TRICARE YOUNG ADULT APPLICATION

OMB No. 0720-0049
OMB approval expires

RETURN COMPLETED FORM TO THE DESIRED SERVICING CONTRACTOR SHOWN BELOW.

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); DoD Instruction 1341.02, Defense Enrollment Eligibility Reporting System (DEERS) Program and Procedures; and E.O. 9397 (SSN), as amended.

PURPOSE: To collect the information necessary to process your request for coverage, to terminate coverage, or to change your provider.

ROUTINE USES: Use and disclosure of your records outside of DoD may occur in accordance with the Privacy Act of 1974, as amended (5 U.S.C. 552a(b)). Collected information may also be shared with entities including the Departments of Health and Human Services, Veterans Affairs, and other Federal, State, local, or foreign government agencies, or authorized private business entities. Additionally, information may be shared with the contractor responsible for management of the system. For a full listing of the Routine Uses, please refer to the applicable SORN.

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 discloses of PHI include, but are not limited to, treatment, payment, and healthcare operations. For a full listing of the applicable Routine Uses for the system, refer to the applicable SORN.

APPLICABLE SORN: DMDC 02 DoD, Defense Enrollment Eligibility Reporting Systems (DEERS) (July 27, 2016, 81 FR 49210) is the system of records notice (SORN) applicable to DD 2947. The SORN can be found at: https://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/627618/dmdc-02-dod/

DISCLOSURE: Voluntary. However, failure to provide all requested information may result in a denial of your request to enroll in or change your TRICARE Young Adult health plan coverage.

TRICARE YOUNG ADULT PROGRAM

The TRICARE Young Adult Program extends dependent medical coverage via a premium-based program that allows former dependents to purchase TRICARE health care plan coverage if qualified. Coverage is extended from age 21 (age 23 if previously enrolled in a full-time course of study at an institution of higher learning) until reaching age 26 for unmarried dependents that are not eligible for medical coverage from employer-sponsored medical coverage as a result of their employment. General eligibility requirements are shown below.

Sponsor Status	TRICARE Prime (1)	TRICARE Prime Remote (1)	TRICARE Select	Uniformed Services Family Health Plan (1)	TRICARE Overseas Prime (1)	TRICARE Overseas Prime Remote (1)	TRICARE Overseas Select
Active Duty	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Retired	Yes	No	Yes	Yes	No	No	Yes
Selected Reserve *(2)*	No	No	Yes	No	No	No	Yes
Retired Reserve *(2)*	No	No	Yes	No	No	No	Yes

(1) To purchase this coverage, it must be offered in your geographic area and you must meet all other eligibility criteria.
(2) If you are an adult child of a non-activated member of the Selected Reserve of the Ready Reserve or of the Retired Reserve, your sponsor must be enrolled in TRICARE Reserve Select or TRICARE Retired Reserve as applicable for you to be eligible to purchase TYA coverage. For specific information on eligibility, coverage, costs, claims submission, go to: **www.tricare.mil/tya**.

APPLICATION OPTIONS

ONLINE: You may electronically complete, submit and print a copy of your enrollment, disenrollment, transfer request to another TYA plan, or Primary Care Manager (PCM) change form by logging into the Beneficiary Web Enrollment (BWE) website at https://www.tricare.mil/bwe/. The BWE website is not available to beneficiaries in overseas areas.

TELEPHONE: You may enroll, disenroll, transfer to another TYA plan, or change your PCM by calling your Regional Contractor or US Family Health Plan (USFHP) at the toll-free numbers on this page.

ENROLLMENT FORM: You may also enroll, disenroll, transfer to another TYA plan, or change your PCM by completing and submitting the form to your Regional Contractor or USFHP at the address or fax number below.

NOTES: You can view your enrollment status at milConnect (www.tricare.mil/milconnect). To learn more about TRICARE, go to www.tricare.mil or your Regional Contractor's or USFHP website below.

For enrollment assistance, please call *International SOS Government Services* *FAX: 1-215-354-5015*

For additional information on TRICARE, visit the TRICARE website at www.tricare.mil, the Contractor's website at *www.tricare-overseas.com/contactus/* or your local TRICARE Service Center (TSC).

International SOS Government Services
TRICARE Young Adult (TYA) Enrollments/Disenrollment
PO Box 11689
Philadelphia, PA 19116
Note: Please leave voice line blank

Uniformed Services Family Health Plan (USFHP) *(Include locations, addresses and telephone numbers.)*

[Region]	*[Region]*	*[Region]*	*[Region]*
[US Family Health Plan]	*[US Family Health Plan]*	*[US Family Health Plan]*	*[US Family Health Plan]*
[Street Address]	*[Street Address]*	*[Street Address]*	*[Street Address]*
[City, State, 9-digit ZIP Code]	*[City, State, 9-digit ZIP Code]*	*[City, State, 9-digit ZIP Code]*	*[City, State, 9-digit ZIP Code]*
FAX: 1-207-828-7822	*[1-800-XXX-XXXX]*	*[1-800-XXX-XXXX]*	*[1-800-XXX-XXXX]*

YOUNG ADULT'S SSN/DBN:

TRICARE YOUNG ADULT OPTION DESIRED:

☐ **TRICARE Select:** Includes dependents of sponsors enrolled in the TRICARE Reserve Select and TRICARE Retired Reserve health plans.

☐ **TRICARE Prime:** Where available. Enrollment is not automatic. If eligible, active duty family members may be enrolled in TRICARE Prime Remote for Active Duty Family Members (TPRADFM).

☐ **TRICARE Overseas Program Prime:** Available in overseas locations for active duty family members only. Must be command sponsored and meet specific overseas enrollment criteria. If eligible, you may be enrolled in TRICARE Overseas Prime Remote.

☐ **TRICARE Overseas Program Select:** Available in overseas locations.

☐ **Uniformed Services Family Health Plan (USFHP):** Available in six locations. Submit the completed Enrollment Application to the USFHP address listed on Page 1. For the service area descriptions and telephone numbers for questions, please visit the TRICARE website at https://www.tricare.mil/usfhp

SECTION I - SPONSOR INFORMATION

1. SPONSOR'S NAME *(Last, First, Middle Initial) (Must match DEERS)*

2. SPONSOR'S SOCIAL SECURITY NUMBER (SSN) *(XXX-XX-XXXX)* **or DoD BENEFITS NUMBER (DBN)** *(XXXXXXXXX-XX)*

3. SPONSOR IS: *(X one)* ☐ Active Duty ☐ Retired ☐ Selected Reserve ☐ Retired Reserve ☐ Deceased *(Go to Section II.)*

SECTION II - ENROLLING TRICARE YOUNG ADULT FAMILY MEMBER INFORMATION OR PCM CHANGE

4.a. FAMILIY MEMBER NAME *(Last, First, Middle Initial) (Must match DEERS)*

b. DATE OF BIRTH *(YYYYMMDD)*

c. REQUESTED ACTION ☐ Enroll ☐ Transfer Enrollment ☐ PCM Change ☐ Disenroll Effective Date:

d. RESIDENCE ADDRESS

(Provide address, with ZIP Code and Country)

e. MAILING ADDRESS

(Provide address, with ZIP Code and Country)

f. TELEPHONE NUMBER *(Include Area Code)*
WORK:
RESIDENTIAL:

g. EMAIL ADDRESS ☐ *(X box to receive TRICARE e-mails)*

h. REASON FOR DISENROLLMENT OR PCM CHANGE

☐ Relocation ☐ Dissatisfied with PCM ☐ PCS
☐ Have employer-sponsored health care coverage ☐ Marriage ☐ Other:

SECTION III - OTHER HEALTH INSURANCE

PLEASE IDENTIFY IF YOU ARE CURRENTLY COVERED BY OTHER HEALTH INSURANCE.

☐ TRICARE Supplement (no other information is needed) _____

☐ **Medical Insurance: Person(s) Covered:** _____

Policy Holder Name: _____ Carrier Name: _____

Policy Number: _____ Policy Effective Date: _____

☐ **Dental Insurance: Person(s) Covered:** _____

Policy Holder Name: _____ Carrier Name: _____

Policy Number: _____ Policy Effective Date: _____

☐ **Vision Insurance: Person(s) Covered:** _____

Policy Holder Name: _____ Carrier Name: _____

Policy Number: _____ Policy Effective Date: _____

☐ **Prescription Insurance: Person(s)** _____

Covered: Policy Holder Name: _____ Carrier Name: _____

Policy Number: _____ Policy Effective Date: _____

YOUNG ADULT'S SSN/DBN:

SECTION IV - ACCESS WAIVER, ATTESTATIONS, AND SIGNATURE (REQUIRED)

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 or assigned PCM is greater than a 30 minute drive-time from my residence, or if I reside outside the Prime Service Area, I understand that: (1) I must also waive the specialty care access standard of one hour drive-time from my residence, and (2) this application constitutes my agreement to waive both the primary care access standard and specialty care access standard as applicable.

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

I understand that it is my responsibility to comply with all TRICARE Young Adult policies and procedures. By signing this form, I certify the information provided 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/or imprisonment under applicable Federal law.

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.

☐ Yes ☐ No I am married.

SIGNATURE OF YOUNG ADULT DEPENDENT APPLICANT	**DATE SIGNED** *(YYYYMMDD)*

ENROLLMENT NOTE: Your regional or USFHP contractor will process your enrollment, disenrollment, or change request for coverage to be effective on the date of receipt or up to 90 days in the future as requested by you. If the contractor receives your enrollment request within 90 days of loss of other TRICARE or healthcare coverage, your TYA coverage starts on the day after the loss of your other coverage. You should confirm enrollment (and PCM assignment for Prime plans) or PCM changes before obtaining care by calling your Regional or USFHP contractor, or by viewing your enrollment on milConnect **(www.tricare.mil/milconnect)**.

DISENROLLMENT NOTE: You may incur a 12 month lock-out from TYA coverage for failure to pay premiums or for voluntary termination not associated with gaining employer-sponsored health plan coverage or regaining TRICARE coverage. You may not be allowed to re-enroll in TYA coverage for 12 months from the date of the disenrollment.

PAYMENT OPTIONS: See Section V.

SECTION V - PAYMENT OF TRICARE YOUNG ADULT PREMIUMS

PREMIUM PAYMENT METHOD: *(X and complete as applicable.) (See **www.tricare.mil/costs** for current rates.)*
Failure to complete both parts a. and b. of this section when requesting new and/or recurring TYA coverage will result in your application being returned without action.

a. INITIAL PREMIUMS*:* To purchase TYA coverage, young adult dependents or other responsible individual should submit an application request along with an initial 2-month payment by check (cashier's or personal check), money order, or credit/debit card at the time of enrollment.

***Note:** Checks (money order, cashier's, or personal) are only accepted for the initial 2-months of premiums. Regional contractors or USFHPs will not accept checks for ongoing payments.*

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

PAYMENT AMOUNT: **$** _____

☐ Visa/MasterCard Credit or Debit Card:

CARD NUMBER: _____

EXPIRATION DATE *(MM/YYYY)*: _____

NAME OF CARDHOLDER: _____

CARDHOLDER SIGNATURE: _____

CARDHOLDER BILLING ADDRESS: _____

YOUNG ADULT'S SSN/DBN:

b. MONTHLY RECURRING PREMIUMS*:* Monthly payments must be recurring electronic payments. You can pay with an allotment from your sponsor's retired pay, Electronic Funds Transfer (ETF), or by credit/debit card. You will not receive a monthly bill.

☐ Allotment From Retired Pay

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

☐ Other Visa/MasterCard Credit or Debit Card:

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 _____

ACCOUNT HOLDER SIGNATURE _____