



THE HARTFORD

Underwritten by: Hartford Life and Accident Insurance Company

Group Tricare Extra/Standard Supplement Insurance Program



POLICY HOLDER: AMERICAN MILITARY INSURANCE TRUST

ORGANIZATION: RETIRED ASSOCIATION FOR THE UNIFORMED SERVICES

Check the appropriate block:

(AGP-1969)

This is a new enrollment form This enrollment form is to add dependent(s) This enrollment form is to change coverage

Member's Information

(PLEASE LEAVE BLANK) REF. NO _____

(Mr. Mrs. Ms.) LAST FIRST INITIAL

Social Security #: - -

STREET ADDRESS _____

Date of Birth: ____/____/____

CITY _____

Rank and Service: _____

STATE _____ ZIP CODE -

Check One: Active Duty Retired
 Widower Former Spouse

() ()

Military Retirement Date: _____

TELEPHONE NO: HOME OFFICE

Are you a ChampVA beneficiary? Yes No

Dependent Information

Name of each dependent for whom coverage is desired:

Spouse: _____ Male Female Date of Birth: ____/____/____
Child: _____ Male Female Date of Birth: ____/____/____
Child: _____ Male Female Date of Birth: ____/____/____
Child: _____ Male Female Date of Birth: ____/____/____

(Complete additional sheet if necessary.)

Coverage Requested

I have checked the coverage I desire below and am enclosing a check for \$ _____ in payment of _____ quarter(s).

(Check the brochure for the appropriate premium schedule.)

Select the Tricare EXTRA/ STANDARD coverage you desire:

Retired Member

High Option II Retiree Plan

Spouse of Retired Member

High Option II Retiree Plan

Each Child of Retired Member

High Option II Retiree Plan

Spouse of Active Duty Member

Active Duty Family II Plan

Each Child of Active Duty Member

Active Duty Family II Plan

I hereby enroll myself and/or my dependents with the Hartford Life and Accident Insurance Company for coverage under RAUS Group Health Insurance Program. I understand that I must be a member of RAUS to be eligible for coverage and that my coverage will become effective on the first day of the month following receipt of this enrollment form and premium.

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.

Member's Signature (X) _____ Date _____

Spouse's Signature (X) _____ Date _____

SRP-1269 ENR (1969)

(IF ENROLLING)

Signature of Agent (X) _____ Agent No. _____ General Agency No. _____

PRINT: NAME OF AGENT

PHONE NO.

AGENT S ADDRESS

BUDGET YOUR PAYMENTS WITH CHECKOMATIC... THE DIRECT MONTHLY PAYMENT PLAN

Your Tricare Supplement Insurance Plan premiums can be deducted directly from your checking account every month... with no worries about missing a payment and losing your valuable insurance protection. Simply complete the Request and Authorization form at the right. **Enclose a blank check (marked VOID) to be kept on file. All future premiums will be deducted from your checking account automatically on the first business day of each month. Completed form and void check must be received by the 15th of the month prior to the month of deduction.**

CHECKOMATIC REQUEST FORM AND BANK CHECK AUTHORIZATION
(Please Print)

(AGP-1969)

NAME OF BANK DEPOSITOR AS SHOWN ON BANK RECORDS	
NAME OF INSURANCE APPLICANT (If not Bank Depositor)	MEMBER ID
CHECKING ACCOUNT NO.	NAME OF BANK AND BRANCH
ABA (BANK ROUTING NUMBER)	

As a convenience to me, I request and authorize Association & Society Insurance Corporation or another Hartford Life and Accident Insurance Company administrator/representative to initiate electronic debit entries each month and charge them to my checking account as indicated above. Authority to charge such debits to my account shall become effective as of the date this authorization is signed and shall remain in effect until revoked by me in writing.

I agree that the bank's rights, with respect to each debit, shall be the same as if it were drawn and signed by me. I further agree that, should any debit be dishonored, whether with or without cause, the bank shall be under no liability whatsoever, even though such dishonor results in the termination of insurance.

SIGNATURE OF DEPOSITOR X	DATE
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INDEMNIFICATION AGREEMENT

TO: The bank named in the authorization.

In consideration of your compliance with the Depositor's Checkomatic Request and Authorization, the Association & Society Insurance Corp. (the "Plan Administrator") agrees that:

1. It will indemnify and hold you harmless from any liability to any persons arising out of payments by you, in accordance with the terms of this Request and Authorization, of any draft or debt advice drawn by means of commercial paper on the specified checking account by the Plan Administrator and payable to the order of the Plan.
2. It will refund to you any amount erroneously paid by you to the Plan on any such draft or other debit advice if claim for the amount of such erroneous payment is made by you within twelve months of the date of the instrument on which erroneous payment was made.
3. It will defend, at its own cost and expense, any action which may be brought by any persons because of your action taken in accordance with the terms of this Request and Authorization or arising in any manner by reason of your participation in the preauthorized payment plan requiring your acceptance of the Request and Authorization.

094-2/06

ASSOCIATION & SOCIETY INSURANCE CORPORATION

**REMEMBER, SEND A VOIDED CHECK
ALONG WITH THIS FORM AND YOUR
PREMIUM PAYMENT**

Monthly Premium Rates—Retirees

Age	High Option II Plan	Active Duty Plan
Under 40	\$ 25	
40 - 44	\$ 27	
45 - 49	\$ 30	
50 - 54	\$ 38	
55 - 59	\$ 48	
60 - 64	\$ 53	
Each Child of Retiree	\$ 20	
Spouse of Active Duty Member	Not Available	\$ 7
Each Child of Active Duty Member	Not Available	\$ 6

Rates and/or benefits are 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.