TRICARE® Retiree Dental Program

OMB No. 0720-0015
Exp:

Enrollment application
trdp.org

Delta Dental Use Only

PRINT CLEARLY and complete all applicable sections.

To process this application, payment information and signature are required.

PRIVACY ACT STATEMENT

This statement serves to inform you of the purpose for collecting personal information required by the TRICARE Retiree Dental Program (TRDP) and how it will be used.

AUTHORITY: 10 U.S.C. Chapter 55, Medical and Dental Care; 38 U.S.C. 1781, Medical Care for Survivors and Dependents of Certain Veterans; 32 CFR 199.22, TRICARE Retiree Dental Program (TRDP); and E.O. 9397 (SSN), as amended.

PURPOSE: To obtain your information for records pertaining to eligibility, claims processing, quality of care review, customer service enhancement, and payment related to the TRDP.

ROUTINE USES: Your records may be disclosed outside of DoD to federal, state, local, or foreign government agencies, and with private business entities, including 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. Use and disclosure of your records may also occur in accordance with the DoD Blanket Route Uses published at http://dpcld.defense.gov/Privacy/SORNsIndex/BlanketRoutineUses.aspx and as permitted by the Privacy Act of 1974, as amended (5 U.S.C. 552a(b)).

Any protected health information (PHI) in your records may be used and disclosed generally as permitted by the HIPAA Privacy Rule (45 CFR Parts 160 and 164), as implemented within DoD. Permitted uses and disclosures of PHI include, but are not limited to, treatment, payment, and healthcare operations.

DISCLOSURE: Voluntary. If you chose not to provide your information, no penalty may be imposed, but absence of the requested information may result in denial of TRDP or delays in processing claims and benefits..

A Applicant

Retiree's Social Security Number or DBN

Applicant's Date of Birth
MM/DD/YYYY

Sex
M/F

Branch of Service

Retiree Retirement Date

Primary Subsriber Information (check one)

- ☐ Retiree
- ☐ Unremarried Surviving Spouse
- ☐ Surviving Child(ren)
- ☐ Family Member(s) Only—See Guidelines (section B) for specific criteria

Enrollment Option (check one)

- ☐ Individual
- ☐ Two-Person
- ☐ Family (3 or more)

Last Name First Name MI

Residence Address of Primary Enrollee City, State (or if overseas, province, county, etc.), ZIP/Foreign Postal Code, Country

Mailing Address ☐ check box for "Same as above"

Primary Telephone Secondary Telephone

TRDP Welcome Packet electronic delivery option

☐ YES, I would like to receive my Explanation of Benefits (EOB) electronically.

Email Address

B Family Member to be Enrolled

FIRST, MI, LAST (if different)	*If child is 21 or older* BIRTH DATE
Spouse	MM/DD/YYYY
Child	MM/DD/YYYY
Child	MM/DD/YYYY
Child	MM/DD/YYYY
Child	MM/DD/YYYY

IMPORTANT - This application is two pages. To avoid processing delays, all sections must be complete.

C Premium Prepayment

"If retired pay is not available or is insufficient to allow the allotment amount, an electronic payment method must be established to continue enrollment. Your electronic payment must be one of two payment options: (1) Electronic Funds Transfer (EFT) directly from a checking or savings account each month; (2) Recurring Credit Card (RCC) payment authorization from a credit card each month.

To determine your regional premium rate and prepayment amount, visit our website at trdp.org, or call our toll-free number, 888-838-8737. Prepayment of two months of premiums is necessary for enrollment. Any unused prepayment will be returned to the enrollee during the third month of enrollment.

Two-month premium prepayment method (check one)

☐ Check/Money Order (made payable to the TRICARE Retiree Dental Program in U.S. dollars)

☐ Discover®/VISA®/MasterCard® (see Guidelines) ☐☐☐☐-☐☐☐☐-☐☐☐☐-☐☐☐☐ cvc/cvv -☐☐☐☐-☐☐☐ Exp. Date ☐☐ / ☐☐

BILLING ADDRESS (if different than mailing address)

Street Address

Street Address

City, State (or if overseas, province, county, etc.), ZIP/Foreign Postal Code, Country

D Enrollment Grace Period/Termination

Each new enrollee in the TRICARE Retiree Dental Program must fulfill an initial enrollment period of 12 consecutive months. This initial enrollment period starts upon the coverage effective date. There is a grace period of 30 days from the coverage effective date in which the enrollee may rescind the application without any further enrollment obligation, provided no covered services have been used during that time period. To exercise the option to rescind, the enrollee must contact Delta Dental in writing within the 30-day grace period. If the option to rescind the application within the 30-day grace period is n ot exercised, the enrollee must remain enrolled in the program for the duration of the initial 12-month period with only limited opportunity for voluntary termination during this time. An enrollment may be terminated involuntarily prior to the end of the 12-month time period due to loss of eligibility. After the 12-month enrollment period, enrollment renewal will continue automatically on a month-to-month basis.

E Agency Disclosure Notice

The public reporting burden for this collection of information is estimated to average 15 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, Suite 02G09, Alexandria, VA 22350-3100 (OMB 0072-0015). 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 RESPONSE TO THE ABOVE ADDRESS. Responses should be sent to: Delta Dental of California, Federal Government Programs, PO Box 537008, Sacramento, CA 95853-7008, United States of America.

F Authorization–This section must be signed and dated

I have read the information contained on this application and choose to enroll in the TRICARE Retiree Dental Program. I understand the benefit restrictions of the program as stated to me and/or explained in the materials provided with this application. I further acknowledge my understanding of the following:

- Deposit of my prepayment does not guarantee coverage.
- My enrollment is subject to receipt of payment and verification of funds.
- My monthly premium payment will be automatically deducted from my retired pay. If retired pay is not available or is insufficient to allow the allotment amount, an electronic payment method must be established to continue enrollment. Your electronic payment must be one of two payment options: (1) Electronic Funds Transfer (EFT) directly from a checking or savings account each month; (2) Recurring Credit Card (RCC) payment authorization from a credit card each month.
- I must remain enrolled for 12 consecutive months and if I choose to continue my enrollment beyond the initial 12-month period, my enrollment will continue on a month-to-month basis.
- This program does not discriminate, or have the effect of discriminating, against anyone on the basis of health status, age, race, sex or sponsor rank.
- I certify under penalty of perjury that I, as well as any of my dependents covered under this program, meet the eligibility requirements as identified in the "Eligibility" section of the guidelines included with this application or on the TRDP website. Eligibility for the TRDP will be verified with the Defense Enrollment Eligibility System (DEERS).
- Notwithstanding this certification of eligibility, if I or any of my dependents do not meet the eligibility requirements of this program, coverage under the program will be cancelled immediately and any premiums previously paid prior to the effective date of cancellation of coverage will be retained by Delta Dental.
- Delta Dental may request military retirement documents to assist in verifying eligibility. I agree to provide them within a timely manner as requested in order to avoid delays in processing my enrollment.

I hereby certify that the information contained on this application is true and complete.

X _____ _____

APPLICANT SIGNATURE (Retiree, Surviving Unmarried Spouse or Surviving Children*) DATE