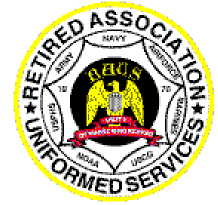
RAUS TRICARE PRIME SUPPLEMENT



PRIME TRICARE SUPPLEMENT ENROLLMENT INSTRUCTIONS

1. Print your name and address clearly on the Enrollment Form attached.
2. Sign and date the Enrollment Form as indicated.
   NOTE: Surviving spouse may sign if sponsor is decease
3. Check the appropriate boxes to indicate the coverage you have chosen.
4. Calculate your premium from the appropriate schedule in this material.
5. Completed Check-O-Matic Form included if you wish to pay monthly. A voided check must be included **in addition** to your first month's payment.
6. If paying Quarterly, include check for first quarter and you will be invoiced every three months.
7. Make your check payable to **"RAUS Group Health Insurance"** and mail it with your Enrollment Form to:

RAUS MEMBERSHIP APPLICATION INSTRUCTIONS:

1. Indicate membership term (1 year—$5.00 or 3 years—$20.00 or 5 years—$35.00)
   (NOTE RAUS membership is **necessary** to enroll in the TRICARE Supplement).
2. Make check payable to RAUS, or you may include the dues in your supplement premium check.

The credit card option is ONLY for the RAUS Membership dues.

RAUS Membership Check payable to: **RAUS**

RAUS Supplement Check payable to: **RAUS Group Health Program**

MAIL TO: **Military Benefits Services**
2474-287 Walnut St.
Cary, NC 27518

www.TricareSupplement.us
info@TricareSupplement.us

IMPORTANT NOTICE:

The Plan is currently not available in : MN, NV, OR, FL, ME NH, VT

RAUS Group TRICARE Prime Supplement Plan Enrollment Form

Please Leave Blank
Ref. No.

UNDERWRITTEN BY: MONUMENTAL LIFE INSURANCE COMPANY, CEDAR RAPIDS, IA, AN AEGON COMPANY

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

Check the appropriate box: ☐ New Enrollment Form ☐ Add Dependent(s) ☐ Change Coverage

Member's Name ______________________________
☐ Mr. ☐ Mrs. ☐ Ms. First M.I. Last

Address ______________________________

City ______________ State ________ Zip ________

CHECK ONE
☐ RETIRED
☐ WIDOW/ER
☐ FORMER SPOUSE

Date of Birth ________ (Mo. Day Yr.) Rank and Service ________ Military Retirement Date ________

Telephone No. ______________________________
Home Office

Name of each dependent for whom coverage is desired: Spouse ________ MO. DAY YR. Date of Birth

Child ________ MO. DAY YR. Date of Birth Child ________ MO. DAY YR. Date of Birth

Child ________ MO. DAY YR. Date of Birth Child ________ MO. DAY YR. Date of Birth

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.

YOU MUST BE ENROLLED IN TRICARE PRIME TO ENROLL IN ONE OF THE FOLLOWING PLANS

RETIRED MEMBER	SPOUSE OF RETIRED MEMBER	EACH CHILD OF RETIRED MEMBER
☐ Plan A	☐ Plan A	☐ Plan A
☐ Plan B	☐ Plan B	☐ Plan B

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

Date ________ Member's Signature (X) ______________________________

Date ________ Spouse's Signature (X) ______________________________
(If applicable)

Signature of Agent (X) *Walt Markovsky* Agent No. 3671 General Agency No. ________

PRINT: Name of Agent Walt Markovsky Phone No. 866-919-6572

Agent's Address Military Benefits Services 2474-287 Walnut St., Cary, NC 27518

(See reverse side for partial list of services and cost share amounts)

The following chart is an example of what the **TRICARE Prime Supplement** pays for some of the most common types of services. Refer to your **TRICARE Prime** Handbook for a more complete description of terms and conditions under TRICARE.

Care Required	TRICARE Prime Pays	Your TRICARE Prime Supplement Pays
	All except the following:	Per Visit/Service:
Civilian Outpatient Care	Per Visit: $12 Office $30 Emergency Room	 $12 $30
Outpatient Mental Health	$25 Individual $17 Group	$25 Individual $17 Group
Civilian Inpatient Admission	$11 per day ($25 minimum per admission)	$11 per day ($25 minimum per admission)
Inpatient Mental Health	$40 per day	$40
Ambulance Service	$20	$20
Outpatient Ambulatory Surgery	$25	$25
Prescription Drugs	$3 Generic $9 Brand Name $22 Non-Formulary	$3 Generic $9 Brand Name $22 Non-Formulary

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 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 Monumental Life 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

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

OFFICE USE ONLY

Member #___________

Certificate #__________

RAUS MEMBERSHIP APPLICATION

Retired Association for the Uniformed Services, Inc.

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

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: _____/_____/_____

<table>
<tr>
<td>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.</td>
<td>

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.
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Date:_______________ Phone:___________________ Signed:__________________________________