

# AMRA (ASI) TRICARE SUPPLEMENT



## **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 deceased
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 "**AMRA Group Health Insurance**" and mail it with your Enrollment Form to:

## **AMRA MEMBERSHIP APPLICATION INSTRUCTIONS:**

1. Indicate membership term (1—\$25.00 or 3 years—\$65.00)  
(NOTE AMRA membership is **necessary** to enroll in the TRICARE Supplement).
2. Make check payable to AMRA, or you may include the dues in your supplement premium check.

**The credit card option is ONLY for the AMRA Membership dues.**

AMRA Membership Check payable to:

**AMRA**

AMRA Supplement Check payable to:

**AMRA Group Health Program**

MAIL TO:

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

[www.tricaresupplement.us](http://www.tricaresupplement.us)  
[info@tricaresupplement.us](mailto:info@tricaresupplement.us)

## **IMPORTANT NOTICE:**

For Plan availability in the following States: CO, MN, NY, OR, SD, WA call 866-919-6572

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

# 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: AMERICAN MILITARY RETIREES ASSOCIATION**

**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

**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 Retired Member**

High Option II Retiree 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 AMRA Group Health Program. I understand that I must be a member of AMRA 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)** *Walter Markowsky* \_\_\_\_\_ **Agent No.** 3671 **General Agency No.** \_\_\_\_\_

Walt Markovsky

866-919-6572

PRINT: NAME OF AGENT

PHONE NO.

Military Benefits Services 2474-287 Walnut St. Cary, NC 27518

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 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 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 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
Under 40	\$ 25
40 - 44	\$ 27
45 - 49	\$ 30
50 - 54	\$ 38
55 - 59	\$ 48
60 - 64	\$ 53
Each Child of Retiree	\$ 20

*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.*



I LOVE AMERICA

# APPLICATION FOR MEMBERSHIP

## TYPE OF MEMBERSHIP:

\_\_\_ New:     1 Year - \$25.00     3 Years - \$65.00

\_\_\_ Renewal:     1 Year - \$25.00     3 Years - \$65.00

**LIFE MEMBERSHIP:** Applies to new or renewal. One time fee based on applicant's age.

To age 45: \$275.00     46-55: \$195.00     56-69: \$155.00     70 and over: \$95.00

**ELIGIBILITY:** Membership must be in military person's name unless surviving spouse\*.

Honorably Retired     Medically Retired     Surviving Spouse\*     100% Service Connected Disability

Membership Number		Expiration Date	Chapter Number
Last Name		First Name	MI
Mailing Address			
City		State	Zip
Date of Birth		Phone # (     )	
Spouse's Name		E-mail Address	
Nearest Military Installation		How Did You Hear About ASI's Insurance Plan?	

## PAYMENT METHOD:

\_\_\_ Check # \_\_\_\_\_ \$ \_\_\_\_\_ \_\_\_ Money Order

## CREDIT CARD

\_\_\_ Master Card    \_\_\_ Visa

|\_\_\_\_\_| |\_\_\_\_\_| |\_\_\_\_\_| |\_\_\_\_\_|

Expiration Date \_\_\_\_\_ \$ \_\_\_\_\_

Membership is effective on date application is processed at \_\_\_\_\_ AMRA.

\*Surviving spouse should apply for membership in his/her own name, **not** their deceased spouse's name.

X \_\_\_\_\_  
Signature Date

**AMERICAN MILITARY RETIREES ASSOCIATION, INC.**

## **AMRA Organized**

“A Non-Profit, Non-Partisan, Non-Sectarian Association organized to protect the earned benefits of Retirees of the Uniformed Services through strength in Unity of purpose and cause.”

## **AMRA Membership Eligibility**

- Retired honorably for length of service from one of the Armed Forces of U.S. and Canada.
- Retired honorably for reasons of disability from one of the Armed Forces of U.S. and Canada.
- Retired honorably from the Reserve and National Guard and Components.
- 100% Service-Connected Disability.
- Retired Members who have completed their requirements for pay.
- Surviving Spouse of any of the above.

## **Why You Should Join AMRA**

- Be a member of an Association organized for, with membership restricted to, Military Retirees and Surviving Spouses.
- To give the strength and financial support necessary to preserve and protect our earned benefits.
- To help support a strong National Defense, second to none.
- Receive a newspaper focusing specifically on Military Retiree/Surviving Spouse issues and benefits.
- Be eligible to participate in excellent supplemental insurance for our members and their dependents covered by TRICARE.
- Receive legislative support with representation by your Association on Capitol Hill regarding state and local issues by the AMRA State and Chapter Representatives in respective areas.
- Collegiate scholarship program for AMRA members, their spouse, children or grandchildren.

Visit [www.amra1973.org](http://www.amra1973.org)  
For current member benefit information.

## **AMRA's Goals**

- Maintain “COLA” Program.
- Authorization for TRICARE for all Military Retirees regardless of age.
- Maintain adequate care at Military/VA Medical Facilities.
- We will fight for rights and benefits which you have earned and paid for, threatened by those who seek to reduce the deficit and expense of retirees. We are against Medicare cuts, higher premiums and VA Budget cuts.
- Authorization of military pay and VA compensation.
- More medical care for active duty/military retirees and their dependents.