SMIP Enrollment Form

TAGCO ASSOCIATES, LP

TAGCO Multiple Employer Trust

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The Hartford
Group Benefits

Senior Medical Insurance Plan Enrollment Form

Hartford Life & Accident Insurance Company **Policy Number(s):**

Policyholder: **TAGCO Multiple Employer Trust**

Participating Firm:

Please print clearly in ink or type

Retiree's Name: _____
First Middle Last

Street: _____

City, State, Zip: _____ Medicare # _____

Sex ☐ Male ☐ Female Date of Birth _____ Social Security # _____

Date of Retirement Telephone #

Spouse's Name: _____
First Middle Last

Date of Birth _____ Social Security # _____

Medicare # _____ Date of Retirement _____

To the best of your knowledge:

1. Do you or your spouse have another Medicare Supplement policy or certificate in force including a health care service contract or health maintenance organization (HMO) contract?
   Retiree ☐ Yes ☐ No **Spouse** ☐ Yes ☐ No
   If so, with which company?

Covered Person	Company Name	Policy Number	Effective Date	Expiration Date

2. Do you or your spouse have any other health insurance including an employer health plan?
   Retiree ☐ Yes ☐ No **Spouse** ☐ Yes ☐ No
   If so, with which company? What kind of policy? _____

Covered Person	Company Name	Policy Number	Kind of Policy	Effective Date	Expiration Date

3. If the answer to question 1 or 2 is yes, do you or your spouse intend to replace these medical or health policies with this policy or certificate?
   Retiree ☐ Yes ☐ No **Spouse** ☐ Yes ☐ No

   If yes, for what reason are you or your spouse replacing the coverage?
   ☐ Additional Benefits ☐ No change in benefits, but lower premiums
   ☐ Fewer benefits and lower premiums ☐ Other (please specify)

4. Are you covered by Medicaid? **Retiree** ☐ Yes ☐ No **Spouse** ☐ Yes ☐ No

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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: _____