse and children's coverage is available. Please list additional dependents on a separate sheet, sign and date it.

	Name	Gender (M/F)	Date of Birth (month/day/year)
Spouse			/ /
Child			/ /
Child			/ /

3. 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 hospital-confined 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.

X ______________________ Member's Signature ______________ Date

X ______________________ Spouse's Signature (if enrolling) ______________ Date

4. Choose payment method:

☐ First month paid by Check or money order $ ________ enclosed, payable to **The Hartford**, I understand I will be billed on a quarterly basis.

☐ Monthly through Automatic Bank Withdrawal. Please complete form below.

☐ Monthly through Credit Card
☐ Visa ☐ Mastercard ☐ NCOA Mastercard
Acct#: ______________
Exp: ________

Use This Form To Activate ABW Option

Sign, date and return with your Confirmation Form and a check for first month's payment. Your bank will make future payments automatically from this checking account.
Save time. Save money. Save headaches. You save time on addressing and mailing payment envelopes. You save money on postage. Best of all, you never have to worry about a gap in your protection because of a forgotten payment or overlooked bill.

Automatic Bank Withdrawal Request & Authorization

As a convenience to me, I authorize The Hartford Financial Services Group and/or its affiliated companies* to withdraw funds from my account. I also authorize you, my financial institution, to pay from my account any checks, drafts or pre authorized electronic fund transfers from my account to the appropriate Company(ies) below.

X ______________________ Date ___/___/___
Authorized Signature as Shown on the Account

X ______________________ Date ___/___/___
Joint Account or Other Authorized Signature

*The Hartford Financial Services Group • Hartford Life and Accident Insurance Company

The Hartford® is The Hartford Financial Services Group, Inc., and its subsidiaries, including issuing company Hartford Life and Accident Insurance Company.

Policy Form #SRP-1269 (HLA)(5716) Master Policy #AGP-5716