TRICARE Prime® Enrollment and Disenrollment Form

The US Family Health Plan is a TRICARE Prime option.

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. 113, Secretary of Defense; 5 U.S.C. 552, Freedom of Information Act, as amended; 5 U.S.C. 552a, Privacy Act of 1974, as amended; 32 CFR part 286, DoD Freedom of Information Act (FOIA) Program; 32 CFR part 310, Protection of Privacy and Access and Amendment of Individual Records Under the Privacy Act of 1974; DoD Directive, 5400.07, DoD Freedom of Information Act (FOIA) Program; DoD Instruction 5400.11, DoD Privacy and Civil Liberties Programs; DoD Manual 5400.07, DoD Freedom of Information Act (FOIA) Program; DoD 5400.11-R, DoD Privacy Program; and Executive Order 9397 (SSN), as amended.

PRINCIPAL PURPOSE(S): To obtain information necessary to permit individuals to enroll or disenroll in the US Family Health Plan, as requested by the individual.

ROUTINE USE(S): In addition to those disclosures generally permitted under 5 U.S.C. § 552a(b) of the Privacy Act of 1974, as amended, these records may specifically be disclosed outside the DoD as a routine use to private physicians and federal agencies to include 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. DoD's Routine Use disclosures are limited to those explicitly stated in each SORN. For a full listing of the Routine Uses, refer to below applicable SORNs hyperlinked below. Any protected health information (PHI) in your records may be used and disclosed generally as permitted by the HIPAA Rules as implemented within DoD. Permitted uses and disclosures of PHI include, but are not limited to, treatment, payment, and healthcare operations.

APPLICABLE SORN: Defense Manpower Data Center (DMDC) 02 DoD, Defense Enrollment Eligibility Reporting Systems (DEERS) (May 31, 2022; 87 FR 32384. https://www.federalregister.gov/documents/2022/05/31/2022-11610/privacy-act-of-1974-system-of-records

DISCLOSURE: Voluntary. If you choose not to provide the requested information, there may be an administrative delay processing your request and the DoD may be unable to process it; however, no penalty will be imposed.

Application Options

(1) Online:
at martinspoint.org/explore-military-benefits/enrollment

(2) By phone:
Call the Martin's Point US Family Health Plan toll-free number listed below.

(3) By mail or FAX:
Complete this form and mail to the Martin's Point address listed below or FAX to the number below.

MARTIN'S POINT US FAMILY HEALTH PLAN:

Address: Martin's Point Health Care, PO Box 9746, Portland, ME 04104
Toll-Free Number: 1-877-363-2939
Fax Number: 1-207-828-7822

SPONSOR'S SSN/DBN: _____

TRICARE PRIME OPTION DESIRED:

☑ **US Family Health Plan (USFHP):** Submit the completed Enrollment Application to the Martin's Point US Family Health Plan address listed on Page 1. For the service area description please visit MartinsPoint.org/TRICARE.

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

4. SPONSOR'S TELEPHONE NUMBER *(Include Area Code)*	**5. SPONSOR'S E -MAIL ADDRESS**	**6. SPONSOR'S DATE OF BIRTH** *(YYYYMMDD)*
a. WORK: c. CELL: b. HOME:		

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

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

9. Optional – Race & Ethnicity for Quality Reporting

Providing this information is voluntary. It is used only to help us understand and improve care for our beneficiaries and does not affect your benefits or eligibility.

a. Race (check one):

☐ White
☐ Black or African American
☐ American Indian or Alaska Native
☐ Asian
☐ Native Hawaiian or Other Pacific Islander
☐ Other Race
☐ Two or More Races
☐ Prefer not to answer

b. Ethnicity (check one):

☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Prefer not to answer

10. SPONSOR'S MILITARY ASSIGNMENT

a. BRANCH OF SERVICE	b. STATE, ZIP CODE AND COUNTRY OF WORK ADDRESS

11. SPONSOR'S REQUESTED ACTION *(X one)*

☐ None (go to Section II) ☐ Enroll ☐ Disenroll (Non-AD only)
Effective Date Requested *(YYYYMMDD):*

12. SPONSOR'S PRIMARY CARE PHYSICIAN (PCP) INFORMATION *(non-active-duty only): Check our online provider directory to see if your current PCP is in our network. Visit MartinsPoint.org/Find-a-Provider*

a. ☐ This is my current in-network PCP.	FULL NAME AND ADDRESS *(Last, First, Name of Practice, Practice Address)*

b. ☐ I have not yet established care with a PCP in the USFHP Network, and would like to pick my own from the Provider Directory.
Note: Once I have established care with my chosen PCP, I will notify the plan by either updating my Member Portal or contacting Member Services.

SPONSOR'S SSN/DBN: _____

SECTION II – ENROLLING FAMILY MEMBER INFORMATION *(USE ADDITIONAL COPIES OF THIS PAGE AS NECESSARY)*

13.a. FAMILY MEMBER NAME *(Last, First, Middle Initial) (Must match DEERS)*	**b. DATE OF BIRTH** *(YYYYMMDD)*
c. REQUESTED ACTION : ☐ Enroll ☐ Disenroll Effective Date Requested *(YYYYMMDD):*	
d. RESIDENCE AND MAILING ADDRESS *(Provide address, with ZIP Code and Country, if different from Sponsor)* ☐ Same as Sponsor ☐ New	
e. TELEPHONE NUMBER *(Include Area Code)* a. WORK: b. HOME: c. CELL:	**f. E –MAIL ADDRESS**
g. PCP INFORMATION – FAMILY MEMBER: ☐ Same as sponsor If not same as sponsor, check our online provider directory to see if your current PCP is in our network. Visit MartinsPoint.org/Find-a-Provider	
a. ☐ This is my current in-network PCP.	FULL NAME AND ADDRESS *(Last, First, Name of Practice, Practice Address)*
b ☐ I have not yet established care with a PCP in the USFHP Network, and would like to pick my own from the Provider Directory. *Note: Once I have established care with my chosen PCP, I will notify the plan by either updating my Member Portal or contacting Member Services.*	

14.a. FAMILY MEMBER NAME *(Last, First, Middle Initial) (Must match DEERS)*	**b. DATE OF BIRTH** *(YYYYMMDD)*
c. REQUESTED ACTION : ☐ Enroll ☐ Disenroll Effective Date Requested *(YYYYMMDD):*	
d. RESIDENCE AND MAILING ADDRESS *(Provide address, with ZIP Code and Country, if different from Sponsor)* ☐ Same as Sponsor ☐ New	
e. TELEPHONE NUMBER *(Include Area Code)* a. WORK: b. HOME: c. CELL:	**f. E –MAIL ADDRESS**
g. PCP INFORMATION – FAMILY MEMBER: ☐ Same as sponsor If not same as sponsor, check our online provider directory to see if your current PCP is in our network. Visit MartinsPoint.org/Find-a-Provider	
a. ☐ This is my current in-network PCP.	FULL NAME AND ADDRESS *(Last, First, Name of Practice, Practice Address)*
b ☐ I have not yet established care with a PCP in the USFHP Network, and would like to pick my own from the Provider Directory. *Note: Once I have established care with my chosen PCP, I will notify the plan by either updating my Member Portal or contacting Member Services.*	

15.a. FAMILY MEMBER NAME *(Last, First, Middle Initial) (Must match DEERS)*	**b. DATE OF BIRTH** *(YYYYMMDD)*
c. REQUESTED ACTION : ☐ Enroll ☐ Disenroll Effective Date Requested *(YYYYMMDD):*	
d. RESIDENCE AND MAILING ADDRESS *(Provide address, with ZIP Code and Country, if different from Sponsor)* ☐ Same as Sponsor ☐ New	
e. TELEPHONE NUMBER *(Include Area Code)* a. WORK: b. HOME: c. CELL:	**f. E –MAIL ADDRESS**
g. PCP INFORMATION – FAMILY MEMBER: ☐ Same as sponsor If not same as sponsor, check our online provider directory to see if your current PCP is in our network. Visit MartinsPoint.org/Find-a-Provider	
a. ☐ This is my current in-network PCP.	FULL NAME AND ADDRESS *(Last, First, Name of Practice, Practice Address)*
b ☐ I have not yet established care with a PCP in the USFHP Network, and would like to pick my own from the Provider Directory. *Note: Once I have established care with my chosen PCP, I will notify the plan by either updating my Member Portal or contacting Member Services.*	

SPONSOR'S SSN/DBN: _____

SECTION III - REASON FOR DISENROLLMENT *(Complete if disenrolling)*

Name of Family Member:	☐ Relocation ☐ Dissatisfied ☐ PCS ☐ Other:
Name of Family Member:	☐ Relocation ☐ Dissatisfied ☐ PCS ☐ Other:
Name of Family Member:	☐ Relocation ☐ Dissatisfied ☐ PCS ☐ Other:
Name of Family Member:	☐ Relocation ☐ Dissatisfied ☐ PCS ☐ Other:

SECTION IV - OTHER HEALTH INSURANCE

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

☐ TRICARE Supplement *(no other information is needed)*

☐ Medical Insurance: Person(s) Covered:_____
Policy Holder Name:_____
Carrier Name:_____
ID number:_____ Policy effective date:_____

☐ Medicare: Person Covered:_____
Medicare Beneficiary ID (MBI):_____
Medicare Part A effective date :_____
Medicare Part B effective date: _____

☐ Medicare: Person Covered:_____
Medicare Beneficiary ID (MBI):_____
Medicare Part A effective date :_____
Medicare Part B effective date: _____

☐ Medicare: Person Covered:_____
Medicare Beneficiary ID (MBI):_____
Medicare Part A effective date :_____
Medicare Part B effective date: _____

SECTION V - SIGNATURE (REQUIRED)

I understand that it is my responsibility to comply with all US Family Health Plan 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.

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

ENROLLMENT NOTE: Martin's Point US Family Health Plan will process your enrollment or disenrollment request to be effective on the date requested or the date of event (e.g., initial eligibility, marriage, birth) as appropriate. If Martin's Point US Family Health Plan receives your enrollment request within 90-days of loss of other TRICARE or healthcare coverage, your TRICARE Prime coverage can start on the day after the loss of your other coverage provided all enrollment fees are paid up. You should confirm the enrollment or change before obtaining care by calling Martin's Point US Family Health Plan or by viewing your enrollment on milConnect (www.tricare.mil/milconnect).

DISENROLLMENT NOTE: Failure to pay premiums may result in involuntary disenrollment, and a lockout period could apply before you can re-enroll with TRICARE. 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). If you don't have an appropriate waiver on file and your address is confirmed ineligible for TRICARE Prime, you will be disenrolled from Prime and automatically enrolled in TRICARE Select.

PAYMENT OPTIONS: See Section VI on next page.

SPONSOR'S SSN/DBN: _____

SECTION VI – PAYMENT OF TRICARE PRIME ENROLLMENT FEES

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

Retired beneficiaries and retiree family members under age 65 who are entitled to Medicare Part A must be enrolled in Medicare Part B to be eligible for enrollment in TRICARE Prime. TRICARE Prime enrollment fees are waived for individuals enrolled in Medicare Part A and Part B, as reflected in DEERS.

PAYMENT OPTIONS: See Sections A, B, and C below for payment options.

Note 1, Monthly Payment: Monthly payments must be recurring payments, via allotment whenever feasible. You will not receive a monthly bill. If you select the monthly payment plan, you must make an initial three month payment by check (cashier's or personal check), credit/debit card, or money order at the time of application. Make checks payable to the Martin's Point US Family Health Plan as listed on page 1 of this form.

Note 2, Quarterly and Annual Payments: You will be billed on a quarterly or annual basis for credit card payments. (Recurring quarterly and/or annual payments option available.)

Note 3, Personal Check: Payment by check (money order, cashier's or personal) is limited to the initial three month payment only. Checks received for ongoing payment will not be accepted.

Note 4, Electronic Funds Transfer: EFT is for monthly or quarterly payments only. The initial payment cannot be made via EFT.

PAYMENT FEE, PLAN AND METHOD 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 (Section C below)
	QUARTERLY ☐
	ANNUAL ☐

A – ALLOTMENT (WHERE FEASIBLE, AS MANDATED BY LAW (NOAA FOR FY2020, SECTION 702))

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

NOTE: Only retired Uniformed Services members may establish an allotment from their retired pay. The Uniformed Service member must sign below. Martin's Point US Family Health Plan will charge the correct fee amount each month based on your enrollment, individual or family. (The current rates are at www.tricare.mil/costs)

B – ELECTRONIC FUNDS TRANSFER

☐ ELECTRONIC FUNDS TRANSFER FOR AUTOMATIC PAYMENTS ☐ Checking *(attach voided check)* ☐ Savings

Name and Address of Financial Institution_____

Name on Account_____Telephone Number of Financial Institution_____

Account Number_____ ABA Routing Number_____

NOTE: Martin's Point US Family Health Plan will charge the correct fee amount based on your enrollment, individual or family. (The current rates are at www.tricare.mil/costs)

C – CREDIT/DEBIT CARD

☐ INITIAL 3-MONTH PAYMENT ☐ MONTHLY RECURRING PAYMENTS

Name of Cardholder_____

CREDIT/DEBIT CARD Number: _____ Exp. Date (MMIYYYY):_____

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

Zip Code associated with Credit/Debit Card Billing Address:_____

NOTE: Martin's Point US Family Health Plan 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 Martin's Point US Family Health Plan to START, CHANGE, or STOP my automated payments as indicated above. Fee amounts, as determined by TRICARE and subject to change each fiscal 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 canceled by me, Martin's Point US Family Health Plan or my financial institution. I understand a $20.00 administrative fee may be assessed for any payments returned due to insufficient or unavailable funds.

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