# TRICARE YOUNG ADULT APPLICATION

*OMB No. 0720-0049*
*OMB approval expires September 30, 2018*



**RETURN COMPLETED FORM TO THE DESIRED SERVICING CONTRACTOR SHOWN BELOW.**

## PRIVACY ACT STATEMENT

This statement informs you of the purpose for collecting personal information required by the TRICARE Young Adult Program and how it will be used.
**AUTHORITY**: 10 U.S.C. Chapter 55, Medical and Dental Care, 32 CFR Part 199, Civilian Health and Medical Program of the Uniformed Serivces (CHAMPUS); DoD Instruction 1341.2, Defense Enrollment Eligibility Reporting System (DEERS) Procedures; and E.O. 9397 (SSN), as amended.
**PRINCIPAL PURPOSE(S)**: To collect the information necessary to process your request for coverage, to terminate coverage, or to change your provider.
**ROUTINE USE(S)**: Any protected health information governed by the HIPAA Privacy Rule (45 CFR Parts 160 and 164), as implemented within DoD by DoD 6025.18-R, may disclosed as permitted under those provisions, which includes for treatment, payment, and healthcare operations. In addition, your records may be disclosed to the Department of Health and Human Services for use in reports and Medicare determinations. 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. Your records may be disclosed outside of DoD to support research concerning the health and wellbeing of TRICARE beneficiaries. Your records may also be used and disclosed 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://dpcld.defense.gov/Privacy/SORNsIndex/BlanketRoutineUses.aspx.
**DISCLOSURE**: Voluntary. However, failure to provide all requested information may result in 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.

**ONLINE:**
You may electronically complete, submit and print a copy of your enrollment, disenrollment, transfer to another TYA plan, or request a change in an assigned Primary Care Manager (PCM) 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.

**MAILING THE FORM:**
For manual enrollment, disenrollment, or PCM changes in a TRICARE Young Adult plan, complete and submit the form to the address below.

1. Forms may be mailed to the contractor identified below or, with the exception of USFHP applications, taken to a TRICARE Service Center (TSC). Call your Contractor to determine when your new or transferred enrollment will begin.

2. For enrollment assistance, please call *Health Net Federal Services* *1-844-866-West (9378)*

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

*(TMA BE&SDs/Contractors will add servicing contractor information. Include name, mailing address and web address of contractor, and enrollment fees.)*

*Health Net Federal Services*
*PO Box 8458*
*Virginia Beach, VA 23450-8458*
*PHONE : 844-866-West (9378) FAX: 844-388-8282*

*Uniformed Services Family Health Plan (USFHP) – West Region*
*Website: www.tricare.mil/usfhp*

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

*USFHP at CHRISTUS Health*
*PO Box 169001,*
*Irving, TX 75016*

*Phone: 1-800-678-7347*
*FAX: 1-210-766-8854*

*Pacific Medical Centers*
*PO Box 84985*
*Seattle, WA 98124*

*Phone: 1-888-958-7347 option 1*
*FAX: 1-206-326-2458*

**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:** For active duty family members only. Must meet specific overseas enrollment criteria. If eligible, may be enrolled in TRICARE Overseas Prime Remote.

☐ **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 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.)*

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

a. WORK:

b. RESIDENTIAL:

**5. SPONSOR'S E-MAIL ADDRESS**

☐ *(X box to receive TRICARE e-mails)*

**6. SPONSOR'S RESIDENCE ADDRESS** *(Street, Apartment No., City, State, ZIP Code, Country)* ☐ New

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

**8. SPONSOR'S MILITARY ASSIGNMENT**

a. UNIT

b. UNIT IDENTIFICATION CODE (UIC) *(If known)*

c. STATE, ZIP CODE AND COUNTRY OF WORK ADDRESS

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

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

**10. DATE OF BIRTH** *(YYYYMMDD)*

**11. REQUESTED ACTION**: ☐ Enroll ☐ Transfer Enrollment ☐ PCM Change ☐ Disenroll Effective Date: _____

**12. RESIDENCE ADDRESS** *(Provide address, with ZIP Code and Country, if different from Sponsor)* ☐ Same as Sponsor ☐ New

**13. MAILING ADDRESS** *(Provide address, with ZIP Code and Country, if different from Sponsor)* ☐ Same as Residence ☐ New

**14. TELEPHONE NUMBER** *(Include Area Code)*

a. WORK:

b. RESIDENTIAL:

**15. E-MAIL ADDRESS** ☐ *(X box to receive TRICARE e-mails)*

**16. PRIMARY CARE MANAGER (PCM) PREFERENCE** *(Complete only if selecting a Prime or USFHP plan, or requesting a PCM change. Please list your first and second choices below. Honoring your preference depends upon availability and local Military Treatment Facility (MTF) policy. Contact your TRICARE Service Center, preferred MTF, or US Family Health Plan Member Services for availability of PCMs. If no PCM preference is indicated, one will be assigned.)*

a. 1st CHOICE ☐ MTF ☐ Civilian ☐ Same as Sponsor — FULL NAME or MTF/CLINIC

b. 2nd CHOICE ☐ MTF ☐ Civilian ☐ Same as Sponsor — FULL NAME or MTF/CLINIC

c. PCM SPECIALTY ☐ No Preference ☐ Family/General Practice ☐ Internal Medicine ☐ Pediatrics ☐ Flight Medicine

d. PREFERRED PCM GENDER ☐ No Preference ☐ Male ☐ Female

**17. REASON FOR DISENROLLMENT OR PCM CHANGE** ☐ Relocation ☐ Dissatisfied with PCM ☐ PCS

☐ Have employer-sponsored health care coverage ☐ Marriage ☐ Other: _____

**SPONSOR'S SSN/DBN:**

## SECTION III - OTHER HEALTH INSURANCE

**18. 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: _____ _____

## 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.

| **19. SIGNATURE OF YOUNG ADULT DEPENDENT APPLICANT** | **20. DATE SIGNED** *(YYYYMMDD)* |
|---|---|
| | |

**ENROLLMENT NOTE**: Initial enrollment effective date for TRICARE Select coverage is the 1st of the month following the month the application is received, or the 1st of the month requested up to 90 days in the future. Effective dates for TRICARE Prime coverage are based primarily on the 20th of the month rule (applications received by the 20th of the month are effective the first day of the next month). If a TYA application is received by the contractor or postmarked within 30 days after termination of previous TRICARE coverage, you can request an effective coverage date immediately following termination of your previous TRICARE coverage. You should confirm enrollment (and PCM assignment for Prime plans) before obtaining routine medical care by calling your contractor.

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

**PAYMENT OPTIONS**: See Section V on the next page.

**SPONSOR'S SSN/DBN:**

## SECTION V - PAYMENT OF TRICARE YOUNG ADULT PREMIUMS

**21. 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** *(Two months of initial premiums are required.)*

☐ 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: _____

**b. RECURRING AUTOMATED MONTHLY PREMIUMS** *(Recurring monthly premiums must be paid via a Recurring Credit Charge on a Visa/MasterCard credit or debit card or an Electronic Funds Transfer from a checking or savings account; either option is initiated and maintained by your servicing contractor. Failure to ensure premiums can be paid monthly via automated means will result in termination of TYA coverage.)*

☐ 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 _____