TRICARE SELECT ENROLLMENT, DISENROLLMENT, AND CHANGE FORM

OMB No. 0720-0061
OMB approval expires: XXXXXXXX

RETURN COMPLETED FORM TO THE REGIONAL CONTRACTOR ADDRESS LISTED BELOW:

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. 1075 and 1086, 38 U.S.C. Chapter 17; 32 CFR 199.17; and E.O. 9397 (SSN), as amended.

PRINCIPAL PURPOSE(S): To obtain information necessary to permit individuals to enroll, disenroll, or change their enrollment region for TRICARE Select coverage as requested by the individual.

ROUTINE USE(S): Collected information may be shared with the Departments of Health and Human Services, Homeland Security, and Veterans Affairs, and other Federal, State, local, or foreign government agencies, 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.

APPLICABLE SORN: EDHA 07, "Military Health Information System" (June 15, 2020, 85 FR 36190) **https://dpcld.defense.gov/Portals/49/Documents/Privacy/SORNs/DHA/EDHA-07.pdf**

DISCLOSURE: Voluntary; however, your failure to provide all the requested information may result in the denial of the request to enroll, disenroll, or change the enrollment for your TRICARE Select health plan coverage.

TRICARE SELECT

TRICARE Select is a preferred provider organization (PPO) plan, offering access to network and non-network providers. Your out-of-pocket expenses are less if you use network providers. Referrals for care are not required.

If eligible for TRICARE, you must enroll in either TRICARE Select (or Prime) or you will be considered as having declined TRICARE coverage. Declining coverage means TRICARE will not process your claims from civilian providers and you will only be eligible for space-available care at a military hospital or clinic. If you choose not to enroll, you can enroll during the annual open enrollment period with coverage starting on the first of the following year or following a qualifying life event (see www.tricare.mil/LifeEvents for details). You have 90 days from the life event to enroll and your coverage will start on the date of the event (e.g., marriage, birth).

The Department of Defense establishes enrollment fees annually. Active duty family members, certain survivors of active duty deceased service members, and medically retired uniformed service members and their dependents do not pay an enrollment fee. All others must pay the appropriate enrollment fee. If you do not pay your TRICARE Select enrollment fee, you will lose your TRICARE coverage and only be eligible for space-available care at a military hospital or clinic.

HOW TO ENROLL, DISENROLL OR MAKE CHANGES

You have 3 ways to enroll, disenroll or change your enrollment:

(1) ONLINE:
Log into the Beneficiary Web Enrollment (BWE) website (www.tricare.mil/BWE). You need a Common Access Card (CAC), DS Logon or a DFAS account to log in.

(2) TELEPHONE:
Call your regional contractor at the toll-free number below.

(3) Mail or FAX:
Complete and mail or FAX this form to your Regional Contractor at the address or FAX number below.

NOTES:
You will be notified of your enrollment or change in writing. 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 website below.

REGIONAL CONTRACTOR

Contractor:

Address:

International SOS Government Services
TRICARE Select Enrollment/Disenrollment
PO Box 11689, Philadelphia, PA 19116

Toll-Free Number:	**Fax Number:**

Website:

SPONSOR'S SSN / DBN

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 ☐ Unremarried Former Spouse ☐ Deceased *(Go to Section II.)*

4. SPONSOR'S TELEPHONE NUMBER *(Include Area Code)*

a. HOME: **c. CELL:**

b. WORK:

5. SPONSOR'S E-MAIL ADDRESS

6. SPONSOR'S DATE OF BIRTH *(YYYYMMDD)*

7. SPONSOR'S RESIDENCE ADDRESS ☐ New

a. STREET **b. CITY**

c. STATE **d. ZIP CODE** **e. COUNTRY**

8. SPONSOR'S MAILING ADDRESS *(Provide APO or FPO if stationed overseas)* ☐ Same as residence ☐ New

a. STREET **b. CITY**

c. STATE **d. ZIP CODE** **e. COUNTRY**

9. REQUESTED ACTION FOR ELIGIBLE BENEFICIARIES *(X one)* ☐ None *(go to Section II)* ☐ Enroll ☐ Disenroll ☐ Change Enrollment Region ☐ Decline Coverage ☐ Effective Date Requested: _____

SECTION II - ENROLLING FAMILY MEMBER INFORMATION *(Use additional copies of this page as necessary)*

10. a. FAMILY MEMBER NAME *(Last, First, Middle Initial)* *(Must match DEERS)*

b. DATE OF BIRTH *(YYYYMMDD)*

c. REQUESTED ACTION ☐ Enroll ☐ Disenroll ☐ Change Enrollment Region ☐ Decline Coverage ☐ Effective Date Requested: _____

d. ADDRESS *(Provide address, if different from Sponsor)* ☐ Same as Sponsor ☐ New

(1) HOME:

(2) MAILING:

e. TELEPHONE NUMBER *(Include Area Code)*

(1) HOME: **(2) WORK:** **(3) CELL:**

f. E-MAIL ADDRESS

11. a. FAMILY MEMBER NAME *(Last, First, Middle Initial)* *(Must match DEERS)*

b. DATE OF BIRTH *(YYYYMMDD)*

c. REQUESTED ACTION ☐ Enroll ☐ Disenroll ☐ Change Enrollment Region ☐ Decline Coverage ☐ Effective Date Requested: _____

d. ADDRESS *(Provide address, if different from Sponsor)* ☐ Same as Sponsor ☐ New

(1) HOME:

(2) MAILING:

e. TELEPHONE NUMBER *(Include Area Code)*

(1) HOME: **(2) WORK:** **(3) CELL:**

f. E-MAIL ADDRESS

12. a. FAMILY MEMBER NAME *(Last, First, Middle Initial)* *(Must match DEERS)*

b. DATE OF BIRTH *(YYYYMMDD)*

c. REQUESTED ACTION ☐ Enroll ☐ Disenroll ☐ Change Enrollment Region ☐ Decline Coverage ☐ Effective Date Requested: _____

d. ADDRESS *(Provide address, if different from Sponsor)* ☐ Same as Sponsor ☐ New

(1) HOME:

(2) MAILING:

e. TELEPHONE NUMBER *(Include Area Code)*

(1) HOME: **(2) WORK:** **(3) CELL:**

f. E-MAIL ADDRESS

SPONSOR'S SSN / DBN

SECTION III - REASON FOR DISENROLLING OR DECLINING COVERAGE

1. NAME OF FAMILY MEMBER:	☐ Gained Other Health Insurance	☐ Chose Other TRICARE Plan
	☐ Other _____	
2. NAME OF FAMILY MEMBER:	☐ Gained Other Health Insurance	☐ Chose Other TRICARE Plan
	☐ Other _____	
3. NAME OF FAMILY MEMBER:	☐ Gained Other Health Insurance	☐ Chose Other TRICARE Plan
	☐ Other _____	
4. NAME OF FAMILY MEMBER:	☐ Gained Other Health Insurance	☐ Chose Other TRICARE Plan
	☐ Other _____	

SECTION IV - OTHER HEALTH INSURANCE

PLEASE IDENTIFY IF ANYONE IS CURRENTLY COVERED BY OTHER HEALTH INSURANCE.

☐ **1. TRICARE Supplement** *(no other information is needed)*				
☐ **2. Medical Insurance:**	**a. Person(s) Covered:**			
	b. Policy Holder Name:	**c. Carrier Name:**	**d. Policy Number:**	**e. Policy Effective Date**
☐ **3. Dental Insurance:**	**a. Person(s) Covered:**			
	b. Policy Holder Name:	**c. Carrier Name:**	**d. Policy Number:**	**e. Policy Effective Date**
☐ **4. Vision Insurance:**	**a. Person(s) Covered:**			
	b. Policy Holder Name:	**c. Carrier Name:**	**d. Policy Number:**	**e. Policy Effective Date**
☐ **5. Prescription Insurance:**	**a. Person(s) Covered:**			
	b. Policy Holder Name:	**c. Carrier Name:**	**d. Policy Number:**	**e. Policy Effective Date**

SECTION V - SIGNATURE (REQUIRED)

☐ I understand it is my responsibility to comply with all TRICARE Select policies and procedures. By signing this form, I certify the information provided is true and accurate. 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.

1. SIGNATURE OF SPONSOR, SPOUSE, OR OTHER LEGAL GUARDIAN OF BENEFICIARY	**2. RELATIONSHIP TO SPONSOR**	**3. DATE SIGNED** *(YYYYMMDD)*

ENROLLMENT NOTE: Your regional contractor will process your enrollment, disenrollment or change request to be effective on the date requested or the date of event (e.g., initial eligibility, marriage, birth) as appropriate. If your regional contractor receives your enrollment request within 90-days of loss of other TRICARE or healthcare coverage, your TRICARE Select coverage starts on the day after the loss of your other coverage. You should confirm the enrollment or change before obtaining care by calling your Regional Contractor or by viewing your enrollment on milConnect (www.tricare.mil/milconnect).

DISENROLLMENT NOTE: If you voluntarily disenroll or do not pay your enrollment fee, you will only have space available care at a military hospital or clinic. You may re-enroll during the next open enrollment period or within 90-days of a qualifying life event (see www.tricare.mil/LifeEvents for details). You have 90-days from the life event to enroll and your coverage will start on the date of the event (e.g., marriage, birth).

PAYMENT OPTIONS: See Section VI on next page.

SPONSOR'S SSN / DBN

SECTION VI - PAYMENT OF TRICARE SELECT ENROLLMENT FEES

NOTE: This section is only for retirees, retiree family members, certain survivors and eligible former spouses.

If you are entitled to Medicare Part A, you must have Medicare Part B to remain TRICARE-eligible. Retired beneficiaries with any Medicare coverage are not eligible to enroll in TRICARE Select. If you are on Medicare and have any questions regarding your TRICARE eligibility, call your Regional Contractor at the toll-free number on page 1.

ACKNOWLEDGMENT REQUIRED

☐ Failure to pay monthly premiums by automated means will result in termination of TRICARE Select coverage and will result in direct care only coverage on a space available basis.

PAYMENT PLAN OPTION:

Monthly Payment Plan: Monthly payments must be recurring electronic payments. You can pay with an allotment from your retired pay, Electronic Funds Transfer (ETF), or by credit/debit card. You will not receive a monthly bill. You must make an initial 3-month payment by check (cashier's or personal check), money order, or credit/debit card at the time of enrollment.
Make your check payable to: _____

Quarterly Payment Plan: Quarterly payments must be made by credit/debit card or EFT. You will receive a bill each quarter. Your regional contractor may give you the option for recurring quarterly payments.

Annual Payment Plan: Annual payments must be made by credit/debit card. You will receive a bill each year. Your regional contractor may give you the option for recurring annual payments.

Note: Checks (cashier or personal) or money orders are only accepted for payment of initial enrollment fees. Regional contractors will not accept checks or money orders for recurring payment of fees.

PAYMENT OPTIONS *(Some options are location specific)*	**MONTHLY**	☐ Allotment From Retired Pay	☐ Electronic Funds Transfer	☐ Credit/Debit Card
	INITIAL 3-MONTH PAYMENT	☐ Check	☐ Money Order	☐ Credit/Debit Card

MONTHLY ALLOTMENT (where feasible, as mandated by law (NDAA for FY2020, Section 702))

Lack of feasibility includes instances where no (e.g., 100% disabled veterans, certain unremarried former spouses, survivors, etc.) or insufficient retired/retainer pay is available to cover monthly enrollment fees. If allotment is not feasible, payments in the form of Electronic Funds Transfer (EFT) via recurring credit or debit card are allowed.

☐ I choose to have my enrollment fees paid by monthly allotment from my Uniformed Services retired pay.

NOTE: Only retired Uniformed Services members and certain Survivors may establish an allotment from their retired pay. The Uniformed Service member must sign below. Your Regional Contractor will charge the correct fee amount each month based on your enrollment, individual or family. (The current rates are at http://www.tricare.mil/costs)

ELECTRONIC FUNDS TRANSFER

☐ CHECKING *(attach voided check)* ☐ SAVINGS

FINANCIAL INSTITUTION

a. Name: _____ **b. Telephone Number:** _____

c. Address: _____

d. Name on Account: _____

e. Account Number: _____ **f. ABA Routing Number:** _____

CREDIT/DEBIT CARD

☐ INITIAL 3-MONTH PAYMENT ☐ VISA/MASTERCARD MONTHLY RECURRING PAYMENTS *(your Regional Contractor may offer other options):*

a. Cardholder Name: _____

b. Credit/Debit Card Number: _____ **c. Expiration Date** *(MM/YYYY)* _____

d. Card Verification Code (CVC) (3-digit number on reverse side of card) _____

NOTE: Your Regional Contractor will charge the correct fee amount based on your enrollment, individual or family. (The current rates are at www.tricare.mil/costs)

SIGNATURE

My signature authorizes the Regional Contractor to START, CHANGE, or STOP my automated payments as indicated above. Fee amounts, as determined by TRICARE and subject to change each year, will be withdrawn between the first and the fifth business day based on the payment option selected. This authorization will remain in force unless cancelled by me, my Regional Contractor or my financial institution. I understand a $20.00 administrative fee may be assessed for any payments returned due to insufficient or unavailable funds.

1. SIGNATURE OF SPONSOR, SPOUSE, OR OTHER LEGAL GUARDIAN OF BENEFICIARY	**2. DATE** *(YYYYMMDD)*