GEA TRICARE Standard/Extra High Option Plus Enrollment Form (FOR NY RESIDENTS ONLY)
Underwritten by Transamerica Financial Life Insurance Company, Harrison, NY.
ORGANIZATION: **GEA (Government Employees Association)**

SelmanCo
Insurance Administrative Services from an Extraordinary Partner

Return the completed form to: TRICARE Supplement | 1620 Main Street #5 | Sarasota, FL 34236

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 Coverage:

Retired Member..... ❑ High Option Plus Retiree Plan
Spouse of Retired Member..... ❑ High Option Plus Retiree Plan
Each Child of Retired Member ..... ❑ High Option Plus Retiree Plan
Retired Reservist ..... ❑ High Option Plus Retiree Plan
Spouse of Retired Reservist ..... ❑ High Option Plus Retiree Plan

I hereby enroll myself and/or my dependents with the Transamerica Financial 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.

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 violation.

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 at the premium mode I have selected. 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: _____

Government Employees Association | Membership Application

Government Employees Association (GEA) is a non-profit, tax-exempt organization; incorporated in 1965 in Washington, D.C. GEA was established to provide active and retired federal, state and local government employees and spouses of employees (including members of the military and National Guard services) with a network of resources including access to valuable insurance plans.

APPLICANT INFORMATION

Name		❑ Male ❑ Female	❑ Married ❑ Single	Date of Birth ___ /___ /___
Employer	Occupation & Grade			❑ Civilian ❑ Military
Address		City	State	Zip
Home Phone ( )	Work Phone ( )	Preferred Email		
Spouse Name		Spouse Date of Birth ___ /___ /___		Number of Children _____

MEMBERSHIP TYPE

GEA Membership	$3.00 Per Month

Please note: If you are currently participating in a GEA sponsored insurance program, dues will be billed along with your insurance premiums.

I affirm that I am actively employed or retired from federal, state, or local government or military service (including the National Guard), or I am the spouse or child, at least age 21, of a GEA member.

Member Signature ✕ _____ Date____ /____ /____

Spouse Signature ✕ _____ Date____ /____ /____

Send your application to:
TRICARE Supplement
ATTN: GEA Membership
1620 Main Street #5
Sarasota, FL 34236

State | Federal | Military | Local | Civilian