Martin's Point

US FAMILY HEALTH PLAN

Enrollment Fee Allotment Authorization

Please type or print all entries.

Name: Last | First | Middle Initial | Social Security Number

Home Address: Street | Apt. No. | City | State | Zip Code

INDICATE BELOW THE ACTION YOU WISH TO TAKE FOR THE ALLOTMENT PROCESS.

Please mark one of the three boxes and complete the requested information. For enrollment fees, see the table on the back of this form.

☐ Please **START** a monthly allotment to the Martin's Point US Family Health Plan from my retirement pay for US Family Health Plan enrollment fees in the amount of $_____

I have enclosed a payment (personal check, cashier's check, traveler's check, money order, or credit card) for the initial 3-month payment if required.

Please select card type: Visa / MasterCard

Card number _____ *Exp* ____/____ *Amount* _____ *Today's date* _____

☐ Please **CHANGE** my existing monthly allotment to Martin's Point from $_____ to $_____. My status changed as of (MM/YY) ____/____.

☐ Please **STOP** my existing allotment to Martin's Point so that my US Family Health Plan coverage is paid through the last day of (MM/YY) ____/____.

I hereby authorize this allotment to be taken from my military retirement pay. I understand that it will remain in effect until I request that it be changed or stopped. However, as a courtesy to me, I also authorize Martin's Point to automatically stop this allotment at a future date if I become disenrolled from the US Family Health Plan for any reason, including transferring my enrollment to a different US Family Health Plan/TRICARE region.

Signature (Required): _____ Date: _____

***Martin's Point Health Care will attempt to start the allotment from your military retirement pay by the next payment due date. You will be notified by Martin's Point to make alternative payment arrangements if the allotment from your retirement pay could not be started by this date.**

Complete and send this form with your enrollment application if completing it as a part of your new enrollment. Otherwise, you can mail this form and your payment to:

Martin's Point Health Care
Attn: Finance
PO Box 9746
Portland, ME 04104-9894

QUESTIONS? CALL 1-888-241-4556

TRICARE® Prime Enrollment Fees as of January 1, 2025

Group A (Sponsor's initial enlistment or appointment occurred before January 1, 2018)

Annual Fees	$372/year for individuals $744/year for families
Quarterly Fees	$93/quarter for individuals $186/quarter for families
Monthly Fees	$31/month for individuals $62/month for families

Group B (Sponsor's initial enlistment or appointment occurred on or after January 1, 2018)

Annual Fees	$450/year for individuals $900.96/year for families
Quarterly Fees	$112.50/quarter for individuals $225.24/quarter for families
Monthly Fees	$37.50/month for individuals $75.08/month for families

Note: Fees valid until December 31, 2025.