TRICARE Young Adult Application

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: Public Law 104-191, Health Insurance Portability and Accountability Act of 1996; 10 U.S.C. Chapter 55, Medical and Dental Care; DoD Manual (DoDM) 6025.18, Implementation of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule in DoD Health Care Programs; and E.O. 9397 (SSN).

PURPOSE: To collect the information necessary to process your request for coverage, to terminate coverage, or to change your provider.

ROUTINE USES: 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 pursuant to 5 U.S.C § 552a(b)(3) as follows: to contractors and others performing or working for the Federal Government when necessary to accomplish an agency function related to this System of Records; to the Department of Health and Human Services, other federal agencies, and academic institutions for the purposes of public health activities and conducting research; For a complete listing of the Routine Uses for this system, refer to the below hyperlinked SORN.

APPLICABLE SORN: Defense Manpower Data Center (DMDC) 02 DoD, Defense Enrollment Eligibility Reporting Systems (DEERS) (May 31, 2022; 87 FR 32384) https://dpcld.defense.gov/Portals/49/Documents/Privacy/SORNs/OSDJS/DMDC-02-DoD.pdf?ver=2019-12-09-111827-743

DISCLOSURE: Voluntary; If you choose not to provide the requested information, there may be an administrative delay; however, care will not be denied and no penalties will be imposed.

TRICARE YOUNG ADULT PROGRAM (THROUGH THE US FAMILY HEALTH PLAN)

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 in the table to the right.

Sponsor Status	US Family Health Plan[1]
Active Duty	Yes
Retired	Yes
Selected Reserve[2]	No
Retired Reserve[2]	No

[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.

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 YOUNG ADULT 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 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 GSSN)** *(XXX-XX-XXXX)* **or DoD BENEFITS NUMBER (D N)** *(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. BRANCH OF SERVICE	b. STATE, ZIP CODE AND COUNTRY OF WORK ADDRESS

SECTION II - ENROLLING FAMILY MEMBER INFORMATION

9. FAMILY MEMBER NAME *(Last, First, Middle Initial) (Must match DEERS)*	**10. DATE OF BIRTH** *(YYYYMMDD)*

11. REQUESTED ACTION : ☐ Enroll ☐ Transfer Enrollment ☐ Disenroll Effective Date *(YYYYMMDD):*

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. 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

15. TELEPHONE NUMBER *(Include Area Code)* a. WORK: b. HOME:	**16. E -MAIL ADDRESS** ☐ (X box to receive TRICARE e-mails)

17. PRIMARY CARE PHYSICIAN (PCP) INFORMATION - FAMILY MEMBER *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.*

18. REASON FOR DISENROLLMENT ☐ Relocation ☐ PCS ☐ Have employer-sponsored health care coverage ☐ Marriage ☐ Other:

SPONSOR'S SSN/DBN: _____

SECTION III – OTHER HEALTH INSURANCE

19. PLEASE IDENTIFY IF APPLICANT IS 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:_____

☐ Medicare: Person Covered:_____

Medicare Beneficiary ID (MBI):_____

Medicare A Effective Date:_____

Medicare B Effective Date:_____

SECTION IV – ATTESTATIONS AND SIGNATURE (REQUIRED)

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.

20. SIGNATURE OF YOUNG ADULT DEPENDENT APPLICANT	**21. DATE SIGNED** *(YYYYMMDD)*

ENROLLMENT NOTE: Martin's Point US Family Health Plan will process your enrollment, or disenrollment for coverage to be effective on the date of receipt or up to 90 days in the future as requested by you. If the contractor receives your enrollment request within 90 days of loss of other TRICARE or healthcare coverage, you may request your TYA coverage to start on the day after the loss of your other coverage. You should confirm enrollment (and PCP assignment , if applicable) before obtaining care by calling your Martin's Point US Family Health Plan, or by viewing your enrollment on https://milconnect.dmdc.osd.mil

DISENROLLMENT NOTE: You may incur a 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.

PAYMENT OPTIONS: See Section V on the next page.

SPONSOR'S SSN/DBN: _____

SECTION V – PAYMENT OF TRICARE YOUNG ADULT PREMIUMS

22. PREMIUM PAYMENT METHOD (X and complete as applicable.) (See www.tricare.mil/costs for cuffent 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: To purchase TYA coverage, young adult dependents should submit an application request along with an initial 2–month payment by check (cashier's or personal check), money order, or credit/debit card at the time of enrollment.

☐ Check/Money Order/Cashier's Check Payment Amount: $ _____
(Enclose applicable premium payable to contractor on first page.)

☐ Visa/MasterCard Credit or Debit Card:

Card Number: _____ Exp. Date (MMIYYYY): _____

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. All options are initiated through and maintained by your servicing contractor.)*

Payment Options

☐ Use same Visa/MasterCard Credit or Debit Card information used for initial payment of premiums.

☐ Other Visa/MasterCard Credit or Debit Card:

Card Number: _____ Exp. Date (MMIYYYY): _____

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: _____

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 year, will be withdrawn between the first and fifth business day based on payment option selected. This authorization will remain in force unless canceled by me, my servicing contractor, or my financial institution. I understand a $20 administrative fee may be assessed for any payments returned due to insufficient or unavailable funds.