RAUSHOME.COM

RAUS Group TRICARE Prime Supplement Plan Enrollment Form

Please Leave Blank
Ref. No.

Underwritten by: Transamerica Financial Life Insurance Company, Harrison, NY, an AEGON company

Policy Holder: American Military Insurance Trust
Organization: Retired Association of the Uniformed Services

Check the appropriate box: ☐ New Enrollment Form ☐ Add Dependent(s) ☐ Change Coverage

Member's Name ______________________________
☐ Mr. ☐ Mrs. ☐ Ms. First M.I. Last

Address ______________________________

City ______________ State ________ Zip ________

CHECK ONE
☐ RETIRED
☐ WIDOW/ER
☐ FORMER SPOUSE

Date of Birth ____________ (Mo. Day Yr.) Rank and Service ________ Military Retirement Date ____________

Telephone No. ______________________________
Home Office

Name of each dependent for whom coverage is desired: Spouse ____________ Date of Birth MO. DAY YR.

Child ____________ Date of Birth MO. DAY YR. Child ____________ Date of Birth MO. DAY YR.

Child ____________ Date of Birth MO. DAY YR. Child ____________ Date of Birth MO. DAY YR.

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.

YOU MUST BE ENROLLED IN TRICARE PRIME TO ENROLL IN ONE OF THE FOLLOWING PLANS

Retired Member	Spouse of Retired Member	Each Child of Retired Member
☐ Plan A	☐ Plan A	☐ Plan A
☐ Plan B	☐ Plan B	☐ Plan B

I hereby enroll myself and/or my dependents with the Transamerica Financial Life Insurance Company for coverage under the RAUS group health program. I understand that I must be a member of RAUS 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.

NY 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Date ____________ Member's Signature (X) ______________________________

Date ____________ Spouse's Signature (X) ______________________________
(If applicable)

Signature of Agent (X) ____________ Agent No. ________ General Agency No. ________

PRINT: Name of Agent ____________ Phone No. ____________

Agent's Address ______________________________

(See reverse side for partial list of services and cost share amounts)

The following chart is an example of what the **TRICARE Prime Supplement** pays for some of the most common types of services. Refer to your **TRICARE Prime** Handbook for a more complete description of terms and conditions under TRICARE.

Care Required	TRICARE Prime Pays	Your TRICARE Prime Supplement Pays
	All except the following:	Per Visit/Service:
Civilian Outpatient Care	Per Visit: $12 Office $30 Emergency Room	 $12 $30
Outpatient Mental Health	$25 Individual $17 Group	$25 Individual $17 Group
Civilian Inpatient Admission	$11 per day ($25 minimum per admission)	$11 per day ($25 minimum per admission)
Inpatient Mental Health	$40 per day	$40
Ambulance Service	$20	$20
Outpatient Ambulatory Surgery	$25	$25
Prescription Drugs	$3 Generic $9 Brand Name $22 Non-Formulary	$3 Generic $9 Brand Name $22 Non-Formulary

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 Transamerica Financial Life Insurance Company 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.

ASSOCIATION & SOCIETY INSURANCE CORPORATION

REMEMBER, SEND A VOIDED CHECK ALONG WITH THIS FORM AND YOUR PREMIUM PAYMENT

RAUSHOME.COM

OFFICE USE ONLY
Member #________________
Certificate #______________

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

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)