GEA CHAMPVA Supplement Insurance Plan

to

The Department of Veterans Affairs

Health Administration Center

Helping Protect You from the **Catastrophic Expense** when you need it.

The Supplement provides Peace of Mind and Supplements

CHAMPVA Medical Bills:

- 100% of Doctors Visits, Pharmacy, and Hospital Co-pays*
- 100% of co-pays and Cost-shares for CHAMPVA*

**After the CHAMPVA Deductible and CHAMPVA Supplement Insurance Plan Deductible have been met.*

Government Employees Association (GEA)

Service to those Who Served our Country

GEAUSA Government Employees Association | Serving Veterans & Government Employees Since 1965

Plan Sponsor: GEA Government Employee Association
Plan Administrator: Selman and Company (Selman Co)
Underwritten by: Hartford Life and Accident Insurance Company, Hartford, CT 06155

GEA CHAMPVA Supplemental Insurance Plan:

The CHAMPVA Supplemental Insurance Plan, when combined with your CHAMPVA benefits, is designed to provide you with the protection you need when you need it

- 100% coinsurance
- 100% out-of-pocket costs for covered services
- Pays 100% of Doctors Visits, Pharmacy, and Hospital Co-pays
- Comprehensive coverage -Issuance of ID cards
- Priced to fit Your Budget
- Smokers Pay Same Price as Non-smokers
- Coverage at Almost Any Hospital, Any doctor
- Guaranteed acceptance (subject to 6-month pre-existing condition limitation**)

CHAMPVA when used with the Supplement Pays 100% of Doctors' Visits and Hospital Co-Pays*

CHAMPVA Primary Coverage	CHAMPVA SUPPLEMENT	YOU PAY*
Pays:	**Pays:**	
75% Doctor Visits	25% of Doctor visits	$0.00
75% Hospitalization Impatient / Outpatient	25% for Hospitalization	$0.00
Rx Copay Pharmacy	**Supplement Pays Rx Copay**	
75% of Prescriptions	25% of Prescriptions	$0.00

* *After the CHAMPVA Deductible and CHAMPVA Supplement Insurance Plan Deductible have been met.*

CHAMPVA deductible is applied to first medical or pharmacy claims processed in 2018 until deductible is met.

- Annual CHAMPVA Deductible is $50 per beneficiary or a maximum of $100 per family per year.
- Annual Supplement Deductible is $250 per beneficiary or a maximum of $500 per family per year.

Premiums illustrated are Per Person. Includes first year discount of 11%.

Age of Spouse, Widow/er	Monthly	Quarterly	Semi-Annual	Annual
Under 40	$32.04	$96.12	$192.24	$384.48
40 - 44	$35.60	$106.80	$213.60	$427.20
45 - 49	$40.94	$122.82	$245.64	$491.28
50 - 54	$52.51	$157.53	$315.06	$630.12
55 - 59	$62.30	$186.90	$373.80	$747.60
60 - 64	$74.76	$224.28	$448.56	$897.12
65+	$94.34	$283.02	$566.04	$1,132.08
Each Child	$24.92	$74.76	$149.52	$299.04

Group TRICARE/CHAMPVA Supplement Insurance Plan Enrollment Form

Underwritten by Hartford Life and Accident Insurance Company, Hartford, CT 06155
(A stock insurance company)

THE HARTFORD

Fields with an asterisk are required. Application processing will be delayed if these fields are missing.

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

SERVICE MEMBER INFORMATION

*Member's Name:			Gender: ☐ Male ☐ Female
*Date of Birth____/_____/_____	*Full Social Security Number ____/____/_____		
Policy Number:	Association ID#:		
*Address:	*City:	*State:	*Zip:
Primary Phone: ( )	*E-Mail Address:	*Organization:	
*Primary Tricare Plan Type:		*Enlistment Date ____/_____/_____	

DEPENDENT INFORMATION (*IF ENROLLING)

*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

Note: Dependent Children must be under age 26 and enrolled in a primary Tricare plan to be eligible. Additional children may be listed on a separate sheet of paper and attached to/submitted with this form.

*COVERAGE SELECTION (PLEASE COMPLETE ENTIRE SECTION)

I have selected my coverage below and I am enclosing a check for $_____for payment of myfirst **quarterly** premium. Check the brochure for the appropriate premium schedule. The first premium must be submitted via check or money order even if electing automatic bank withdrawals. Remember to complete the Automatic Payment Option Form, including a voided check, if electing automatic bank withdrawals.

Tricare Select ☐ Tricare Prime ☐ Tricare Active Duty ☐ Tricare Reserve Select ☐ Tricare Retired Reserve ☐ Tricare Young Adult Select ☐ Tricare Young Adult Prime ☐ CHAMPVA ☐

CONFIRMATION Please read, sign and date:

I acknowledge that I have been given the opportunity to enroll in the [Plan Name] and that I am age 64 or younger, unless ineligible for Medicare, a(n) [name of association] Member and that the above information is true and complete to the best of my knowledge.

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.

I understand that my coverage will become effective on the first day of the month following receipt of my completed Enrollment Form and payment of my initial premium.

I understand that eligibility to receive benefits under the TRICARE/CHAMPVA Supplement is dependent on my (or my deceased spouse's) entitlement to uniformed services retired pay.

I understand and agree that insurance will go into effect upon receipt of my first premium payment and this Enrollment Form and remain in effect only in accordance with the provisions, terms and conditions of the insurance policy. I understand and agree that only the insurance policy issued to [name of association] can fully describe the provisions, terms, conditions, limitations and exclusions of my insurance.

***Member** Signature_____ Date____/____/____

***Spouse** Signature (*if enrolling)_____ Date____/____/____

Agent MILOPS Insurance Services **888-654-3129** | **Agent ID A041403671**

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 New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. Any person who includes any false or misleading information on an application for insurance is subject to criminal and civil penalties.

For Residents of New York:
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.

For Residents of Ohio:
Any person who, with intent to defraud or knowing that he or she 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 Tennessee:
It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines and denial of insurance benefits.

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

For Residents of Washington:
It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, and denial of insurance benefits.

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: CHAMPVA Supplement
(Leave Blank)

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: GEA Administrator, 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 (Branch of Service)	Occupation & Grade 100% Service Related Disabled Veteran T&P			❑ 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	$2.00 Per Month

PAYMENT OPTIONS

❑ **VISA** ❑ **MASTERCARD**	Card Number	Expires ___ /___ /___
Name Printed on Card		

❑ **Check Enclosed in the Amount of:** $ _____

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 and your membership fee to:
Selman & Company
ATTN: GEA Membership
6110 Parkland Boulevard
Cleveland, OH 44124

State | Federal | Military | Local | Civilian

INSTRUCTIONS

IT'S EASY TO ENROLL GEA CHAMPVA SUPPLEMENT

AS A REMINDER: You must be a GEA member to enroll in the supplement plan. The GEA membership form is attached and can be added to your premium option.

1) Complete the Group GEA CHAMPVA Supplement Plan Enrollment Form; sign and date where indicated.

- **Member Information** - The Member is the Disabled Veteran
- **Association ID#** - leave blank if GEA Membership is enclosed with application
- **Dependent Information** - Spouse and or children
- **Coverage Selection** - Indicate the total payment for all covered Dependents
- **Select Coverage** - Check if Spouse if covering , check if covering children
- **Signature required** of Member and Spouse if Spouse is covered
- **Include check** made to: **"GEA Group Health Program"**

2) Automatic Payment Option (APO) Form.

- Complete form
- **Policy Number;** Leave Blank
- **Type of Insurance:** CHAMPVA Supplement
- **Include** a **VOID** check with the APO

3) GEA Membership Invitation

- Complete form
- **Applicant Information -** Applicant is the Veteran member
- **Select Military check box**
- **Monthly membership: Monthly $2.00** add to your premium, if quarterly add $6.00

4) Mail Completed Forms and Checks in ONE ENVELOPE

- Be sure to include all forms, GEA CHAMPVA Application, APO (with void check) and GEA Membership
- Include (2) checks,
  - CHAMPVA Supplement check payable **"GEA Group Health Program"**
  - **Voided** Check along with the APO Form

MAIL TO:

GEA Insurance Administrator
6110 Parkland Boulevard
Cleveland, OH 44124−4187

GEA CHAMPVA Supplement Plan

GET THE PROTECTION YOU MAY NEED, AT A COMPETITIVE PRICE.

The GEA CHAMPVA Supplement Plan, when combined with your CHAMPVA benefits, is designed to provide you with the protection you need when you need it. The plan will pay your cost share for both covered inpatient and outpatient medical expenses after you satisfy the calendar year plan deductible of $250 per person, $500 family maximum. Take a moment now to read the details below. Then enroll today to give your family the additional protection of the GEA CHAMPVA Supplement Plan that complements your CHAMPVA benefits.

Plan Sponsor: Government Employees Association (GEA)

The Government Employees Association 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 (including members of the military and National Guard services) with a network of resources.

Important Notice

This coverage is available to GEA members and their dependents. If you are not already a GEA member, please complete the enclosed GEA membership application. The $24.00 per year membership dues will be added to your insurance premium according to the payment option you select. Continued membership and benefit enjoyment requires renewal of membership upon expiration of the initial period. For additional inquiries, call Selman & Company, the plan administrator, toll-free at: 1.800.638.2610.

Eligibility

Eligible “Spouse” means your spouse who is under age 65 and a CHAMPVA benefits recipient, but not a spouse from whom you are legally separated or divorced. “Spouse” also means widow(er) if he or she is a member of the Participating Organization. Spouses over age 65 are also eligible if documentation from the Social Security Administration certifying their non-entitlement to Medicare Part A benefits is submitted with their enrollment form. Eligible dependent and unmarried children under age 18 (23 if a full-time college student) may also enroll. Individuals who are Medicare beneficiaries may not enroll in the CHAMPVA Supplement Plan.

Effective Date

Coverage for dependents becomes effective on the first day of the month following receipt of your Enrollment Form and first premium payment.

Covered Dependent Effective Date

Subject to the Deferred Effective Date provision, an Eligible Dependent will become covered by the Policy on the Certificate Effective Date that first shows coverage for him or her. Your coverage is shown on your Schedule of Insurance. Newborn children not named in your enrollment form are automatically covered from birth for injury or sickness, including treatment of congenital defects and birth abnormalities, for 31 days. You must notify the Plan Administrator in writing and pay the additional premium due within 31 days of birth for coverage to continue beyond this period. Insured children who are incapable of self-sustaining employment because of mental retardation or physical disability – and who are unmarried and chiefly dependent on the insured member for support and maintenance – may continue coverage past policy age limits, with requested proof. Otherwise, each dependent child's insurance terminates on the premium due date following the date he or she is no longer a dependent.

Deferred Effective Date

If on the date that an Eligible Dependent is to become covered under the Policy he or she is confined in a Hospital, coverage of such person will be deferred until the first day after he or she is discharged.

Renewability

Your coverage is renewable to age 65. As long as premiums are paid on time, everyone remains eligible, the Master Policy remains in effect, and GEA membership remains current, no one can be individually canceled. So even if you or a covered dependent develops a serious health condition in the future, the coverage will not terminate, provided these four conditions are met.

Pre-Existing Conditions Limitations

Any injuries or sickness whether diagnosed or undiagnosed, for which a covered person received medical care or treatment within the 6 month period preceding the effective date of his or her insurance will not be covered until the coverage has been in effect for 6 months. However, new conditions will be covered immediately.

HERE'S HOW THE CHAMPVA SUPPLEMENT PLAN WORKS

Covered Care Required	CHAMPVA Pays	CHAMPVA Supplement Plan Pays
Inpatient Services Confinement[1] in civilian hospital or skilled nursing facility	DRG[2] rate, less the beneficiary cost share	The lesser of (1) $535 per day, times number of inpatient days (2) 25% of the billed amount, or (3) the DRG[2] rate
Inpatient Services Non-DRG[2] based	75% of the Allowable Amount	25% of the Allowable Amount
Inpatient Physician Services Visits, surgeons, anesthesiologist, etc.	75% of the Allowable Amount	25% of the Allowable Amount
Outpatient Services Office visits, clinics, laboratory and pharmacy services, durable medical equipment (non-VA source)	75% of the Allowable Amount, after the CHAMPVA Annual Outpatient Deductible	25% of the Allowable Amount
We will pay the Inpatient and Outpatient covered medical expenses once the Calendar Year plan deductible of $250 per person and $500 family maximum has been satisfied. Expenses incurred to satisfy the CHAMPVA Calendar Year Outpatient deductible cannot be used to satisfy the CHAMPVA Supplement Plan deductible.		

INSURANCE PREMIUM RATE CHART Competitively-Priced Premiums to Fit Your Budget

Age of Spouse, Widow(er)	First-Year Quarterly Rate (includes 11% discount[4])	Base Rate Quarterly Rate (after 12 months[4])
Under 40	$96.12	$108.00
40-44	$106.80	$120.00
45-49	$122.82	$138.00
50-54	$157.53	$177.00
55-59	$186.90	$210.00
60-64	$224.28	$252.00
65+	$283.02	$318.00
Each Child	$74.76	$84.00

As a member, you benefit from your Association's mass purchasing power, making the rates for this valuable coverage more affordable. What's more, the insurance company guarantees you'll never be singled out for a rate increase, no matter how many claims you file.[3]

Change of Policy Premiums

We have the right on each Premium Due Date to change the rate at which premiums will be calculated. This includes the right to change premium rates for a benefit that applies to all individuals of the same class, age, plan and effective date. Rates may be changed based on claims experience of the Policy. We will give the Policyholder or Organization notice of any change(s) at least 45 days before the Premium Due Date on which it is to become effective.

[1] Confinement or confined means being an inpatient in a hospital (or skilled nursing facility) due to sickness or injury. And skilled nursing facility does not mean: a) a hospital; or b) a place for rest, custodial care, or the aged; or c) a place for the treatment of mental disease, drug addicts or alcoholics.

[2] Diagnosis-Related Groups (DRG): An agreement between most hospitals and CHAMPVA to accept a fixed rate for inpatient care regardless of the billed amount.

[3] Rates and/or benefits are based on the attained age of the Insured Person and increase as you enter each new age category. Rates and/or benefits may be changed on a class basis. Plan or rate changes may be subject to final approval by the applicable regulatory authorities.

[4] Members receive an 11% rate discount during their first twelve months of coverage. There are no other discounts. After the 12th month, the rates go up 11%.

Exclusions

This Policy does not cover 1) injury or sickness resulting from war or act of war, whether war is declared or undeclared; 2) treatment or confinement not ordered by a Physician or necessary for medical care; 3) intentionally self-inflicted injury; 4) suicide or attempted suicide, whether sane or insane (in Colorado and Missouri while sane); 5) routine physical exams and immunizations, except when considered Well Baby Care covered by CHAMPVA; 6) domiciliary or custodial care, care received in a retirement home, rest home or halfway house; 7) rest cures; 8) eye refractions and routine eye exams except when considered Well Baby Care covered by CHAMPVA; 9) eyeglasses and contact lenses; 10) cosmetic procedures, except those resulting from Sickness or Injury while a Covered Person; 11) hearing aids or hearing exams except when considered Well Baby Care covered by CHAMPVA; 12) orthopedic footwear; 13) care for the mentally incapacitated or physically handicapped if the care is required because of the mental incapacitation or physical handicap; 14) drugs which do not require a prescription, except insulin and other diabetic supplies; 15) any confinement, service, or supply that is not covered under CHAMPVA; 16) expenses in excess of the CHAMPVA Cap; 17) expenses in excess of the CHAMPVA Allowed Amount; 18) expenses which are paid in full by CHAMPVA; 19) any expenses or portion thereof applied to the CHAMPVA Deductible; 20) any part of a covered expense which the Covered Person is not legally obligated to pay; 21) care received as part of a grant, study or research program; 22) care considered experimental or investigational.

Exclusions for the State of New York

This Policy does not cover 1) injury or sickness resulting from war or act of war, whether war is declared or undeclared; 2) intentionally self-inflicted injury; 3) suicide or attempted suicide; 4) custodial care; 5) rest cures; 6) eye refractions and routine eye exams except when considered Well Baby Care covered by CHAMPVA; 7) eyeglasses; 8) cosmetic surgery, except that cosmetic surgery shall not include reconstructive surgery when such surgery is incidental to or follows surgery resulting from trauma, infection, or other diseases of the involved part, and reconstructive surgery because of a congenital disease or anomaly of a covered dependent child which has resulted in a functional defect; 9) hearing aids or hearing exams except when considered Well Baby Care covered by CHAMPVA; 10) any confinement, service, or supply that is not covered under CHAMPVA; 11) expenses in excess of the CHAMPVA Cap; 12) expenses in excess of the CHAMPVA Allowed Amount; 13) expenses which are paid in full by CHAMPVA; 14) any expenses or portion thereof applied to the CHAMPVA Deductible; 15) any part of a covered expense which the Covered Person is not legally obligated to pay.

Limitations (Nervous, Mental, Emotional Disorder, Alcoholism, and Drug Addiction Limits)

The coverage provided under the Inpatient Benefit of the CHAMPVA Supplement plan for nervous, mental and emotional disorders, including alcoholism and drug addiction, is limited to: 1) 30 Inpatient treatment days for a Covered Person age 19 or older; or 2) 45 Inpatient treatment days for a Covered Person under age 19; or 3) 150 Inpatient treatment days in a CHAMPVA authorized Residential Treatment Center for a Covered Person under age 21 per Calendar Year. This Inpatient limit is based on the number of days CHAMPVA normally provides each Calendar Year for such confinements. In rare instances, CHAMPVA extends these daily limits. If this occurs, we will limit the number of days that we provide for such confinement to the lesser of: 1) the number of days CHAMPVA pays for such Inpatient treatment during the Calendar Year; or 2) 90 Inpatient days per Calendar Year. The coverage provided under the Outpatient Benefit of the CHAMPVA Supplement plan for: 1) nervous, mental, and emotional disorders; and 2) alcoholism and drug addiction; is limited to $500 during any Fiscal Year for all such disorders. Coverage provided under the CHAMPVA Supplement plan for: 1) routine newborn and Well Baby Care; 2) hospital nursery charges for a well newborn; 3) dental care; 4) treatment for the prevention or cure of alcoholism or drug addiction; 5) and prosthetic devices; will be limited to those expenses covered by CHAMPVA for such care or service.

Termination

A Covered Person's coverage under the Policy will cease on the first to occur of the date the Policy terminates, or the date GEA ceases to be a Participating Organization of the Policyholder; the date the required premium is not paid, subject to the Grace Period provision; the date you or your widow(er) terminates membership in the Participating Organization; the first premium due date on or next following the date a dependent ceases to be an Eligible Spouse or an Eligible Child; the date we or the group cancel coverage for a class of Eligible Person to which he or she belongs; the first premium due date on or next following the date he or she ceases to be covered by CHAMPVA; the date he or she becomes eligible for Medicare unless the covered person resides in an area where Medicare is not available, in which case coverage will not terminate until the covered person returns to residency in an area where Medicare is available.; if a child, the date he or she attains age 18, or age 23 if enrolled full-time in a school of higher learning; if a spouse, the date he or she attains age 65. Termination of insurance will not prejudice any claim which occurred before the effective date of termination. Limitations and exclusions may vary by state. Please see your Certificate for details.

IT'S EASY TO ENROLL

AS A REMINDER: You must be a GEA member to enroll in the supplement plan. GEA membership dues are $24.00 per year. If you are already a member of GEA, please include your Member/Association ID# on the Enrollment Form for verification purposes.

1) Complete the enclosed Enrollment Form; sign and date where indicated.
2) If applicable, complete the enclosed GEA membership application; sign and date where indicated.
3) Include your first quarterly payment with your completed Enrollment Form.
   - Quarterly premium rates are provided in the 'Insurance Premium Rate Chart'.
   - If you are also applying for GEA membership, please add your first quarterly membership dues payment in the amount of $6.00 to your check total.
   - Make your check payable to: **"GEA Group Health Program"**.
4) For future premium insurance payments, be sure to complete the enclosed Automatic Payment Option Form.
5) Mail your completed Enrollment Form, GEA membership application (if applicable), Automatic Payment Option Form and quarterly payment to:

   GEA Insurance Administrator
   6110 Parkland Boulevard
   Cleveland, OH 44124-4187

SATISFACTION GUARANTEED | 30 DAY FREE LOOK

You cannot be turned down for coverage, although a pre-existing condition may initially limit the extent of your coverage. After your completed Enrollment Form and first premium payment have been processed, you'll receive a Certificate of Insurance which you can examine for a 30 day free look. Return it for a full refund if you are not completely satisfied.

SelmanCo

Plan Administrator

Selman & Company, based in Cleveland, Ohio, has marketed and administered life and health insurance products to members of associations and affinity groups, customers of financial institutions, and employees through their employers for over 30 years. Selman & Company is among the largest privately held firms in the nation with focus on the markets in which it serves.

How to Contact Selman & Company

Our Call Center Representatives are available if you have questions about your TRICARE Supplement Plan.

1.800.638.2610 | memberservices@selmanco.com

PThis brochure explains the general purpose of the insurance described, but in no way changes or affects the policy as actually issued. In the event of any discrepancy between this brochure and the contract, the terms of the contract will apply. Complete details are found in the certificate of insurance issued to each insured individual. Coverage may not be available in all states; you will be advised.