TRICARE YOUNG ADULT APPLICATION

OMB No.
OMB approval expires

 PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ORGANIZATION. RETURN COMPLETED FORM TO THE FOLLOWING SERVICING CONTRACTOR:

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. Chapter 55, Medical and Dental Care; 38 U.S.C. Chapter 17, Hospital, Nursing Home, Domiciliary, and Medical Care; 32 CFR Part 199, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS); 45 CFR Parts 160 and 164, Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Rules; and E.O. 9397 (SSN), as amended.

PRINCIPAL PURPOSES: To obtain information to permit certain former military health care beneficiaries to purchase, transfer, or terminate extended dependent health care coverage under the TRICARE Young Adult Program.

ROUTINE USES: In addition to those disclosures generally permitted under 5 U.S.C. 552a(b) of the Privacy Act of 1974, as amended, these records may specifically be disclosed outside the Department of Defense as a routine use pursuant to 5 U.S.C. 552a(b)(3) as follows: to the Departments of Veterans Affairs, Health and Human Services and Homeland Security, and to other Federal, State, local, or foreign government agencies, and to private business entities, including entities under contract with the Department of Defense 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 or criminal litigation.

DISCLOSURE: Voluntary; however, failure to furnish all requested information may result in denial of the individual's purchase, transfer, or termination of TRICARE Young Adult Program health plan coverage.

1. TRICARE COVERAGE DESIRED *(X one. Based on Uniformed Service sponsor's status.)*

- ☐ TRICARE Prime *(where available and if qualified)*
- ☐ TRICARE Standard
- ☐ TRICARE Overseas Prime *(dependent must be command sponsored and meet specific enrollment criteria of the overseas area)*
- ☐ TRICARE Reserve Select *(sponsor must be enrolled in TRS)*
- ☐ TRICARE Retired Reserve *(sponsor must be enrolled in TRR)*
- ☐ TRICARE Prime Remote for Active Duty Family Members *(sponsor must be enrolled in TPR)*
- ☐ Uniformed Services Family Health Plan *(where available and if qualified)*

2. REQUESTED ACTION *(X one)*

- ☐ Start coverage *(complete all items)*
- ☐ Terminate TYA coverage *(complete items 2 - 10, 12-15, and 17)*:
  - ☐ Have employer-sponsored healthcare
  - ☐ Marriage
  - ☐ Voluntary
- ☐ Transfer coverage to another TYA Plan *(complete items 2 - 10, 11 as needed, and 17)*. If necessary, recurring monthly premiums will be adjusted accordingly.

3. REQUESTED EFFECTIVE/TERMINATION/TRANSFER DATE *(YYYYMMDD)*

APPLICANT INFORMATION

4. NAME *(Last, First, Middle Initial)*	**5. SOCIAL SECURITY NUMBER (SSN) OR DoD BENEFITS NUMBER** *(If known)*	**6. DATE OF BIRTH** *(YYYYMMDD)*

7. TELEPHONE NUMBER *(Include Area Code)*		**8. E-MAIL ADDRESS**
a. HOME	b. CELLULAR	

9. RESIDENCE ADDRESS *(Street, Apartment No., City, State, ZIP Code)*	**10. MAILING ADDRESS** *(If correspondence, including premium notices, are to be mailed to an address other than the residence address)*
X X X	D R A F T

11. PRIMARY CARE MANAGER (PCM) PREFERENCE *(Complete only if selecting a Prime plan or USFHP.) (Honoring your preference depends upon availability and local Military Treatment Facility (MTF) policy. Contact your TRICARE Service Center, preferred MTF, or US Family Health Plan Member Services for availability of PCMs.) (Complete all that apply.)*

a. PCM FULL NAME, MTF/CLINIC ADDRESS *(If known)*	1st CHOICE ☐ MTF ☐ Other			
	2nd CHOICE ☐ MTF ☐ Other			
b. PCM SPECIALTY	☐ No Preference	☐ Family/General Practice	☐ Flight Medicine	☐ Internal Medicine
c. PREFERRED PCM GENDER	☐ No Preference	☐ Male	☐ Female	

UNIFORMED SERVICES SPONSOR THROUGH WHOM APPLICANT QUALIFIES FOR COVERAGE

12. NAME *(Last, First, Middle Initial)*	13. SOCIAL SECURITY NUMBER (SSN) OR DoD BENEFITS NUMBER *(If known)*	14. DATE OF BIRTH *(YYYYMMDD)*

15. STATUS *(X one)*

☐ Active Duty ☐ Retired ☐ Selected Reserve ☐ Retired Reserve ☐ Transitional Assistance Management Program

16. PREMIUM PAYMENT METHOD *(Three months of initial premiums are required. See below for currently monthly premiums.) (X as applicable.)*

☐ Check/Money Order/Cashiers Check for initial payments only *(Enclose applicable premium payable to contractor listed below)*

3 MONTHS OF PREMIUMS NOW DUE:
$ _____

☐ Visa/Mastercard initial payments only *(NOT monthly payments)*

☐ Visa/Mastercard initial and automatic monthly payments

CARD NUMBER: _____ EXPIRATION DATE *(MM/YYYY)*: _____

NAME OF CARDHOLDER: _____ CARDHOLDER SIGNATURE: _____

☐ Electronic Funds Transfer - automatic monthly payments ☐ Checking *(attach voided check)* ☐ Savings

NAME AND ADDRESS OF FINANCIAL INSTITUTION: _____

NAME ON ACCOUNT: _____ TELEPHONE NUMBER OF FINANCIAL INSTITUTION: _____

ACCOUNT NUMBER: _____ BANK OR ABA ROUTING NUMBER: _____

17. APPLICANT'S SIGNATURE AND DATE

By signing this form, I understand that it is my responsibility to comply with all TRICARE Young Adult requirements. I certify the information provided 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 and State laws.

☐ I certify that I am not eligible to enroll in an employer-sponsored health plan offered through my employer as defined by Section 5000A(f)(2) of the IRS Code of 1986. If I should become eligible to enroll in an employer-sponsored health plan offered through my employer as defined by Section 5000A(f)(2) of the IRS Code of 1986, I will submit a request to terminate my TRICARE Young Adult coverage.

☐ I certify that I am not married.

☐ I certify that I understand that a noonsufficient funds fee will be charged whenever a financial institution rejects a premium payment transaction due to insufficient funds.

☐ **Complete as necessary if purchasing Prime coverage.** If I am outside the service area, I understand and accept that my travel time to the network of primary care delivery sites may exceed 30 minutes from my home to the delivery site and my travel time for specialty care may exceed 1 hour.

☐ **Complete as desired.** If available, I elect to receive TRICARE Young Adult information, premium statements, and benefit change correspondence via e-mail or by links to websites.

a. APPLICANT SIGNATURE	b. DATE SIGNED *(YYYYMMDD)*

TRICARE YOUNG ADULT PROGRAM

Submission of this form does not automatically result in a requested action. You must meet all qualifications for coverage and pay appropriate premiums. Policy premiums are updated annually.

The TRICARE Young Adult Program extends dependent medical coverage via a premium-based program. Coverage is extended from age 21 (age 23 if enrolled in a full-time course of study at an institution of higher learning approved by the Secretary of Defense) up to age 26 for unmarried dependents that are not eligible for medical coverage from an eligible employer-sponsored health plan as a result of their employment.

Qualified dependents can purchase either the TRICARE Prime or Standard/Extra benefits based upon meeting specific program requirements and the availability of a desired plan in their geographic location.

For information on eligibility, enrollment, coverage, costs, claims submission, and additional program information, go to: www.tricare.mil or contact the servicing contractor listed below:

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