HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY
ONE HARTFORD PLAZA
HARTFORD, CONNECTICUT 06155
(A STOCK INSURANCE COMPANY)

MAIL YOUR COMPLETED ENROLLMENT FORM TO:
AFSA MEMBER INSURANCE PROGRAM ADMINISTRATOR
1200 E. GLEN AVE.
PEORIA HEIGHTS, IL 61616-5384

QUESTIONS?
CALL 888.834.9024 OR
EMAIL CUSTOMERSERVICE@AFSAINSURANCE.COM

AFSA FLIGHTCARE TRICARE SUPPLEMENT INSURANCE PLAN

GUARANTEE ISSUE* ENROLLMENT FORM

NOTE: PLEASE PRINT ALL INFORMATION IN DARK INK.

1. TELL US ABOUT YOURSELF. NOTE: NAME MUST BE IDENTICAL TO HOW IT APPEARS ON YOUR MILITARY ID CARD.

Last Name _____ First Name _____ Middle Initial _____ AFSA Member Number _____

Address _____ City _____ State _____ Zipcode _____

Member Social Security Number _____ Member Date of Birth (MM/DD/YY) _____

Sex: ❍ Male ❍ Female Email Address _____ Daytime Phone Number _____

Service Status*: ❍ Active Duty ❍ Retired ❍ Reservist ❍ Disabled

Are you retired from the military?* ❍ Yes ❍ No Date of retirement (or initial eligibility for TRICARE benefits): MM/DD/YY _____

*Widow(er)s do not need to complete these items

2. CHOOSE YOUR FLIGHTCARE COVERAGE OPTION. NOTE: YOUR FLIGHTCARE SUPPLEMENT SELECTION MUST MATCH YOUR TRICARE HEALTH PLAN.

Family members can choose different plans. You do not need to take the same coverage.

RETIREE TRICARE SELECT PLAN ($250 INDIVIDUAL/ $500 FAMILY DEDUCTIBLE)

❍ **Member** ❍ **Spouse** ❍ **Child(ren)** ❍ **Under Age 21** (23 if Student) ❍ **Age 21-25** (if enrolled in TRICARE Young Adult)

RETIREE TRICARE PRIME PLAN WITHOUT POINT OF SERVICE ($0 DEDUCTIBLE)

❍ **Member** ❍ **Spouse** ❍ **Child(ren)** ❍ **Under Age 21** (23 if Student) ❍ **Age 21-25** (if enrolled in TRICARE Young Adult)

ACTIVE DUTY FAMILY TRICARE SELECT PLAN ($0 DEDUCTIBLE)

❍ **Spouse** ❍ **Child(ren)** ❍ **Under Age 21** (23 if Student) ❍ **Age 21-25** (if enrolled in TRICARE Young Adult)

TRICARE RESERVE SELECT PLAN ($0 DEDUCTIBLE)

❍ **Member** ❍ **Spouse** ❍ **Child(ren)** ❍ **Under Age 21** (23 if Student) ❍ **Age 21-25** (if enrolled in TRICARE Young Adult)

If enrolling in the TRICARE Prime Supplement (or USFHP), please tell us the date your TRICARE Prime (or USFHP) protection started: MM/DD/YY _____

3. SIGNING UP FAMILY MEMBERS? PLEASE COMPLETE THE INFORMATION BELOW. NOTE: NAME(S) MUST BE IDENTICAL TO HOW THEY APPEAR ON MILITARY ID CARDS.

Note: 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.

Spouse Name: _____ Date of Birth (MM/DD/YY) _____ **Sex:** ❍ **M** ❍ **F**

Child Name: _____ Date of Birth (MM/DD/YY) _____ **Sex:** ❍ **M** ❍ **F**

Child Name: _____ Date of Birth (MM/DD/YY) _____ **Sex:** ❍ **M** ❍ **F**

Child Name: _____ Date of Birth (MM/DD/YY) _____ **Sex:** ❍ **M** ❍ **F**

Dependent children must be under age 21 (23 if a full-time student or 26 if enrolled in TRICARE Young Adult). Please include proof of full-time status or proof of enrollment in TRICARE Young Adult with your form. If you would like to enroll more than 3 children, please attach a separate sheet that includes the information requested.

TRICARE Form Series includes GBD-3000, GBD-3100, or state equivalent.
Policy # AGP-5964
201871-AFSA-TRI-APP

4. PLEASE READ, SIGN, AND DATE.

I acknowledge that I have been given the opportunity to enroll in the AFSA FlightCare TRICARE Supplement Insurance Plan and that I am age 64 or younger, an AFSA member, and that the above information is true and complete to the best of my knowledge. I understand that this program may not cover pre existing conditions (conditions for which I received medical advice or treatment within 6 months prior to the effective date of coverage or until the coverage has been in effect for 6 months). This pre-existing condition limitation will not apply if waived in accordance with policy provisions. I understand that my coverage will become effective on the first day of the month following receipt of my completed Enrollment Form and payment of my initial premium. I understand that eligibility to receive benefits under the FlightCare Retiree Supplement is dependent on my (or my deceased spouse's) entitlement to uniformed services retired pay. I understand and agree that insurance will go into effect upon receipt of my first premium payment and this Enrollment Form and remain in effect only in accordance with the provisions, terms, and conditions of the insurance policy. I understand and agree that only the insurance policy issued to AFSA can fully describe the provisions, terms, conditions, limitations, and exclusions of my insurance.

5. FRAUD NOTICES.

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 false, incomplete, or misleading information is guilty of a felony of the third degree. **For KY residents:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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. **For LA 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 and confinement in prison. **For MD residents:** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **For NJ residents:** Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. Any person who includes any false or misleading information on an application for insurance is subject to criminal and civil penalties. **For NY 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation. **For OH residents:** Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. **For TN residents:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines and denial of insurance benefits. **For VA residents:** Any person who, with the intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.

Member's Signature X | **Date** (MM/DD/YY)

Spouse's Signature (If enrolling) X | **Date** (MM/DD/YY)

*This policy is guaranteed issue, but does contain a Pre-Existing Condition Limitation. Please refer to the enclosed brochure for more information on exclusions and limitations, such as Pre-Existing Conditions.

AIR FORCE SERGEANTS ASSOCIATION AFSA MCMLXI

THE HARTFORD

Underwritten by:
Hartford Life and Accident Insurance Company
One Hartford Plaza
Hartford, CT 06155

Plan Administrator:
PEARL® INSURANCE

DON'T SEND MONEY NOW! PREMIUMS WILL BE BILLED QUARTERLY.

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