HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY
One Hartford Plaza
Hartford, Connecticut 06155
(A stock insurance company)

MOAA INSURANCE PLANS

THE HARTFORD

HOSPITAL INDEMNITY AND SHORT TERM RECOVERY INSURANCE PLAN ENROLLMENT FORM

MEMBERS AGES 65 AND OLDER

Group Policyholder: Military Officers Association of America
Policy Number: AGP-40008

1. Member Information:

Member Name: _____

Street: _____ City: _____ State: _____ ZIP CODE: _____

MOAA Membership Number: _____ Gender: ☐ Male ☐ Female Member Social Security Number: _____

Member Date of Birth: _____ Email Address: _____ Preferred Phone #: _____

2. Spouse Information:

Is Spouse coverage desired? ☐ Yes ☐ No Spouse Gender: ☐ Male ☐ Female

Spouse Full Name (if enrolling): _____ Spouse Date of Birth: _____

3. Coverage Information:

☐ **Yes**, enroll me in the Hospital Indemnity and Short Term Recovery Insurance Plan. I understand I have 30 days to review my Certificate at no risk.

AGE REDUCTION

At age 80, Home Recovery benefits reduce to $200 a day for up to 20 days per Accrual Year (one benefit period or up to $4,000 per year). The Hospital and/or Skilled Nursing Facility Benefits do not change regardless of age.

I HEREBY ENROLL IN THE FOLLOWING COVERAGE (check all that apply):

☐ **Member Only** (S101)
☐ **Spouse Only** (S105)
☐ **Member and Spouse** (S101, S105)

Mail your completed enrollment form to: MOAA Insurance Plans, P.O. Box 14536, Des Moines, IA 50306

Questions? **Call:** 1-800-247-2192 **Email:** moaa.service@getamba.com **Visit:** moaainsurance.com

4. Authorization:

I hereby confirm my enrollment in the Hospital Indemnity and Short Term Recovery Insurance Plan. Please process my enrollment form and send my Certificate of Insurance immediately. I understand I must be a member of MOAA to be eligible for coverage. I hereby certify that the above statements are complete and true to the best of my knowledge. I understand that this Plan will not cover pre existing conditions (conditions for which I received medical advice or treatment within 6 months until the coverage has been in effect for 6 months. I understand the above coverage will become effective on the first day of the month following receipt of my enrollment form and first premium payment. I further understand that new conditions will be covered immediately. I hereby attest that I have major medical health insurance or Medicare that meets the requirements of minimum essential coverage as defined by the Affordable Care Act.

Member Signature: _____ **Date:** _____

Spouse Signature (if enrolling): _____ **Date:** _____

THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.

Coverage will be issued upon receipt of this form and will begin when your first premium is received. However, insurance benefits payable are subject to the policy's Pre-Existing Conditions Limitation. You're covered immediately for ALL new health conditions and any current health conditions you have will be covered fully after 6 months. Please refer to the enclosed brochure for more information on exclusions and limitations, such as pre-existing conditions.

Hospital Indemnity Form Series includes GBD-2800, GBD-2900, or state equivalent.

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Form PA-9751

OVER →

5. Payment Options:

Option 1. Electronic Funds Transfer – Select Frequency: ☐ Monthly ☐ Quarterly ☐ Semiannually ☐ Annually

Routing Number: _____ Account Number: _____

I request that you pay and charge my account debits drawn from my account by the Plan Administrator to its order. This authorization will stay in effect until I revoke it in writing. Until you receive such notice, I agree that you shall be fully protected in honoring any such debits. I also agree that you may, at any time, end this agreement by giving 30 days advanced written notice to me and to the Plan Administrator. You are to treat such debit as if it were signed by me. If your dishonor such debit with or without cause, I will not hold you liable even if it results in loss of my insurance.

Signature of Premium Payer: _____ **Date:** _____

Option 2. Direct Bill – Select Frequency: ☐ Quarterly ☐ Semiannually ☐ Annually

6. Fraud Notice(s):

For Residents of Florida:
Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

For Residents of Kentucky:
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

For Residents of Louisiana:
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.

For Residents of Maryland:
Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or 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.

For Residents of Ohio:
Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

For Residents of Virginia:
Any person who, with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or who files a claim containing a false or deceptive statement may have violated state law.

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