TRICARE PLUS DISENROLLMENT REQUEST *(Read Agency Disclosure Notice, Privacy Act Statement, and Instructions before completing form.)*	*OMB No. 0720-0028* *OMB approval expires*

AGENCY DISCLOSURE NOTICE

The public reporting burden for this collection of information is estimated to average 7 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, Washington Headquarters Services, Executive Services Directorate, Information Management Division, 4800 Mark Center Drive, Alexandria, VA 22350-3100 (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.

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PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. Chapter 55, Medical and Dental Care; 32 CFR Part 199, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS); and E.O. 9397 (SSN), as amended.

PRINCIPAL PURPOSE(S): This form collects the information necessary to process your request to disenroll from TRICARE Plus.

ROUTINE USE(S): Your records may be disclosed to Federal agencies, and state, local and territorial governments, in order to collect debts and overpayments, to determine whether beneficiaries are eligible for, or enrolled in, other government or private health insurance plans, and to stop fraud, waste, and abuse. Use and disclosure of your records outside of DoD may occur in accordance with 5 U.S.C. 552a(b) of the Privacy Act of 1974, as amended, which incorporates the DoD Blanket Routine Uses published at: http://dplco.defense.gov/privacy/SORNs/blanket_routine_uses.html.
Any protected health information (PHI) in your records may be used and disclosed generally as permitted by the HIPAA Privacy Rule (45 CFR Parts160 and 164), as implemented within DoD by DoD 6025.18-R. Permitted uses and disclosures of PHI include, but are not limited to, treatment, payment, and healthcare operations.

DISCLOSURE: Voluntary; however, failure to provide the requested information may result in the denial of your request to disenroll from 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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TRICARE PLUS DISENROLLMENT REQUEST

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

1. Sponsor Social Security Number (SSN) or DoD Benefits Number (DBN)	**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)*

	Reason		
	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
N E E	D S D D	6 7

f. E-mail Address

☐ X to receive TRICARE e-mails

5.

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

c. Reason for Disenrollment *(X one)*

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