

# Group TRICARE Standard/Extra Supplement Plan



Underwritten by:  
Monumental Life Insurance Company,  
Cedar Rapids, IA, an AEGON company

**POLICY HOLDER: AMERICAN MILITARY INSURANCE TRUST**  
**ORGANIZATION: RETIRED ASSOCIATION FOR THE UNIFORMED SERVICES**

**Check the appropriate block:** ☐ New enrollment ☐ Add dependent(s) ☐ Change coverage

## Member's Information

(☐ Mr. ☐ Mrs. ☐ Ms.) LAST FIRST INITIAL  
STREET ADDRESS  
CITY  
STATE ZIP CODE  
( ) ( )  
TELEPHONE NO: HOME OFFICE

(PLEASE LEAVE BLANK) REF. NO  
**Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_  
**Rank and Service:**\_\_\_\_\_  
**Check One:** ☐ Retired ☐ Widow(er)  
☐ TRR ☐ Active Duty  
**Military Retirement Date:**\_\_\_\_\_

## 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 STANDARD/EXTRA coverage you desire:**

### Retired Member

☐ High Option II Retiree Plan

### Spouse of Active Duty Member

☐ Active Duty Family II Plan

### Spouse of Retired Member

☐ High Option II Retiree Plan

### Each Child of Active Duty Member

☐ Active Duty Family II Plan

### Each Child of Retired Member

☐ High Option II Retiree Plan

I hereby enroll myself and/or my dependents with the Monumental Life Insurance Company for coverage under RAUS Group Health 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.

AR, CO, KY, LA ME, NM, OH, OK, TN and WA Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of a claim or an application containing any false, incomplete or misleading information is guilty of a crime and may be subject to fines or confinement in prison. DC and RI 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. FL Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of a claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree. MD Residents: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefits or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. FRD1000A.MD. NJ Residents: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties. 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 a person to criminal and civil penalties.

**Member's Signature (X)** \_\_\_\_\_ **Date** \_\_\_\_\_

**Spouse's Signature (X)** \_\_\_\_\_ **Date** \_\_\_\_\_  
(IF ENROLLING)

**Signature of Agent (X)** \_\_\_\_\_ **Agent No.** \_\_\_\_\_ **General Agency No.** \_\_\_\_\_

**PRINT: NAME OF AGENT**

**PHONE NO.**

**AGENT'S ADDRESS**

**Complete Checkomatic Form on Reverse Side if You Wish to Pay Premiums Monthly**

MLTRC1000GE

19466681

MZ0925772H0000A

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

Your TRICARE Supplement 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)

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                         |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|
| NAME OF BANK DEPOSITOR<br>AS SHOWN ON BANK RECORDS                                                                                                                                                                                                                                                                                                                                                                                                              |                         |
| NAME OF INSURANCE APPLICANT<br>(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 Monumental Life Insurance Company or 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<br>DEPOSITOR X                                                                                                                                                                                                                                                                                                                                                                                                                                     | DATE                    |

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.

094-9/10 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 may be 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.