TRICARE PRIME DISENROLLMENT APPLICATION

Form Approved
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AGENCY DISCLOSURE NOTICE

The public reporting burden for this collection of information is estimated to average 5 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to the Department of Defense, Executive Services and Communications Directorate (0720-0008). Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number.

PLEASE DO NOT RETURN YOUR APPLICATION TO THE ABOVE ORGANIZATION. SEND YOUR APPLICATION TO THE ADDRESS SHOWN IN THE INSTRUCTIONS.

PRIVACY ACT STATEMENT

AUTHORITY: 5 U.S.C. 552a, 10 U.S.C. 1079 and 1086, 58 FR 45318, 65 FR 30966, May 15, 2000.

PRINCIPAL PURPOSE(S): To implement disenrollment from TRICARE Prime, TRICARE Prime Remote or the Uniformed Services Family Health Plan as requested by the enrollee.

ROUTINE USE(S): Information from disenrollment application and related documents may be given to the Department of Health and Human Services, and/or the Department of Transportation consistent with their statutory administrative responsibilities under TRICARE; to the Department of Justice for representation of the Secretary of Defense in civil actions. Appropriate disclosures may be made to other Federal, State, local, and foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, fraud, program abuse, program integrity, and civil and criminal litigation related to the operation of the TRICARE Program.

DISCLOSURE: Voluntary; however, failure to provide information will result in continued enrollment and responsibility for payment of an enrollment fee.

This form is for eligible beneficiaries whose enrollment in TRICARE Prime, TRICARE Prime Remote, or US Family Health Plan is voluntary. **Do not use this form if transferring to another region. Contact the contractor in your new region to request an enrollment form.**

GENERAL INSTRUCTIONS

1. **For TRICARE Prime and TRICARE Prime Remote disenrollments**, submit your completed disenrollment application to the TRICARE contractor in your area or the TRICARE Service Center. For US Family Health Plan, see instruction 8 below.

[Contractor's Name]
[Street Address]
[City, State, 9-digit ZIP Code]

2. Families with more than four members need multiple copies of page 3.

3. Print all information in **ink**. Make sure the information is complete and accurate.

4. Ensure personal and family information matches information in the Defense Enrollment Eligibility Reporting System (DEERS). To check your DEERS information, call the Defense Manpower Data Center (DMDC) Support Office at 1-800-538-9552 and refer to your name as printed on your military ID card. The mailing address and telephone numbers you include on this form will update DEERS.

5. Sign and date the application (Section III).

NOTE: Once disenrolled you will incur a 12 month lock-out from TRICARE Prime. You will not be allowed to re-enroll in TRICARE Prime for 12 months from the date of the disenrollment. ***By legislation, this one-year period does not apply to any dependent whose sponsor is in the grade of E-1 to E-4.***

6. Please keep a copy of the completed application for your records.

7. For information on TRICARE, contact the local TRICARE Service Center (TSC) or visit the TRICARE website at www.tricare.osd.mil , or call 1-800-TRICARE or 1-800-874-2273.

8. **For US Family Health Plan disenrollments**, submit your completed disenrollment application to the US Family Health Plan facility where you are currently enrolled.

9. For information on US Family Health Plan, visit the US Family Health Plan website at www.usfhp.org, or please call *[1-800-XXX-XXXX]*

TRICARE PRIME DISENROLLMENT APPLICATION

(Please read Agency Disclosure Notice, Privacy Act Statement, and Instructions before completing this form.)

SECTION I - SPONSOR INFORMATION *(Must be completed on all applications)*

1. SPONSOR SOCIAL SECURITY NUMBER (SSN)
2. SPONSOR NAME *(Last, First, Middle Initial) (Must match DEERS)*
3. SPONSOR DATE OF BIRTH *(YYYYMMDD)*

SECTION II - INDIVIDUAL(S) REQUESTING DISENROLLMENT
(Print extra copies of this page if more than 4 family members disenrolling)

a. NAME *(Last, First, Middle Initial) (Must match DEERS)*

b. DATE OF BIRTH *(YYYYMMDD)*

c. RELATIONSHIP TO SPONSOR

	Self		Spouse		Former Spouse		Child

d. REASON FOR DISENROLLMENT *(X one)*

	Moved
	Other Health Insurance
	Request for Voluntary Disenrollment
	Other *(Explain)*

e. REQUESTED DISENROLLMENT DATE *(YYYYMMDD)*

f. TELEPHONE NUMBERS *(Include Area Code)*	(1) HOME	(2) WORK

a. NAME *(Last, First, Middle Initial) (Must match DEERS)*

b. DATE OF BIRTH *(YYYYMMDD)*

c. RELATIONSHIP TO SPONSOR

	Self		Spouse		Former Spouse		Child

d. REASON FOR DISENROLLMENT *(X one)*

	Moved
	Other Health Insurance
	Request for Voluntary Disenrollment
	Other *(Explain)*

e. REQUESTED DISENROLLMENT DATE *(YYYYMMDD)*

f. TELEPHONE NUMBERS *(Include Area Code)*	(1) HOME	(2) WORK

SECTION II - INDIVIDUAL(S) REQUESTING DISENROLLMENT *(Continued)*

a. NAME *(Last, First, Middle Initial) (Must match DEERS)*

b. DATE OF BIRTH *(YYYYMMDD)*

c. RELATIONSHIP TO SPONSOR

	Self		Spouse		Former Spouse		Child

d. REASON FOR DISENROLLMENT *(X one)*

	Moved
	Other Health Insurance
	Request for Voluntary Disenrollment
	Other *(Explain)*

e. REQUESTED DISENROLLMENT DATE *(YYYYMMDD)*

f. TELEPHONE NUMBERS *(Include Area Code)*	(1) HOME	(2) WORK

a. NAME *(Last, First, Middle Initial) (Must match DEERS)*

b. DATE OF BIRTH *(YYYYMMDD)*

c. RELATIONSHIP TO SPONSOR

	Self		Spouse		Former Spouse		Child

d. REASON FOR DISENROLLMENT *(X one)*

	Moved
	Other Health Insurance
	Request for Voluntary Disenrollment
	Other *(Explain)*

e. REQUESTED DISENROLLMENT DATE *(YYYYMMDD)*

f. TELEPHONE NUMBERS *(Include Area Code)*	(1) HOME	(2) WORK

SECTION III - SIGNATURE

By signing this form, I certify that the information on this form is true, accurate and complete. Federal funds are involved in this program and any false claims, statements, comments or concealment of a material fact may be subject to fine and imprisonment under applicable Federal law. I understand that by voluntarily disenrolling from TRICARE Prime, TRICARE Prime Remote or US Family Health Plan, prior to the annual renewal, that I will not be allowed to reenroll in TRICARE Prime, TRICARE Prime Remote, or US Family Health Plan for the 12 month period following my disenrollment. *(E-1 through E-4 exempt from lockout period)*.

SIGNATURE	DATE SIGNED