TRICARE SUPPLEMENT INSURANCE PLAN ENROLLMENT FORM

I understand that this program may not cover pre-existing conditions (conditions for which I received medical advice or treatment within 6 months prior to the effective date of coverage or until the coverage has been in effect for 6 months). This pre-existing condition limitation will not apply if waived in accordance with policy provisions.

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 ¾	*EMPLOYEE SIGNATURE:	DATE:

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