Group CHAMPVA 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			Association ID#
Date of Birth ____ /____ /____	Social Security Number		
Address	City	State	Zip
Home Phone ( )	Work Phone ( )	Email	
Rank and Service			

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: ❑ Spouse of Disabled Veteran ❑ Each Child of Disabled Veteran

I hereby enroll myself and/or my dependents with the Transamerica Premier Life Insurance Company for coverage under the Association CHAMPVA 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 an 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____ /____ /____