

Check Desired Coverage:

TAGCO MET	Policy(s) #:
Retiree	
Spouse	

Complete this form answering all questions. Please be sure to date and sign the form and return to:

Group Administrative Concepts
PO Box 24420
Tampa, FL 33623

I (we) understand and agree that any pre-existing conditions (conditions for which medical advice or treatment has been received or recommended in the past six months) will not be covered until six consecutive months after the effective date of coverage. I (we) understand that if I (we) plan on replacing any existing group medical coverage with this plan, then this pre-existing condition limitation will be waived to the extent it was satisfied under the previous policy. I (we) understand that coverage will become effective on the first day of the month following receipt by the Company of this enrollment form and first premium payment.

Date: _____ Retiree Signature: _____

Date: _____ Spouse Signature: _____