Group TRICARE Standard/Extra Supplement Plan Enrollment Form
Underwritten by Transamerica Premier Life Insurance Company, Cedar Rapids, IA.
ORGANIZATION: **RAUS (Retired Assn for the Uniformed Services)**

RAUSHOME.COM

SelmanCo
Insurance Administrative Services from an Extraordinary Partner

Return completed form to the plan administrator: Selman & Company | 6110 Parkland Blvd | Cleveland, OH 44124 | **Fax:** 800.311.3124

MEMBER INFORMATION

Member's Name				Association ID#
Date of Birth ____ /____ /____	Social Security Number			
Address		City	State	Zip
Home Phone ( )	Work Phone ( )	Email		
Rank and Service		Military Retirement Date ____ /____ /____		

DEPENDENT INFORMATION

Spouse Name	Date of Birth ____ /____ /____	❑ Female ❑ Male
Child Name	Date of Birth ____ /____ /____	❑ Female ❑ Male
Child Name	Date of Birth ____ /____ /____	❑ Female ❑ Male
Child Name	Date of Birth ____ /____ /____	❑ Female ❑ Male

COVERAGE SELECTION

I have selected my coverage below and I am enclosing a check for $_____ in payment of my first **quarterly** premium.
Check the brochure for the appropriate premium schedule. Remember to complete the Automatic Payment Option Form.

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
Spouse of Active Duty Member ..... ❑ Active Duty Family II Plan
Each Child of Active Duty Member ..... ❑ Active Duty Family II Plan

I hereby enroll myself and/or my dependents with the Transamerica Premier Life Insurance Company for coverage under the Association TRICARE Supplement Insurance Plan. I understand that I must be a member of the Association and that 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. After 6 months from that person's effective date, he or she will become covered regardless of any preexisting conditions he or she may have. 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 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 a n 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 Signature ✕ _____ Date____ /____ /____

Spouse Signature ✕ _____ Date____ /____ /____

SelmanCo Automatic Payment Option (APO)
Savings or Checking Account Deduction Authorization Form

1. Applicant's Information *(proposed insured)*

Applicant's Name _____ Date of Birth ____/____/____

Street Address _____

City_____ State_____ Zip Code _____

Please list the Insurance Policy you wish to have premium deductions made from the account indicated below:

Policy Number: _____ Type of Insurance: _____

2. Financial Institution Information

Depositor Name (Payor)_____
(As it appears on Financial Institution Records)

Financial Institution Name _____ Account Number _____
(Include Branch Name)

Financial Institution City_____ State_____ Zip Code_____

3. Account Selection: I authorize an automatic deduction from my *(please choose one):*

❒ **Checking Account.** Attach a sample VOIDED check.

❒ **Savings Account.** Account Number: _____ Routing Number: _____

Premium deduction should be made:

❒ **Monthly** ❒ **Quarterly** ❒ **Semi-Annually** ❒ **Annually**

Please include your first modal premium check made payable to Selman & Company. All subsequent premium payments will be made as indicated above.

4. Signature/Authorization

In accordance with the agreements and conditions listed below, I hereby request and authorize Selman & Company to initiate debit entries on the Financial Institution account listed herein for the purpose of paying premium. This authorization is to remain in full force and effect until Company and Depository have received written notification from me of its termination in such time and manner as to afford Company and Depository a reasonable opportunity to act on such notification. Written notification must be mailed to: Selman & Company, 6110 Parkland Boulevard ,Cleveland, OH 44124-4187.

Signature of **Depositor** _____

Print Name of **Depositor** _____ **Date** ____/____/____

Signature of **Applicant/Insured** *(If different from Depositor)* _____

Print Name of **Insured/Applicant** _____ **Date** ____/____/____

5. Agreements & Conditions

Automatic Payment Option (Account Deduction Authorization) is subject to the following conditions:

1. Premium payments will be debited from your account on or about the premium due date.
2. Additional premium that may be required in order to keep policy(ies)/certificate(s) current may be drawn from your account through the use of multiple debits.
3. Selman & Company (Company) may revoke the privilege of paying premium under this Automatic Payment Option (APO) if any payment is dishonored.
4. A service fee of $15.00 may be assessed for each dishonored payment.
5. Payment of premium under APO may be discontinued by the Company or the undersigned upon thirty (30) days written notice.
6. If APO is discontinued, an alternate payment mode acceptable to the Company will be used to remit the premiums needed to keep the policy(ies)/certificate(s) in force and current.
7. The Company will not send premium notices while APO is in effect.
8. A request for change or adjustment to the APO must be sent directly to the Company's Customer Service Department.
9. If you cancel this service, any refund of premium due you will take sixty (60) days to process.

NOTE: Please keep a copy of this completed document for your record.

OFFICE USE ONLY Insured ID: _____ APO Effective Date: _____

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RAUS MEMBERSHIP APPLICATION

The Retired Association for the Uniformed Services, Inc.
504 Autumn Springs Court, Suite 8, Franklin, TN 37067-8278
800-321-RAUS Fax 615-790-2210

OFFICE USE ONLY
Member #_____
Certificate #_____

Member Name: _____ / / _____
Last Name First Name Initial Social Security # Date of Birth

Spouse Name: _____ / / _____
Last Name First Name Initial Social Security # Date of Birth

Address: _____
Street City State ZIP

Military Data: _____ | _____ | _____ / / _____ / / _____ _____
Branch Rank Service # Military Entry Date Discharge Date Email Address

Check One: [ ] Retired [ ] Widow(er) [ ] TRR [ ] Active Duty Military Retirement Date: ____/____/____

I hereby request membership in RAUS to take advantage of the member-only association benefits. I have included the initial membership dues and understand that, except for Life Membership, continued membership and benefit enjoyment requires renewal of my membership upon expiration of the initial period.

DUES RATES	Amount
[ ] 1 year membership	$15.00
[ ] 3 year membership	$37.00
[ ] 5 year membership	$60.00
[ ] Life memberships are based on age. (See below)	

Date_____ Phone: _____ Signed: _____

Life Membership

AGE RANGE	40 or less	41 to 45	46 to 50	51 to 55	56 to 60	61 to 65	66 to 70	70 and up
LIFE DUES	$325	$300	$275	$250	$225	$200	$175	$100

THE RAUS ASSOCIATION

RAUS is a non-political military association organized in 1970 to secure quality benefits for its members at rates only available to groups. Qualified retired and active members of the United States armed forces and related departments may join RAUS by making application and paying the membership dues. Association benefits are available to all members, their spouses and eligible dependents. The various association benefits are designed for the needs of the general membership and therefore will change from time to time. The association objective is to always provide membership benefits as follows: newsletter; insurance products; discount buying and travel services; credit cards; other products and services as deemed feasible.

WHO MAY JOIN THE ASSOCIATION?

Both Retired and Active duty military personnel may join the Association. All military branches and military ranks are eligible. Membership and benefits are available to:

1. military members
2. military spouse
3. members dependents
4. widows
5. widowers
6. former spouse

AIR FORCE ARMY MARINES NAVY	COAST GUARD COSTAL & GEODETIC SURVEY PUBLIC HEALTH SERVICE NATIONAL GUARD	CIVIL AIR PATROL NOAA ACTIVE & RETIRED OFFICER & ENLISTED

Write two checks--one check for your premium payable to SelmanCo, and one for your dues payable to RAUS. Mail membership application and enrollment forms with your checks for dues and premium to:

RAUS
504 Autumn Springs Court, Suite 8
Franklin, TN 37067-8278
1-800-321-RAUS (7287)