RESERVE COMPONENT HEALTH COVERAGE REQUEST

OMB No. 0720-RCHC
Expires TBD

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. 1076d and 1076e.
PRINCIPAL PURPOSE(S): This form is used by certain Reserve Component members and retired members to purchase or make changes to coverage under the TRICARE Reserve Select and TRICARE Retired Reserve (TRR) health plan. Please see 32 CFR 199.24(c) and 199.25(b) for a list of eligible beneficiaries.
ROUTINE USES(S): In addition to those disclosures generally permitted under 5 U.S.C. 552a(b) of the Privacy Act, disclosures may be made to Federal, State, local and foreign government agencies, private business entities, and individual providers of care on matters relating to entitlement, fraud, program abuse, program integrity, or civil and criminal litigation related to the operation of the TRICARE Reserve Select and TRICARE Retired Reserve programs.
DISCLOSURE: Voluntary; however, failure to furnish all requested information will result in the applicant being unable to obtain TRICARE Reserve Select or TRICARE Retired Reserve health plan coverage.

INSTRUCTIONS

Please review the information in Block 1 for accuracy and provide corrections in Block 2. Then, verify the information printed in Blocks 3 - 6 and sign Block 6 if paying initial payment by Visa or MasterCard. Finally, sign in Block 7 and submit to address in Block 6 along with correct payment.

Submission of this form does not automatically result in a requested action. You must meet all qualifications and follow all procedures.

POLICY PREMIUMS: Premiums are updated annually. Obtain current premium rates from www.tricare.osd.mil/.

MEMBER INFORMATION: If any of this information is incorrect, please make corrections on this form. If you have family members not listed below you want covered, please contact a RAPIDS Office (Military Identification Card Issuing Office) to determine their eligibility status in DEERS. Visit www.dmdc.osd.mil/rsl/owa/home to locate your nearest RAPIDS office. If there are family members listed below that you do not wish covered, please draw a single line through their names. **Failure to have accurate information in DEERS may result in delays in enrollment, treatment, or claims processing.**

1. INFORMATION IN DEERS	2. CORRECTIONS AND UPDATES TO DEERS INFORMATION

3. REQUESTED EFFECTIVE DATE *(YYYYMMDD)*

4. PROGRAM QUALIFIED FOR

5. REQUESTED ACTION

6. INITIAL PREMIUM PAYMENT METHOD: *(select one if purchasing coverage in block 5)*

☐ CHECK / MONEY ORDER / CASHIERS CHECK. PREMIUM AMOUNT DUE NOW:
(Enclose one month's premium payable to:) _____ **$** _____

☐ VISA/MASTERCARD INITIAL PAYMENT ONLY *(NOT monthly payments)*.

☐ VISA/MASTERCARD INITIAL AND AUTOMATIC MONTLY PAYMENTS.

VISA/MASTERCARD Number: _____ Exp. Date: _____ Cardholder Signature: _____

7. APPLICANT'S SIGNATURE AND DATE.
By signing this form, the applicant understands that it is his/her responsibility to comply with all TRICARE Reserve Select or TRICARE Retired Reserve procedures. The applicant certifies that the information provided on this form is true, accurate, and complete.

☐ I certify that I am not eligible for a health coverage plan under 5 U.S.C. 89 (FEHB) *(not applicable to surviving family members)*.

☐ I understand that should I become eligible for a health coverage plan under 5 U.S.C. 89 (FEHB) I am required to terminate TRS or TRR coverage *(not applicable to surviving family members)*.

☐ I understand that periodic validation of my eligibility for a health plan under 5 U.S.C. 89 (FEHB) will be conducted *(not applicable to surviving family members)*.

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.

a. SIGNATURE	b. DATE