TRICARE PRIME DISENROLLMENT REQUEST

Form Approved
OMB No. 0720-0008

AGENCY DISCLOSURE NOTICE

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

PRIVACY ACT STATEMENT

AUTHORITY: 5 U.S.C. 552a, 10 U.S.C. 1079 and 1086, 71 FR 15705, March 29, 2006.

PRINCIPAL PURPOSE(S): To disenroll 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 Homeland Security 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 may result in continued enrollment and responsibility for payment of applicable enrollment fee.

NEEDS DD 67

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 enrollment 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 request to the TRICARE contractor in your region or the TRICARE Service Center. For US Family Health Plan, see instruction 2 below.

2. **For US Family Health Plan disenrollments**, submit your completed disenrollment request to the US Family Health Plan facility where you are currently enrolled. For information on US Family Health Plan, visit the US Family Health Plan website at www.usfhp.org, or please call

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

4. Print all information in blue or black **ink**. Make sure the applicable information is complete and accurate.

5. Make sure all personal and family information matches that in the Defense Enrollment Eligibility Reporting System (DEERS). To check your DEERS information, call the Support Office at 1-800-538-9552 or log on to http://www.dmdc.gov and refer to your name as printed on your military ID card.

6. Sign and date the request (Section III).

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

7. Please keep a copy of the completed request for your records. If faxed, please maintain a confirmation of fax.

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

TRICARE PRIME DISENROLLMENT REQUEST

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

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

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 6 family members disenrolling)

(Number)	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)* **You may be subject to a 12-month lockout.**

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

NEEDS DD 67

e. REQUESTED DISENROLLMENT DATE *(YYYYMMDD) (If different from above. Must not be more than 30 days in the future.)*	f. TELEPHONE NUMBERS *(Include Area Code)* (1) HOME ( )	(2) WORK ( )

(Number)	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)* **You may be subject to a 12-month lockout.**

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

e. REQUESTED DISENROLLMENT DATE *(YYYYMMDD) (If different from above. Must not be more than 30 days in the future.)*	f. TELEPHONE NUMBERS *(Include Area Code)* (1) HOME ( )	(2) WORK ( )

(Number)	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)* **You may be subject to a 12-month lockout.**

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

e. REQUESTED DISENROLLMENT DATE *(YYYYMMDD) (If different from above. Must not be more than 30 days in the future.)*	f. TELEPHONE NUMBERS *(Include Area Code)* (1) HOME ( )	(2) WORK ( )

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

(Number)	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)* **You may be subject to a 12-month lockout.**

☐	Moved	☐	Other Health Insurance	☐	Other Voluntary Disenrollment *(Explain)*

NEEDS DD 67

e. REQUESTED DISENROLLMENT DATE *(YYYYMMDD)* *(If different from above. Must not be more than 30 days in the future.)*	f. TELEPHONE NUMBERS *(Include Area Code)*	
	(1) HOME ( )	(2) WORK ( )

(Number)	a. NAME *(Last, First, Middle Initial) (Must match DEERS)*	b. DATE OF BIRTH *(YYYYMMDD)*

c. RELATIONSHIP TO SPONSOR

☐	Self	☐	Spouse	☐	Former Spouse	☐	Child

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e. REQUESTED DISENROLLMENT DATE *(YYYYMMDD)* *(If different from above. Must not be more than 30 days in the future.)*	f. TELEPHONE NUMBERS *(Include Area Code)*	
	(1) HOME ( )	(2) WORK ( )

(Number)	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)* **You may be subject to a 12-month lockout.**

☐	Moved	☐	Other Health Insurance	☐	Other Voluntary Disenrollment *(Explain)*

e. REQUESTED DISENROLLMENT DATE *(YYYYMMDD)* *(If different from above. Must not be more than 30 days in the future.)*	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**