TRICARE PRIME DISENROLLMENT REQUEST

Form Approved OMB No. 0720-0008

AGENCY DISCLOSURE NOTICE

The public reporting burden for this collection of information is estimated to average 5 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, 1155 Defense Pentagon, Washington, DC 20301-1155 (0720-0008). 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 REQUEST TO THE ABOVE ORGANIZATION. SEND YOUR REQUEST TO THE ADDRESS SHOWN IN THE INSTRUCTIONS.

PRIVACY ACT STATEMENT

AUTHORITY: 5 U.S.C. 552a, 10 U.S.C. 1079 and 1086, 71 FR 15705, March 29, 2006.

PRINCIPAL PURPOSE(S): To disenroll from TRICARE Prime, TRICARE Prime Remote or the Uniformed Services Family Health Plan as requested by the enrollee.

ROUTINE USE(S): Information from disenrollment application and related documents may be given to the Department of Health and Human Services, and/or the Department of Homeland Security consistent with their statutory administrative responsibilities under TRICARE; to the Department of Justice for representation of the Secretary of Defense in civil actions. Appropriate disclosures may be made to other 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, and civil and criminal litigation related to the operation of the TRICARE Program.

DISCLOSURE: Voluntary; however, failure to provide information may result in continued enrollment and responsibility for payment of applicable enrollment fee.

This form is for eligible beneficiaries whose enrollment in TRICARE Prime, TRICARE Prime Remote, or US Family Health Plan is voluntary. **Do not use this form if transferring enrollment to another region. Contact the contractor in your new region to request an enrollment form.**

GENERAL INSTRUCTIONS

- 1. **For TRICARE Prime and TRICARE Prime Remote disenrollments**, submit your completed disenrollment request to the TRICARE contractor in your region or the TRICARE Service Center. For US Family Health Plan, see instruction 2 below.
- 2. **For US Family Health Plan disenrollments**, submit your completed disenrollment request to the US Family Health Plan facility where you are currently enrolled. For information on US Family Health Plan, visit the US Family Health Plan website at www.usfhp.org, or please call
- 3. Families with more than six members need multiple copies of page 2.
- 4. Print all information in blue or black ink. Make sure the applicable information is complete and accurate.
- 5. Make sure all personal and family information matches that in the Defense Enrollment Eligibility Reporting System (DEERS). To check your DEERS information, call the Support Office at 1-800-538-9552 or log on to http://www.dmdc.gov and refer to your name as printed on your military ID card.
- 6. Sign and date the request (Section III).

<u>NOTE</u>: For some enrollees, you may incur a 12 month lock-out from TRICARE Prime. You may not be allowed to re-enroll in TRICARE Prime for 12 months from the date of the disenrollment. *This one-year period does not apply to any dependent whose sponsor is in the grade of E-1 to E-4.*

- 7. Please keep a copy of the completed request for your records. If faxed, please maintain a confirmation of fax.
- 8. For information on TRICARE, contact the local TRICARE Service Center (TSC) or visit the TRICARE website at www.tricare.mil, or call 1-800-TRICARE or 1-800-874-2273.

TRICARE PRIME DISENROLLMENT REQUEST (Please read Agency Disclosure Notice, Privacy Act Statement, and Instructions before completing this form.)				
SECTION I - SPONSOR INFORMATION (Must be completed on all requests)				
1. SPONSOR SOCIAL SECURITY NUMBER (SSN)	2. SPONSOR NAME (Must match DEERS)	(Last, First, Middle Initial))	3. SPONSOR DATE OF BIRTH (YYYYMMDD)	
SECTION II - INDIVIDUAL(S) REQUESTING DISENROLLMENT (Print extra copies of this page if more than 6 family members disenrolling)				
(Number) a. NAME (Last, First, Middle Initial)	(Must match DEERS)		b. DATE OF BIRTH (YYYYMMDD)	
c. RELATIONSHIP TO SPONSOR				
Self Spouse		Former Spouse	Child	
d. REASON FOR DISENROLLMENT (X or	ne) You may be subje	•		
	alth Insurance	Other Voluntary Disenrollmen	t (Explain)	
NEEDS DD 67				
e. REQUESTED DISENROLLMENT DATE		TELEPHONE NUMBERS (Includ	e Area Code)	
(If different from above. Must not be more th	an 30 days in the (1)) HOME	(2) WORK	
future.)	()	()	
		,	,	
(Number) a. NAME (Last, First, Middle Initial) (Must match DEERS) b. DATE OF BIRTH (YYYYMMDD)				
c. RELATIONSHIP TO SPONSOR				
Self Spouse		Former Spouse	Child	
d. REASON FOR DISENROLLMENT (X or	ne) You may be subje			
Moved Other Hea	alth Insurance	Other Voluntary Disenrollmen	t (Explain)	
e. REQUESTED DISENROLLMENT DATE	` 00 1 1 11	TELEPHONE NUMBERS (Includ	,	
(If different from above. Must not be more the future.)	(1)) HOME	(2) WORK	
	()	()	
(Number) a. NAME (Last, First, Middle Initial)	(Must match DEERS)		b. DATE OF BIRTH (YYYYMMDD)	
c. RELATIONSHIP TO SPONSOR				
Self Spouse		Former Spouse	Child	
d. REASON FOR DISENROLLMENT (X or	ne) You may he suhie	· · · · · · · · · · · · · · · · · · ·		
	alth Insurance	Other Voluntary Disenrollmen	t (Explain)	
e. REQUESTED DISENROLLMENT DATE (If different from above. Must not be more the	E (YYYYMMDD) f.	TELEPHONE NUMBERS (Includ		
future.)	(1)) I TOWIL	(2) VVOICIC	

SECTION II - INDIVIDUAL(S) RE	QUESTING DISENROLL	MENT (Continued)		
(Number) a. NAME (Last, First, Middle Initial) (Must match DEERS	S)	b. DATE OF BIRTH (YYYYMMDD)		
c. RELATIONSHIP TO SPONSOR		Louisi		
d. REASON FOR DISENROLLMENT (X one) You may be se	Former Spouse	Child		
Moved Other Health Insurance	Other Voluntary Dise			
Moved Strict Hoditi modification	,,,			
MEED	Q D D			
NEED	2 DD	6 /		
e. REQUESTED DISENROLLMENT DATE (YYYYMMDD)	f. TELEPHONE NUMBERS	S. (Include Area Code)		
(If different from above. Must not be more than 30 days in the	(1) HOME	(2) WORK		
future.)	(1) 110.112	(2) WORK		
		,		
(Number) a. NAME (Last, First, Middle Initial) (Must match DEERS	S)	b. DATE OF BIRTH (YYYYMMDD)		
c. RELATIONSHIP TO SPONSOR				
Self Spouse	Former Spouse	Child		
d. REASON FOR DISENROLLMENT (X one) You may be si	•			
Moved Other Health Insurance	Other Voluntary Diser			
THOUGH CHICK FROM THOUGHT TO CHICK THOUGHT THO		(= 4		
e. REQUESTED DISENROLLMENT DATE (YYYYMMDD) (If different from above. Must not be more than 30 days in the	f. TELEPHONE NUMBERS			
future.)	(1) HOME	(2) WORK		
(Number) a. NAME (Last, First, Middle Initial) (Must match DEERS) b. DATE OF BIRTH (YYYYMMDD)				
a. Wille (East, First, Middle Millar) (Mast Mater Beerle	5)	5. 5.112 G1 5.1111 (1111 11111155)		
c. RELATIONSHIP TO SPONSOR				
Self Spouse	Former Spouse	Child		
d. REASON FOR DISENROLLMENT (X one) You may be st				
Moved Other Health Insurance Other Voluntary Disenrollment (Explain)				
e. REQUESTED DISENROLLMENT DATE (YYYYMMDD)	f. TELEPHONE NUMBERS			
(If different from above. Must not be more than 30 days in the future.)	(1) HOME	(2) WORK		
,	()			
SECTION III - SIGNATURE				
By signing this form, I certify that the information on this form 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 imprisonment under applicable Federal law. I understand that by voluntarily disenrolling from TRICARE				
Prime, TRICARE Prime Remote or US Family Health Plan, prior to the annual renewal, that I will not be allowed to reenroll in TRICARE Prime, TRICARE Prime Remote, or US Family Health Plan for the 12 month period following my				
· · · · · · · · · · · · · · · · · · ·				
disenrollment (F-1 through F-4 exempt from lockout period)	•	or the 12 month period renewing my		
disenrollment. (E-1 through E-4 exempt from lockout period)	•			
disenrollment. (E-1 through E-4 exempt from lockout period) SIGNATURE	•	DATE SIGNED		