TRICARE PLUS DISENROLLMENT REQUEST

(Read Agency Disclosure Notice, Privacy Act Statement, and Instructions before completing form.)

OMB No. 0720-0028
OMB approval expires Mar 31, 2005

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 Directorate (0720-0028). 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 FORM TO THE ABOVE ORGANIZATION. Return completed form to the military treatment facility where you are currently enrolled.

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. 1079, 1086 and 1095; and E.O. 9397.

PRINCIPAL PURPOSE(S): To identify those individuals who have requested disenrollment from the Military Health System TRICARE Plus enrollment option.

ROUTINE USE(S): Information from disenrollment forms and related documents may be disclosed to the Department of Health and Human Services, and/or Department of Veterans Affairs consistent with their statutory administrative responsibilities under TRICARE and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS); CHAMPVA; the Department of Justice and the United States attorneys where the United States is an interested party; and to Congressional Offices in response to inquiries made in the request of the person to whom a record pertains. Based on a valid "need to know" and with strict compliance with applicable routine use, appropriate disclosure may be made to Federal, state, local, and foreign government agencies, private business entities, and individual providers of care, on matters relating to eligibility, claims pricing and payment, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third party liability, coordination of benefits, and civil and criminal litigation related to the operation of the TRICARE program.

DISCLOSURE: Voluntary; however, failure to provide required information may result in denial of application for disenrollment in TRICARE Plus.

INSTRUCTIONS

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

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

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

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

5. Submit your completed disenrollment application to the MTF where you are currently enrolled.

6. For information on TRICARE, visit the TMA Website at www.tricare.osd.mil.

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

1. Sponsor Social Security Number (SSN)	2. Sponsor Name *(Last, First, Middle Initial)*	3. Date of Birth *(YYYYMMDD)*

SECTION II - INDIVIDUAL(S) REQUESTING DISENROLLMENT

4.	a. Name *(Last, First, Middle Initial)*	b. Date of Birth *(YYYYMMDD)*

c. Reason for Disenrollment *(X one)*

☐	Moved	☐	Other *(Explain)*
☐	Loss of TRICARE Eligibility		
☐	Request for Voluntary Disenrollment		
☐	Death		

d. Requested Disenrollment Date *(YYYYMMDD)*	e. Telephone Number *(Include area code)*	
	(1) Home	(2) Work

5.	a. Name *(Last, First, Middle Initial)*	b. Date of Birth *(YYYYMMDD)*

c. Reason for Disenrollment *(X one)*

☐	Moved	☐	Other *(Explain)*
☐	Loss of TRICARE Eligibility		
☐	Request for Voluntary Disenrollment		
☐	Death		

d. Requested Disenrollment Date *(YYYYMMDD)*	e. Telephone Number *(Include area code)*	
	(1) Home	(2) Work

SECTION III - SIGNATURE

6. By signing this form, I certify that the information on this form is true, accurate, and complete.

a. Signature	b. Date Signed *(YYYYMMDD)*

Return WHITE completed form to the Military Treatment Facility where you are currently enrolled. Keep a copy for your records.

Reset