SelmanCo
Insurance Administrative Services from an Extraordinary Partner

TRICARE SUPPLEMENT PLAN ENROLLMENT FORM

FOR EXISTING AND NEW EMPLOYEES

ADMINISTERED BY: SELMAN & COMPANY
SPONSORED BY: GOVERNMENT EMPLOYEES ASSOCIATION (GEA)
UNDERWRITTEN BY: TRANSAMERICA PREMIER LIFE INSURANCE COMPANY, CEDAR RAPIDS, IA

❑ **New Enrollment**	❑ **Add Dependent(s)**	❑ **Terminate Coverage**
❑ **Terminate Member Only**	❑ **Terminate Dependent(s) Only**	❑ **Change Address**

CHECK THE BOX BELOW IF YOU ARE:	**SELECT YOUR TRICARE OPTION BELOW:**	**POLICY #: MZ0925784H0000A**
❑ Retired Military ❑ Retired Military Spouse/Surviving Spouse ❑ Retired Reservist ❑ Retired Reservist Spouse/Surviving Spouse ❑ National Guard or Reserve Member	❑ Standard ❑ Retired Reserve ❑ Prime ❑ Reserve Select (TRS) *Medicare beneficiaries are not eligible to enroll.*	**Group Code: 0001838 PD** Member ID #: (LEAVE BLANK) Coverage Effective Date:
Employee SSN: __ __ __-__ __-__ __ __ __	Enroll Myself: ❑ Yes ❑ No	Employee Date of Birth:
Employee Last Name:	Employee First Name:	Middle Initial: / Gender: ❑ M ❑ F
Home Address:	City:	State: / Zip Code:
Home Phone:	Work Phone:	

LIST ALL DEPENDENTS TO BE ENROLLED IN THE PLAN

Relationship Codes	Last Name	First Name	MI	Date of Birth MM/DD/YYYY	SSN	Gender		If Disabled Check **Yes**
S-Spouse						❑ M	❑ F	
C-Child						❑ M	❑ F	❑ Yes
C-Child						❑ M	❑ F	❑ Yes
C-Child						❑ M	❑ F	❑ Yes
C-Child						❑ M	❑ F	❑ Yes

I hereby enroll myself and/or my dependents with the Transamerica Premier Life Insurance Company for coverage under the Government Employees Association (GEA) sponsored TRICARE Supplement Plan. I understand that I must be a member of GEA to be eligible for coverage and that my coverage will become effective on the receipt of this enrollment form and premium.

AR, CO, KY, LA, ME, NM, OH, OK, TN and WA Residents: Any person who knowingly and with intent to inquire, 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 or willfully presents a false or fraudulent claim for payment of a loss or benefits or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. 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.

By signing below I authorize my employer to deduct the monthly premiums from my paycheck on a pre-tax basis. I hereby authorize my employer to reduce my gross salary before taxes are calculated according to the benefit elected.

SIGN HERE ➢	**EMPLOYEE SIGNATURE:**	**DATE:**