TRICARE YOUNG ADULT APPLICATION

OMB No. 0720-0049
OMB approval expires

 PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ORGANIZATION. RETURN COMPLETED FORM TO THE DESIRED SERVICING CONTRACTOR SHOWN ON THE LAST PAGE.

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. REQUESTED ACTION *(X one)*

- ☐ Start coverage *(complete Items 1 - 10, 11 as needed, 12 - 17)*
- ☐ Terminate TYA coverage *(complete items 1 - 10, 12 - 14, and 17)*:
  - ☐ Have employer-sponsored healthcare ☐ Marriage ☐ Voluntary
- ☐ Transfer coverage to another TYA Plan *(complete items 1 - 10, 11 as needed,12 - 14, and 16 - 17)*. If necessary, recurring monthly premiums will be adjusted accordingly.
- ☐ Request change of Primary Care Manager (PCM) *(complete items 1 - 2, 4 - 14,and 17)*.

2. REQUESTED EFFECTIVE/TERMINATION/ TRANSFER/PCM CHANGE DATE *(YYYYMMDD)*

3. TRICARE COVERAGE DESIRED *(X one) (See Instructions for additional information about what TYA coverage you may be eligible to purchase based on your Uniformed Services sponsor status and your geographical location. Not all applicants will qualify for TRICARE Prime or Uniformed Services Familly Health Plan coverage.)*

☐ TRICARE Prime ☐ TRICARE Standard ☐ Uniformed Services Family Health Plan

TYA APPLICANT INFORMATION

(Enter information about the Young Adult Dependent)

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)*

11. PRIMARY CARE MANAGER (PCM) PREFERENCE *(Complete only if selecting a Prime plan or USFHP, or requesting a PCM change.) (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.)*

a. FULL NAME OF PCM OR MTF PREFERENCE	1st CHOICE			
	2nd CHOICE			
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

(Enter information about the Uniformed Services Sponsor of the Young Adult Dependent)

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

15. PREMIUM PAYMENT METHOD *(X and complete as applicable.) (See last page for monthly premium amounts.)*
Failure to complete this section when requesting new and/or recurreng TYA coverage will result in your application being returned without action.

a. Initial Premiums *(Three months of initial premiums are required.)*

☐ Check/Money Order/Cashier's Check
(Enclose applicable premium payable to contractor on last page)

PAYMENT AMOUNT: **$** _____

☐ Visa/MasterCard Credit or Debit Card:

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

NAME OF CARDHOLDER: _____ CARDHOLDER SIGNATURE: _____

CARDHOLDER BILLING ADDRESS: _____

b. Recurring Automated Monthly Premiums *(Recurring monthly premiums must be paid via a Recurring Credit Charge on a Visa/MasterCard credit or debit card or an Electronic Funds Transfer from a checking or savings account; either option is initiated and maintained by your servicing contractor. Failure to ensure premiums can be paid monthly via automated means will result in termination of TYA coverage.)*

☐ Use same Visa/MasterCard Credit or Debit Card information used for initial payment of premiums.

☐ Other Visa/MasterCard Credit or Debit Card:

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

NAME OF CARDHOLDER: _____ CARDHOLDER SIGNATURE: _____

CARDHOLDER BILLING ADDRESS: _____

☐ Electronic Funds Transfer (EFT). From: ☐ Checking *(Optional - attach voided check)* or ☐ Savings

NAME AND ADDRESS OF FINANCIAL INSTITUTION _____

NAME ON ACCOUNT _____ TELEPHONE NUMBER OF FINANCIAL INSTITUTION _____

ACCOUNT NUMBER _____ BANK OR ABA ROUTING NUMBER *(see example below)* _____

ACCOUNT HOLDER SIGNATURE _____

16. ATTESTATIONS BY THE YOUNG ADULT DEPENDENT APPLICANT

By signing this form, I understand that it is my responsibility to comply with all TRICARE Young Adult Program 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 understand that a nonsufficient funds fee may be charged whenever a financial institution rejects a premium payment transaction due to insufficient funds.

I understand that recurring monthly premiums must be paid via Recurring Credit Charge on a Visa/MasterCard credit or debit card or an Electronic Funds Transfer from a checking or savings account. Failure to ensure premiums can be paid monthly via automated means will result in termination of my TYA coverage.

I understand that recurring monthly premiums may be adjusted as necessary based on a change in the TYA coverage desired or due to changes in monthly premium amounts required by law.

If I should become eligible to enroll in an employer-sponsored health plan offered by 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 Program coverage.

I understand that if I selected a Primary Care Manager (PCM) by name, team or location (MTF or civilian), the TRICARE Program will enroll me with that PCM if capacity exists. If my selected PCM is greater than a 30 minute drive-time from my residence, I understand that I must waive this primary care access standard. If I reside outside the Prime Service Area, I understand that I must also waive the specialty care access standard of one hour drive-time from my PCM's location. This application constitutes my request for and my agreement to waive both the primary care access standard and the specialty care access standard as applicable.

COMPLETION IS MANDATORY - X YES OR NO FOR EACH STATEMENT

☐ Yes ☐ No I am 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.

☐ Yes ☐ No I am married.

COMPLETION IS OPTIONAL - X YES OR NO

☐ Yes ☐ No If available, I elect to receive TRICARE Young Adult Program information and correspondence via electronic media (e-mail, links to websites, etc.).

17. SIGNATURE OF YOUNG ADULT DEPENDENT APPLICANT

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

TRICARE YOUNG ADULT PROGRAM

Submission of this form does not automatically result in a requested action. Applicants 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 (including Uniformed Services Family Health Plan) or Standard/Extra coverage based upon the uniformed service sponsor status, availability of a desired plan in a geographic location, and meeting specific program requirements of a desired plan. General eligibility requirements are shown in the table below.

DEPENDENT ELIGIBILITY TO PURCHASE TRICARE YOUNG ADULT COVERAGE					
INSIDE THE CONTINENTAL UNITED STATES				OUTSIDE THE CONTINENTAL UNITED STATES	
Sponsor Status	TRICARE Prime	TRICARE Standard/Extra	Uniformed Services Family Health Plan	TRICARE Prime	TRICARE Standard/Extra
Active Duty	Yes	Yes	Yes	Yes	Yes
Retired	Yes	Yes	Yes	No	Yes
Selected Reserve	No	Yes	No	No	Yes
Retired Reserve	No	Yes	No	No	Yes

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

(Enter servicing contractor contact information. Include current TYA premiums.)