

# USBA TRICARE RESERVE SELECT (TRS) SUPPLEMENT



## TRS 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 "**ASI Group Health Insurance**" and mail it with your Enrollment Form to:

Check payable to: **ASI Group Health Program**

MAIL TO: **Military Benefits Services  
1304 Crossroads Manor Ct.  
Cary, NC 27518**

## USBA MEMBERSHIP APPLICATION INSTRUCTIONS

(USBA Membership Must Accompany the Supplement Application)

1. Complete Application for USBA Membership
2. Complete the Eligibility section
3. Sign and date

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



P.O. Box 25956
Overland Park, KS 66225-5956

Underwritten by:
Monumental Life Insurance Company
Cedar Rapids, IA

Group TRS Supplement Plan ASI ASSOCIATION & SOCIETY INSURANCE CORPORATION

Check the appropriate block:
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

Social Security #: - -

Date of Birth: / /

Rank and Service:

Check All That Apply:

National Guard Reservists

Effective Date of Coverage:

First Month Second Month

( )

( )

TELEPHONE NO. HOME

OFFICE

Dependent Information

Name of each dependent for whom coverage is desired: (Complete additional sheet if necessary.)

Spouse: Male Female Date of Birth: / /

Child: Male Female Date of Birth: / /

Child: Male Female Date of Birth: / /

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.)

Note: If you are eligible for FEHBP, you are NOT eligible for the TRICARE Reserve Select Supplement.

Selected Reserve Member

TRICARE Reserve Select Plan

Spouse of Selected Reserve Member

Add Spouse Plan

Each Child of Selected Reserve Member

Add child(ren) plan

Answer the following below:

Enter the date your TRICARE Reserve Select Coverage began: Member: / / Spouse: / /

I hereby enroll myself and/or my dependents with the Monumental Life Insurance Company for coverage under the USBA Group Health Insurance Program. I understand that I must be a member of USBA to be eligible for coverage.

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 (waived if enrolling within 30 days of the date Tricare Reserve Select coverage begins).

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 and 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)

Complete Checkomatic Form if you wish to pay premiums monthly. If you are not already a USBA member, please complete the USBA Membership Application on the reverse side of this application.



# Application For USBA Membership (Complete only if not already a USBA Member)

PLEASE PRINT IN BLACK INK

Sex  Male  Female

First Initial Last

Street Address

City State (or Province) Zip Code

Social Security # Date of Birth: Month Day Year

( ) ( )

Home Phone Work Phone

## ELIGIBILITY

### Duty Status: (Check one)

- Full Time Active Duty
- Reserves
- Retired
- Nat'l Guard
- I.R.R.
- Honorably Discharged Veteran
- Date of separation \_\_\_\_\_

### Branch of Service: (Check one)

- Army  MC
- Navy  CG
- AF  PHS
- NOAA

Rank \_\_\_\_\_

Estimated date of separation or retirement \_\_\_\_\_

If member of reserve or ROTC Unit, complete below:  
Reserve Assignment or ROTC University

\_\_\_\_\_  
(If none, attach copy of Reserve Orders)

I hereby apply for membership in The Uniformed Services Benefit Association, I am eligible for such membership and the statements I have made are true and complete.

Member's Signature X \_\_\_\_\_ Date \_\_\_\_\_  
*(Please sign in black ink)*

*Walt Markovsky* \_\_\_\_\_

Walt Markovsky  
1304 Crossroads Manor Ct., Cary, NC 27518  
General Agency 538-3630

## The TRICARE Reserve Select Supplement Plan Offers Affordable Help With Your Cost Shares and Copayments

Out-of-pocket expenses can mount up quickly when you receive medical care outside the military system.

That's why supplemental health insurance like the TRICARE Reserve Select Supplement Plan is so important for you and your family. With this economical insurance coverage, you're better protected against the high cost of medical expenses you might face each year in the event of illness or injury.



### A Few Words About This Plan...

Many people like you are concerned about getting good insurance coverage at economical prices. It's not easy to get that kind of information on your own... and it can eat up a lot of your precious time.

We are proud to offer the TRICARE Reserve Select Supplement Plan for the National Guard and Reservists.

The TRICARE Reserve Select Supplement provides benefits to help pay your TRICARE cost share for in-hospital and outpatient care, doctor visits, emergency room care, prescription medications, and much more.

TRICARE Reserve Select Supplement pays 100% of all covered expenses in excess of the TRICARE allowed amount, not to exceed the legal limit - after the TRICARE deductibles are met.

You can purchase the TRICARE Reserve Select Supplement plan at any time throughout the year as long as you are eligible for TRICARE Reserve Select.

There is no specific period of coverage. Coverage is effective unless terminated or you are not eligible for the TRICARE Reserve Select program (see Renewability section).

### 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)
CERTIFICATE NO.
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's administrator/representatives 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.

**REMEMBER**, send a voided check or deposit slip along with this form and your premium payment.