THE HARTFORD

Group Tricare Extra/Standard Supplement Insurance Program

ASI ASSOCIATION & SOCIETY INSURANCE CORPORATION

Underwritten by: Hartford Life and Accident Insurance Company

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

( ) TELEPHONE NO: HOME ( ) OFFICE

Military Retirement Date: _____

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 <u>EXTRA/ STANDARD</u> 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 _____

(IF ENROLLING)

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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

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 (AGP-1969)
(Please Print)

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

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.

ASSOCIATION & SOCIETY INSURANCE CORPORATION

094-2/06

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.

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RAUS MEMBERSHIP APPLICATION

Retired Association for the Uniformed Services, Inc.

326 Main Street
Franklin, Tennessee 37064-2614
800-321-RAUS

OFFICE USE ONLY

Member #_____

Certificate #_____

Member
Name: (Last)_____ (First)_____ (Initial)_____

Member Social Security #_____ Date of Birth:_____

Spouse
Name: (Last)_____ (First)_____ (Initial)_____

Spouse Social Security #_____ Date of Birth:_____

Address:
Street_____

City_____ State_____ ZIP Code_____

Email Address:_____

Military
Data: (Branch)_____ (Rank)_____ (Service #)_____

Military Entry Date: _____/_____/_____ Discharge Date: _____/_____/_____

I hereby request membership in RAUS to take advantage of the member-only association benefits. I have included the discounted initial membership dues and understand that continued membership and benefit enjoyment requires renewal of my membership upon expiration of the initial period.	**DUES RATES** — **Initial Dues** — **Future Renewal** [ ] 1 year membership — $ 5.00 — $10.00 [ ] 3 year membership — $20.00 — $25.00 [ ] 5 year membership — $35.00 — $40.00 [ ] Life memberships are based on age.

Date:_____ Phone:_____ Signed:_____