ENROLLMENT INSTRUCTIONS

MetLife®
Metropolitan Life Insurance Company, New York, NY

Please review these instructions before submitting the Enrollment/Change Authorization.

For help completing the Enrollment/Change Authorization call:

CONUS: 1-855-MET-TDP1 (1-855-638-8371)
OCONUS: 1-855-MET-TDP2 (1-855-638-8372)
TDD/TYY: 1-855-MET-TDP3 (1-855-638-8373)

Send Enrollment/Change Authorization with payments to: **MetLife, P.O. Box 14185, Lexington, KY 40512**

Section I

All information in this section refers to the Sponsor.

AGR = Active Guard/Reserve; SELRES = Selected Reserve; IRR = Individual Ready Reserve

Notice of Intent – The TDP has a mandatory 12-month enrollment period. If your Expiration of Term of Service (ETS) date is less than 12 months away, you are not eligible for the TDP unless you intend to continue your service commitment for at least 12 months. This service commitment is calculated based on the time remaining in your current status (*active duty, Selected Reserve or IRR*) plus any uninterrupted combination thereof. **By applying for this program, you are agreeing to a minimum 12-month enrollment and to any premium rate changes that occur during this period.** If you intend to remain in the service for at least 12 months, please check yes. **Failure to pay the premiums during the 12-month enrollment commitment will result in termination of dental coverage and a 12-month lockout from the TDP.**

Section II

Information in this section refers to the family member(s).

Section III

Please indicate (*with a value listed below*) the reason for termination.

G Transfer to duty station where space-available dental care is readily available in the Military Dental Treatment Facility
J Moved to an OCONUS location
N Voluntary disenrollment by sponsor
O Voluntary disenrollment by family member (*sponsor signature required*)
P Dissatisfied with program after 12-month mandatory enrollment period was completed
99 Other reason not listed. Please explain in the space provided.

Section IV

Initial payment of one month's premium **must** be sent with the completed enrollment authorization. If enrolling a National Guard or Reserve member and family, only one check or money order for the total premium amount should be sent. Please include the sponsor's Social Security number (SSN) or DoD Benefits Number (DBN) on the memo portion of the check or money order. **Recurring payment** – By setting up a recurring payment, you have the flexibility to pay your premium by payroll allotment (*required method if coverage and pay status permits*), electronic check (EFT) from your savings or checking account, or by credit or debit card. **If paying by electronic check (EFT) from your savings or checking account, please attach a voided check to this authorization.** Signatures are required from all account holders. *This authorization is to remain in full force and effect until you notify your bank or notify the payee of its termination by canceling any pending payments and recurring payment instructions at least three banking days before your account is scheduled to be debited.* **Checks and money orders should be made payable to MetLife.**
Note: *In the event that a payment is returned for insufficient funds for either initial or recurring payments, you authorize MetLife to electronically debit your bank account for the original amount of the transaction, as well as a returned fee, up to the maximum amount allowed by law.* Additional information can be found at **www.tricare.mil**.

Section V

All information in this section pertains to other dental insurance.
For question 2, if this is a joint service marriage, please check yes and list spouse's SSN or DBN.

Section VI

The Enrollment/Change Authorization must be signed by the sponsor. An individual with power of attorney (POA) may sign for the Sponsor; however, the entire copy of the valid POA must be submitted with the Enrollment/Change Authorization.

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FOR TRICARE® DENTAL PROGRAM

ENROLLMENT/CHANGE AUTHORIZATION

MetLife®
Metropolitan Life Insurance Company, New York, NY

☐ **New Enrollment/Reenrollment** (*complete entire authorization*) Choose when a contract does not currently exist.
☐ **Add Family Member** (*complete sections I, II, V and VI*) Choose when a contract already exists for one or more family members.
☐ **Terminate Enrollment** (*complete sections I, III and VI*) Choose when an entire contract needs to be terminated.
☐ **Change Address/Telephone** (*complete sections I, II and VI*) If the update applies only to certain family members, list in section II.
☐ **Terminate Individual Family Member** (*complete sections I, II, III and VI*) Choose when one or more family members need to be terminated, but one or more will remain enrolled.

Section I

NOTE: Incomplete information on this authorization will delay your enrollment.

Sponsor Name – Last Name _____ MI ____ First Name _____
Sponsor SSN or DBN _____ Date of Birth (*mm/dd/yy*) _____ Gender ☐ M ☐ F
Home Address _____ City _____ State ____ Zip Code _____
Country _____ Home Phone _____ E-mail Address _____
Sponsor's Military Status ☐ Active Duty* ☐ AGR* ☐ SELRES ☐ IRR
*If Active Duty or AGR, you may only enroll eligible family members, not yourself.
Please indicate if you intend to remain in the service for at least 12 months. ☐Yes ☐No
(*If no, you will not be enrolled.*) (*See Section I on page 1 for "Notice of Intent."*)

Section II

NOTE: National Guard and Reserve sponsors and their family members will be enrolled to separate contracts, but may enroll on a single Enrollment/Change Authorization.

ALL ELIGIBLE FAMILY MEMBERS, AGE FOUR OR OLDER, RESIDING AT THE SAME ADDRESS, MUST BE ENROLLED IF ANY ONE OF THEM IS ENROLLED. PLEASE LIST ALL FAMILY MEMBERS TO WHOM THIS ENROLLMENT/CHANGE PERTAINS.
If you are a National Guard and Reserve sponsor, to whom does this enrollment/change request pertain?
☐ Sponsor only ☐ Family only ☐ Sponsor and family

Spouse – Last Name	First Name	Gender	Date of Birth (*mm/dd/yy*)	Address (*if different than Sponsor's*)
		☐M ☐F		
Family Member – Last Name	First Name	Gender	Date of Birth (*mm/dd/yy*)	Address (*if different than Sponsor's*)
		☐M ☐F		
		☐M ☐F		
		☐M ☐F		
		☐M ☐F		

Please list additional family member(s) on a separate sheet and attach to the enrollment authorization.

Section III

Desired End Date _____ Reason for Termination _____ (*see values listed in Section III on page 1*)
If other, please explain _____

Section IV

Desired Enrollment Start Date _____ Amount of Initial Payment (*see Section IV on page 1*) _____
Method of Initial Payment
☐ Check or money order ☐ Visa® ☐ MasterCard® ☐ American Express ☐ Discover
Credit Card Number _____ Expiration Date (*mm/yy*) _____ Security Code _____
▶ Authorized Signature _____ Name of card holder (*As it appears on credit card*) _____

Section IV (*continued*)

Recurring Payments

Note: Payroll allotment is required for active duty personnel and will be automatically established.

☐ Payroll Allotment (*for other than active duty, when coverage and pay duty status permits*)
☐ EFT

Routing Number _____ Account Number _____

Name(s) on the Account _____

Bank Name _____

Bank Branch Address _____

▶ Signature(s) from all account holders _____

☐ Visa® ☐ MasterCard® ☐ American Express ☐ Discover

Credit Card Number _____ Expiration Date (*mm/yy*) _____ Security Code _____

▶ Authorized Signature _____

Name of card holder (*As it appears on credit card*) _____

Section V

1. Do you or your family member(s) have other dental insurance? ☐ Yes ☐ No

   If yes, please complete the following information:

   Policy Holder _____ Effective Date of Policy (*mm/dd/yy*) _____

   Insurance Company _____ Policy Number _____

   Please list family members covered under this policy _____

   Group Plan Name _____

   Group Employer Name _____ Group Employer Phone _____

   Insurance Company Contact Name _____ Contact Phone Number _____

   Insurance Company Address _____

   Company Phone Number _____

2. Is your spouse a uniformed services member? ☐ Yes ☐ No If yes, spouse's SSN or DBN _____

Section VI

This is my application for coverage, or change to coverage, under the TRICARE Dental Program. I authorize monthly deductions of required premiums from my earnings if my coverage and pay status permit payroll deduction. I understand and agree that IRR sponsors and Selected Reserve and IRR family members will be billed directly for the cost of coverage. I understand that enrollment is subject to verification of eligibility and receipt of one month's premium payment. I understand that coverage does not begin upon deposit of my initial premium payment. For applications received by the 20th of each month, coverage will become effective the first day of the next month. For applications received after the 20th of each month, coverage will not become effective until the first day of the second month. I must remain enrolled for a minimum of 12 months. Termination is not automatic upon fulfillment of this period and must be initiated by the sponsor. I understand that I am responsible for full payment of any dental services provided prior to the effective date or after the termination date of the policy.

▶ Sponsor's Signature: _____ Date: _____