GEA TRICARE Supplement Insurance Plan

to

The Military TRICARE Health Plan

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

The Supplement provides Peace of Mind and Supplements

TRICARE Medical Bills:

- 100% of Doctors' Visits and Hospital Co-Pays for TRICARE*
- 100% of co-pays and Cost-shares for TRICARE. Select, Prime, Reserve Select*
- 100% of covered Excess Charges above the TRICARE Select Allowable Amount**

**After the TRICARE Deductible and TRICARE 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: Transamerica Premier Life Insurance Company, Cedar Rapids, IA. Transamerica Financial Life Insurance Company, Harrison, NY (NY residents only)

TRICARE Prime Supplemental Insurance Plan | Features

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	YOU PAY*
	All except the following:	**Per Visit/Service:**	
Civilian Outpatient Care	Per Visit: $12 Office $30 Emergency Room	$12 $30	$0.00
Outpatient Mental Health	$25 Individual $17 Group	$25 Individual $17 Group	$0.00
Civilian Inpatient Admission	$11 per Day ($25 minimum per admission)	$11 per Day ($25 minimum per admission)	$0.00
Inpatient Mental health	$40 per Day	$40	
Ambulance Service	$20	$20	
Outpatient Ambulatory Surgery	$25	$25	$0.00
Prescription Drugs	$3 Generic $9 Brand Name $22 Non-Formulary	$3 Generic $9 Brand Name $22 Non-Formulary	$0.00

* After reimbursement.

TRICARE Prime Supplemental Insurance | Rates 2018

Premiums illustrated are Per Person. Members receive a 16% rate discount during their first twelve months of coverage

PLAN A	Monthly Check-O-Matic	Quarterly	Semi-Annual	Annual
Under 40	$13.16	$39.48	$78.96	$157.92
40 - 44	$13.72	$41.16	$82.32	$164.64
45 - 49	$16.52	$49.56	$99.12	$198.24
50 - 54	$20.16	$60.48	$120.96	$241.92
55 - 59	$24.92	$74.76	$149.52	$299.04
60 - 65	$27.72	$83.16	$166.32	$332.64
Each Child*	$12.04	$36.12	$72.24	$144.48

PLAN B	Monthly Check-O-Matic	Quarterly	Semi-Annual	Annual
Under 40	$14.56	$43.68	$87.36	$174.72
40 - 44	$16.52	$49.56	$99.12	$198.24
45 - 49	$19.60	$58.80	$117.60	$235.20
50 - 54	$25.20	$75.60	$151.20	$302.40
55 - 59	$30.52	$91.56	$183.12	$366.24
60 - 65	$35.00	$105.00	$210.00	$420.00
Each Child*	$14.53	$43.68	$87.36	$156.00

Group TRICARE Prime Supplement Plan Enrollment Form

Underwritten by Transamerica Premier Life Insurance Company, Cedar Rapids, IA.
ORGANIZATION: **GEA (Government Employees Association)**

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			Member/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.

YOU MUST BE ENROLLED IN TRICARE PRIME TO ENROLL IN ONE OF THE FOLLOWING PLANS. ALL PERSONS APPLYING FOR COVERAGE MUST BE IN THE SAME PLAN (A or B)

Retired Member..... ❑ Plan A ❑ Plan B
Spouse of Retired Member..... ❑ Plan A ❑ Plan B
Each Child of Retired Member ..... ❑ Plan A ❑ Plan B

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____ /____ /____

Agent: 3671 Walter Markovsky **888-654-3129**

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	$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

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: _____

INSTRUCTIONS

IT'S EASY TO ENROLL GEA TRICARE SUPPLEMENT

AS A REMINDER: You must be an 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 TRICARE Supplement Plan Enrollment Form; sign and date where indicated.

- **Member Information** - The Member is the 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:** TRICARE 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 TRICARE Application, APO (with void check) and GEA Membership
- Include (2) checks,
  - TRICRE 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 TRICARE Prime Supplement Plan

Why do I Need a TRICARE Prime Supplement?

The Two TRICARE Prime Supplement Plans available to you are designed to help pay your cost share and copayments under TRICARE (In-Network and Out-of-Network expenses). Enrollment in the TRICARE Prime Supplement Plan provides you and your eligible family members with flexibility in converting your coverage should you move out of a TRICARE Prime area and then apply for a TRICARE Standard/Extra Supplement. When this happens, under the TRICARE Standard/Extra Supplement Plan, you receive credit towards the Pre-Existing Condition Provision for the time spent in the TRICARE Prime Supplement Plan.

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

Retired GEA members and spouses, under age 65, who are currently enrolled in TRICARE PRIME, are eligible to apply for any one of the two supplemental plans described in this brochure. Unmarried dependent children under age 21 (23 if in college) are also eligible to enroll. Coverage is extended to adult dependent children who are under age 26 and enrolled in TRICARE Young Adult (TYA) program. Enrollment for these dependents must include a copy of the TYA enrollment card. Coverage is also available to eligible surviving spouses, who are enrolled in TRICARE PRIME.

Effective Date

Your coverage and that of your covered dependents becomes effective on the first day of the month following receipt of your Enrollment Form and first premium payment. If, on that day, you or a covered dependent are confined in a hospital, the effective date will be the day following discharge from the hospital. 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 coverage 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 you are to become covered under the Policy you are confined in a Hospital, your coverage will be deferred until the first day after you are discharged.

Deferred Effective Date (Dependent)

If on the date that an Eligible Dependent is to become covered under the Policy he or she is confined at home, in a Hospital or elsewhere because of injury or sickness, coverage of such person will be deferred until the first day after he or she is discharged from the Hospital or place of confinement.

Limitations

Routine newborn and well baby care, hospital nursery charges for a well newborn, dental care, treatment for prevention or cure of alcoholism or drug addiction, and prosthetic devices are limited to expenses covered by TRICARE PRIME. INPATIENT treatments for mental, nervous or emotional disorders, drug addiction or alcoholism are limited to a maximum of $500 per fiscal year.

Pre-Existing Conditions Limitations

Any injury 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.

What the TRICARE Prime Supplement Plans Pay For Retirees and Eligible Dependents

(You must be enrolled in TRICARE Prime to apply for one of the following plans)

	In-Network Charges THE PLAN PAYS:	Out-of Network Charges (Point of Service Option) THE PLAN PAYS:	YOU PAY:
PLAN A	Your eligible TRICARE Prime copayments and cost shares up to the TRICARE Prime catastrophic limits.[1]	Nothing	The Point of Service deductible[3] your 50% cost share for Out-of-Network charges and charges in excess of the TRICARE allowed amount.
PLAN B	Your eligible TRICARE Prime copayments and cost shares up to the TRICARE Prime catastrophic limits.[1]	Your 50% of the TRICARE allowed amount[2] (your cost share) for In-Patient and Out-Patient charges after you pay the Point of Service deductible.	The Point of Service Deductible[3] and charges in excess of the TRICARE allowed amount.

INSURANCE PREMIUM RATE CHART Competitively-Priced Premiums to Fit Your Budget (Premiums shown are per person)

Premiums increase based on your effective date of coverage and as you move from one age bracket to another. The insurance company reserves the right to change premiums on a group wide basis.[4]

Age of Retiree, Spouse, Widow(er):	PLAN A (RATES SHOWN ARE PER QUARTER)			PLAN B (RATES SHOWN ARE PER QUARTER)	
	DISCOUNTED First-Year Rate (includes 16% discount[5])	Base Rate (after 12 months[5])		DISCOUNTED First-Year Rate (includes 16% discount[5])	Base Rate (after 12 months[5])
Under 40	$39.48	$47.00		$43.68	$52.00
40-44	$41.16	$49.00		$49.56	$59.00
45-49	$49.56	$59.00		$58.80	$70.00
50-54	$60.48	$72.00		$75.60	$90.00
55-59	$74.76	$89.00		$91.56	$109.00
60-65	$83.16	$99.00		$105.00	$125.00
Each Child	$36.12	$43.00		$43.68	$52.00

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 at least 45 days before the Premium Due Date on which it is to become effective.

[1] In-Network-$3,000 per enrollment year for retirees and dependents. In-Network Care must be provided or referred by a Primary Care Manager; or referred by a Health Care Finder; or is for an emergency.

[2] Subject to maximum payable under this benefit of $7,500 per family per fiscal year.

[3] These plans do not cover the Point of Service (POS) deductible.

[4] Rates are based on the attained age of the insured person and increase as you enter each new 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.

[5] Members receive a 16% rate discount during their first twelve months of coverage. There are no other discounts. After the 12th month, the rates go up 16%.

- These plans do not pay the TRICARE Prime annual enrollment fee.
- The Prime Supplement Plans A and B are not available in NC and ND. Plan B is not available in FL or IA.

Exclusions

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, whether sane or insane (in Colorado and Missouri while sane); 4) routine physical exams and immunizations, except when: a) rendered to a child up to 6 years from his or her birth; or b) ordered by a Uniformed Service: (i) for a Covered Spouse or Child of an Active Duty Member; (ii) for such spouse or child's travel out of the United States due to the Member's assignment; 5) domiciliary or custodial care; 6) eye refractions and routine eye exams except when rendered to a child up to 6 years from the child's birth; 7) eyeglasses and contact lenses; 8) prosthetic devices, (except artificial limbs and eyes and devices which must be implanted by surgery are covered); 9) cosmetic procedures, except those resulting from Sickness or Injury while a Covered Person; 10) hearing aids; 11) orthopedic footwear; 12) care for the mentally incapacitated or physically handicapped if: a) the care is required because of the mental incapacitation or physical handicap; or b) the care is received by an Active Duty Member's child who is covered by the "Extended Care Health Option (ECHO)" under TRICARE; 13) drugs which do not require a prescription, except insulin; 14) dental care unless such care is covered by TRICARE, and then only to the extent that TRICARE covers such care; 15) any confinement, service, or supply that is not covered under TRICARE; 16) Hospital nursery charges for a well newborn, except as specifically provided under TRICARE; 17) any routine newborn care except Well Baby Care, as defined, for a child up to 6 years from his or her birth; 18) expenses in excess of the TRICARE Cap; 19) expenses which are paid in full by TRICARE; 20) any expense or portion thereof applied to the TRICARE Outpatient Deductible; 21) treatment for the prevention or cure of alcoholism or drug addiction except as specifically provided under TRICARE; 22) any part of a covered expense which the Covered Person is not legally obligated to pay because of payment by a TRICARE alternative program; and 23) any claim under more than one of the TRICARE Supplement Plans, or under more than one Inpatient Benefit or more than one Outpatient Benefit of the TRICARE Supplement Plans. If a claim is payable under more than one of the stated Plans or Benefits, payment will only be made under the one that provides the highest coverage, subject to the Pre Existing Condition Limitation.

Exclusions with the state of New York

The 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) eye refractions and routine eye exams except when rendered to a child up to 6 years from the child’s birth; 6) eyeglasses; 7) 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; 8) hearing aids; 9) dental care or treatment, except for such care or treatment due to accidental injury to sound natural teeth within 12 months of the accident and except for dental care or treatment necessary due to congenital disease or anomaly; 10) any confinement, service, or supply that is not covered under TRICARE; 11) expenses in excess of the TRICARE Cap; 12) expenses which are paid in full by TRICARE; 13) any expense or portion thereof applied to the TRICARE Outpatient Deductible; 14) treatment for the prevention or cure of alcoholism or drug addiction except as specifically provided under TRICARE; 15) any part of a covered expense which the Covered Person is not legally obligated to pay because of payment by a TRICARE alternative program; and 16) any claim under more than one of the TRICARE Supplement Plans, or under more than one Inpatient Benefit or more than one Outpatient Benefit of the TRICARE Supplement Plans. If a claim is payable under more than one of the stated Plans or Benefits, payment will only be made under the one that provides the highest coverage, subject to the Pre-Existing Condition Limitation.

Termination

A Covered Person’s coverage under the Policy will cease Your coverage under the Policy will cease on the first to occur of: 1) the date the Policy terminates or the date the Organization ceases to be a Participating Organization of the Policyholder; 2) the date the required premium is not paid, subject to the Grace Period provision; 3) the first day of the month on or next following the date you cease to be a member of the Organization; 4) the first day of the month on or next following the date you cease to be eligible for the Plan under which you are covered; 5) the date we or the Organization cancel coverage for a Class of Eligible Person to which you belong; 6) the date you attain age 65; 7) the date you cease to be covered under TRICARE; 8) the date you become eligible for Medicare unless you reside in an area where Medicare is not available, in which case coverage will not terminate until you return to residency in an area where Medicare is available. 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.

Conversion

If you end your participation in TRICARE Prime because you leave the network area, you may convert you TRICARE Prime supplement to a TRICARE Standard/Extra Supplement Plan within 60 days of disenrollment. Premiums for the TRICARE Standard/Extra Supplement Plan will be those then in effect at time of conversion and the Pre-Existing Condition Limitation will be credited for the period of time covered by the TRICARE Prime supplement. Conversion from the TRICARE Prime supplement to a TRICARE Standard/Extra supplement is available following disenrollment for any other reason from TRICARE Prime (after a minimum of one year enrollment in TRICARE Prime) and is subject to satisfaction of the TRICARE Supplement Plan Pre-Existing Conditions Limitation.

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

Plan Underwriter

Transamerica Premier Life Insurance Company, Cedar Rapids, IA, Group Policy MLTRC1000GP
Transamerica Financial Life Insurance Company, Harrison, NY, Group Policy TFTRC1000GP

This 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.

(0115) 1057644