

**TRICARE PRIME ENROLLMENT APPLICATION AND  
PCM CHANGE FORM**

*(Please read Agency Disclosure Notice, Privacy Act Statement, and  
Instructions before completing this form.)*

*Form Approved  
OMB No. 0720-0008  
Expires Jan 31, 2007*

**AGENCY DISCLOSURE NOTICE**

The public reporting burden for this collection of information is estimated to average 15 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, Executive Services and Communications Directorate (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 APPLICATION TO THE ABOVE  
ORGANIZATION.  
SEND YOUR APPLICATION TO THE ADDRESS SHOWN ON THE  
APPLICATION INSTRUCTION SHEET.**

**PRIVACY ACT STATEMENT**

**AUTHORITY:** 5 U.S.C. 552a, 10 U.S.C. 1079 and 1086, 58 FR 45318, 65 FR 30966, May15, 2000.

**PRINCIPAL PURPOSE(S):** To evaluate eligibility for medical care provided by civilian sources to Military Health Services System beneficiaries applying for coverage under the TRICARE Program (32 CFR 199.17).

**ROUTINE USE(S):** Information from application forms and related documents may be given to the Department of Health and Human Services, and/or the Department of Transportation 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 will result in the denial of enrollment.

## TRICARE PRIME ENROLLMENT APPLICATION AND PCM CHANGE FORM

This form is for the following:

- Eligible beneficiaries who want to enroll in TRICARE Prime, TRICARE Prime Remote (TPR), or US Family Health Plan.
- Portability transfers to a new region for the TRICARE program listed above.
- Address changes within the same region for the TRICARE program listed above.
- Primary Care Manager (PCM) changes as follows: Within the same Military Treatment Facility (MTF)/Clinic, to an MTF/Clinic, or to a civilian PCM.

Review the eligible categories (1 through 5) below to determine the application sections you must complete.

ELIGIBLE CATEGORIES	SECTION I Sponsor Information	SECTION II Enrolling Family Members	SECTION III Other Health Insurance	SECTION IV Reason for PCM Change	SECTION V Signature	SECTION VI Enrollment Fee Payment
1. Active Duty Members, Reserve Component Members called or ordered to active duty for 30 days or more.	X			Complete if changing PCM		
2. Active Duty Family Members (ADFM) and Survivors of Active Duty (first three years in survivor status).	X	X	X	Complete if changing PCM	X	
3. Active Duty Family Members of Reserve Component Members called or ordered to active duty for 31 days or more. Must be eligible in DEERS.	X	X	X	Complete if changing PCM	X	
4. Retirees, retiree family members, survivors, and eligible former spouses under 65 years of age who reside within the 50 United States or the District of Columbia. <b>This excludes beneficiaries over the age of 65 who are eligible for TRICARE Prime.</b>	X	X	X	Complete if changing PCM	X	X <i>(Must include required payment)</i>
5. ADFMs, Retirees, retired family members, survivors and eligible former spouses 65 years or older and entitled to Medicare Part A. <b>(Applicable only to US Family Health Plan.)</b>	X	X	X	Complete if changing PCM	X	X <i>(If not enrolled in Medicare Part B)</i>

## GENERAL INSTRUCTIONS

1. **TRICARE Prime** - Active duty service members are required to enroll in Prime. Active duty family members, retirees and their family members are encouraged, but not required, to enroll in Prime.
2. **TRICARE Prime Remote (TPR)** is a program for active duty service members and their family members when the sponsor lives and works over 50 miles or one hour drive from a Military Treatment Facility (MTF) and the family member lives with the sponsor.
3. Families with more than three members need multiple copies of page 6.
4. Print all information in ink. Make sure the information is complete and accurate.
5. Ensure personal and family information matches information in the Defense Enrollment Eligibility Reporting System (DEERS). To check your DEERS information, call the Defense Manpower Data Center (DMDC) Support Office at 1-800-538-9552 and refer to your name as printed on your military ID card.

**If you are an unremarried former spouse, please remember to use your personal SSN as the sponsor number.**

6. There are two address fields for the sponsor and each family member. The Residence address block should be completed if it is known. If you haven't established a residence at the time you are completing this form, insert "To be determined." in the Residence address block and complete the Mailing address block. The Mailing address block is only to be completed if mail is to be sent to an address other than the Residence address. If the Mailing address block is blank, all mail will be sent to the Residence address. The addresses and telephone numbers you include on this form will update DEERS.

**It is very important that you update your personal information in DEERS whenever your residence address, mailing address, telephone number or Medicare status changes. Please see instruction 5 above.**

7. Sign and date the application (Section VI).

**8. Please keep a copy of the completed TRICARE Prime Application/PCM Change Form for your records.**

**Enrollment in TRICARE Prime requires that all services, except for emergencies, must be coordinated through the PCM. If not, the beneficiary will be responsible for payment of charges in accordance with the Point-of-Service (POS) option as described in the TRICARE Beneficiary Handbook.**

## GENERAL INSTRUCTIONS *(Continued)*

9. **US Family Health Plan** is a TRICARE Prime enrollment option for eligible individuals and families who live in seven specific parts of the country: Seattle, Washington; Cleveland, Ohio; Portland, Maine; Brighton, Massachusetts; Staten Island, New York; Baltimore, Maryland; and Houston, Texas. The primary difference between other TRICARE options and the US Family Health Plan is that US Family Health Plan may be used by uniformed service retirees and their eligible family members who are age 65 or older.

10. For enrollment or PCM changes in the **US Family Health Plan**, submit the completed Application/PCM Change Form to the US Family Health Plan address listed below. For questions regarding enrollment/PCM changes in the US Family Health Plan, contact the US Family Health Plan member services at:

*US Family Health Plan  
Enrollment Management, Dept. 4568  
P.O. Box 34936  
Seattle, WA 98124-1936  
1-888-958-7347, option 1*

## MAILING INSTRUCTIONS

1. Submit the completed Application/PCM Change Form to the address below. For enrollment or PCM changes in the US Family Health Plan please see instruction 10 above.

***TriWest Healthcare Alliance  
P.O. Box 43590  
Phoenix, Arizona 85080-3590***

**Applications can be mailed to the contractor identified above or dropped off at a TRICARE Service Center (TSC).** Contact the local TSC in person or call the telephone number listed below in instruction 3 to determine when your new or transferred enrollment will begin.

2. For additional information on TRICARE, contact the local TRICARE Service Center (TSC) or visit the TMA website at [www.tricare.osd.mil](http://www.tricare.osd.mil).

3. For enrollment assistance, please call ***TriWest Healthcare Alliance*** at ***1-888-TRIWEST (1-888-874-9378)***.

## PAY INSTRUCTIONS

1. If you have elected monthly allotment from retired pay as the payment method for your TRICARE Prime enrollment fees, you must complete an allotment authorization letter provided. If you select this type of payment, you must make the first quarterly payment by check at the time of application.

2. If you elected electronic funds transfer (EFT) as the payment method for your TRICARE Prime enrollment fees, ensure you provide your banking information in Section VI, Part B of the enrollment application form. If you select this type of payment, you must make the first quarterly payment by check at the time of application.

3. If you elected credit card as the method for your TRICARE Prime enrollment, ensure you provide your credit card information in Section VI, Part C of the enrollment application form. If you select this type of payment, these payments are made either quarterly or annually.

## TRICARE PRIME ENROLLMENT APPLICATION AND PCM CHANGE FORM

*(Please read Agency Disclosure Notice, Privacy Act Statement, and  
Instructions before completing this form.)*

<b>X</b>	<b>one:</b>	<input type="checkbox"/> Prime Enrollment	<input type="checkbox"/> Prime Remote Enrollment	<input type="checkbox"/> US Family Health Plan Enrollment	<input type="checkbox"/> PCM Change	
SECTION I - SPONSOR INFORMATION	1. SPONSOR SOCIAL SECURITY NUMBER (SSN)					
	2. SPONSOR NAME <i>(Last, First, Middle Initial) (Must match DEERS)</i>					
	3. SPONSOR DATE OF BIRTH <i>(YYYYMMDD)</i>					
	4. SPONSOR IS: <i>(X one)</i>		<input type="checkbox"/> Active Duty	<input type="checkbox"/> Retired		
			<input type="checkbox"/> Deceased <i>(Go to Section II.)</i>	<input type="checkbox"/> Former Spouse		
	5. RESIDENCE ADDRESS <i>(Street/P.O. Box, Apartment No., City, State, ZIP Code)</i>					
	6. MAILING ADDRESS <i>(If different from residence address)</i>					
	7. SPONSOR TELEPHONE NUMBERS <i>(Include Area Code)</i>		a. HOME		b. WORK	
	8. CITY AND COUNTRY OF MILITARY ASSIGNMENT <i>(OCONUS only)</i>					
	9. MEMBER'S UNIT AND UNIT IDENTIFICATION CODE (UIC) <i>(If known)</i>					
	10. ZIP CODE OF WORK ADDRESS					
	11. E-MAIL ADDRESS					
	12. SPONSOR'S ACTION <i>(X one)</i>		<input type="checkbox"/> New Enrollment	<input type="checkbox"/> PCM Change	<input type="checkbox"/> None	
13. SPONSOR PRIMARY CARE MANAGER (PCM) PREFERENCE <i>(Honoring your preference depends upon availability and local Military Treatment Facility (MTF) policy. Contact your TRICARE Service Center, preferred MTF, or US Family Health Plan Member Services for availability of PCMs.) (Complete all that apply.)</i>						
a. PCM NAME MTF/CLINIC <i>(If known)</i>		1st CHOICE				
		2nd CHOICE				
b. PCM SPECIALTY		<input type="checkbox"/> No Preference	<input type="checkbox"/> Flight Medicine			
		<input type="checkbox"/> Family/General Practice	<input type="checkbox"/> Internal Medicine			
c. PREFERRED PCM GENDER		<input type="checkbox"/> No Preference	<input type="checkbox"/> Male	<input type="checkbox"/> Female		

## TRICARE PRIME ENROLLMENT APPLICATION AND PCM CHANGE FORM

*(Please read Agency Disclosure Notice, Privacy Act Statement, and  
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<b>X</b>		Prime Enrollment		Prime Remote Enrollment		US Family Health Plan Enrollment		PCM Change	
SECTION I - SPONSOR INFORMATION	1. SPONSOR SOCIAL SECURITY NUMBER (SSN)								
	2. SPONSOR NAME <i>(Last, First, Middle Initial) (Must match DEERS)</i>								
	3. SPONSOR DATE OF BIRTH <i>(YYYYMMDD)</i>								
	4. SPONSOR IS: <i>(X one)</i>		Active Duty			Retired			
			Deceased <i>(Go to Section II.)</i>			Former Spouse			
	5. RESIDENCE ADDRESS <i>(Street/P.O. Box, Apartment No., City, State, ZIP Code)</i>								
	6. MAILING ADDRESS <i>(If different from residence address)</i>								
	7. SPONSOR TELEPHONE NUMBERS <i>(Include Area Code)</i>				a. HOME		b. WORK		
	8. CITY AND COUNTRY OF MILITARY ASSIGNMENT <i>(OCONUS only)</i>								
	9. MEMBER'S UNIT AND UNIT IDENTIFICATION CODE (UIC) <i>(If known)</i>								
	10. ZIP CODE OF WORK ADDRESS								
	11. E-MAIL ADDRESS								
	12. SPONSOR'S ACTION <i>(X one)</i>		New Enrollment			PCM Change		None	
13. SPONSOR PRIMARY CARE MANAGER (PCM) PREFERENCE <i>(Honoring your preference depends upon availability and local Military Treatment Facility (MTF) policy. Contact your TRICARE Service Center, preferred MTF, or US Family Health Plan Member Services for availability of PCMs.) (Complete all that apply.)</i>									
a. PCM NAME MTF/CLINIC <i>(If known)</i>		1st CHOICE							
		2nd CHOICE							
b. PCM SPECIALTY		No Preference			Flight Medicine				
		Family/General Practice			Internal Medicine				
c. PREFERRED PCM GENDER		No Preference			Male		Female		

SPONSOR SOCIAL SECURITY NUMBER										
SPONSOR NAME <i>(Last, First, Middle Initial) (Must match DEERS)</i>										
SECTION II – ENROLLING FAMILY MEMBER INFORMATION <i>(Use additional copies of this page to continue as necessary)</i>	a. FAMILY MEMBER NAME <i>(Last, First, Middle Initial) (Must match DEERS)</i>									
	b. DATE OF BIRTH <i>(YYYYMMDD)</i>									
	c. RESIDENCE ADDRESS <i>(Street/P.O. Box, Apartment No., City, State, ZIP Code)</i>									
	Same as Sponsor									
	d. MAILING ADDRESS <i>(If different from residence address)</i>									
	Same as Sponsor									
	e. RELATIONSHIP TO SPONSOR			<input type="checkbox"/> Spouse		<input type="checkbox"/> Former Spouse		<input type="checkbox"/> Child		
	f. TELEPHONE NUMBERS <i>(Include Area Code)</i>			(1) HOME			(2) WORK			
	g. PRIMARY CARE MANAGER (PCM) PREFERENCE <i>(Honoring your preferences depends upon availability and local MTF policy. Contact your TRICARE Service Center, preferred MTF or US Family Health Plan Member service for availability of PCMs.) (Complete all that apply.)</i>									
	(1) PCM NAME MTF/CLINIC <i>(If known)</i>		1st CHOICE							
			<input type="checkbox"/> Same as Sponsor							
	(2) PCM SPECIALTY		2nd CHOICE							
			<input type="checkbox"/> Same as Sponsor							
	(3) PREFERRED PCM GENDER		<input type="checkbox"/> No Preference		<input type="checkbox"/> Flight Medicine		<input type="checkbox"/> Pediatrics			
			<input type="checkbox"/> Family/General Practice		<input type="checkbox"/> Internal Medicine					
	(3) PREFERRED PCM GENDER		<input type="checkbox"/> No Preference		<input type="checkbox"/> Male		<input type="checkbox"/> Female			
	a. FAMILY MEMBER NAME <i>(Last, First, Middle Initial) (Must match DEERS)</i>									
	b. DATE OF BIRTH <i>(YYYYMMDD)</i>									
	c. RESIDENCE ADDRESS <i>(Street/P.O. Box, Apartment No., City, State, ZIP Code)</i>									
Same as Sponsor										
d. MAILING ADDRESS <i>(If different from residence address)</i>										
Same as Sponsor										
e. RELATIONSHIP TO SPONSOR			<input type="checkbox"/> Spouse		<input type="checkbox"/> Former Spouse		<input type="checkbox"/> Child			
f. TELEPHONE NUMBERS <i>(Include Area Code)</i>			(1) HOME			(2) WORK				
g. PRIMARY CARE MANAGER (PCM) PREFERENCE <i>(Honoring your preferences depends upon availability and local MTF policy. Contact your TRICARE Service Center, preferred MTF or US Family Health Plan Member service for availability of PCMs.) (Complete all that apply.)</i>										
(1) PCM NAME MTF/CLINIC <i>(If known)</i>		1st CHOICE								
		<input type="checkbox"/> Same as Sponsor								
(2) PCM SPECIALTY		2nd CHOICE								
		<input type="checkbox"/> Same as Sponsor								
(3) PREFERRED PCM GENDER		<input type="checkbox"/> No Preference		<input type="checkbox"/> Flight Medicine		<input type="checkbox"/> Pediatrics				
		<input type="checkbox"/> Family/General Practice		<input type="checkbox"/> Internal Medicine						
(3) PREFERRED PCM GENDER		<input type="checkbox"/> No Preference		<input type="checkbox"/> Male		<input type="checkbox"/> Female				

SPONSOR SOCIAL SECURITY NUMBER										
SPONSOR NAME <i>(Last, First, Middle Initial) (Must match DEERS)</i>										
SECTION II – ENROLLING FAMILY MEMBER INFORMATION <i>(Use additional copies of this page to continue as necessary)</i>	a. FAMILY MEMBER NAME <i>(Last, First, Middle Initial) (Must match DEERS)</i>									
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	Same as Sponsor									
	d. MAILING ADDRESS <i>(If different from residence address)</i>									
	Same as Sponsor									
	e. RELATIONSHIP TO SPONSOR			<input type="checkbox"/> Spouse		<input type="checkbox"/> Former Spouse		<input type="checkbox"/> Child		
	f. TELEPHONE NUMBERS <i>(Include Area Code)</i>			(1) HOME			(2) WORK			
	g. PRIMARY CARE MANAGER (PCM) PREFERENCE <i>(Honoring your preferences depends upon availability and local MTF policy. Contact your TRICARE Service Center, preferred MTF or US Family Health Plan Member service for availability of PCMs.) (Complete all that apply.)</i>									
	(1) PCM NAME MTF/CLINIC <i>(If known)</i>		1st CHOICE							
			<input type="checkbox"/> Same as Sponsor							
	(2) PCM SPECIALTY		2nd CHOICE							
			<input type="checkbox"/> Same as Sponsor							
	(3) PREFERRED PCM GENDER		<input type="checkbox"/> No Preference		<input type="checkbox"/> Flight Medicine		<input type="checkbox"/> Pediatrics			
			<input type="checkbox"/> Family/General Practice		<input type="checkbox"/> Internal Medicine					
	(3) PREFERRED PCM GENDER		<input type="checkbox"/> No Preference		<input type="checkbox"/> Male		<input type="checkbox"/> Female			
	a. FAMILY MEMBER NAME <i>(Last, First, Middle Initial) (Must match DEERS)</i>									
	b. DATE OF BIRTH <i>(YYYYMMDD)</i>									
	c. RESIDENCE ADDRESS <i>(Street/P.O. Box, Apartment No., City, State, ZIP Code)</i>									
Same as Sponsor										
d. MAILING ADDRESS <i>(If different from residence address)</i>										
Same as Sponsor										
e. RELATIONSHIP TO SPONSOR			<input type="checkbox"/> Spouse		<input type="checkbox"/> Former Spouse		<input type="checkbox"/> Child			
f. TELEPHONE NUMBERS <i>(Include Area Code)</i>			(1) HOME			(2) WORK				
g. PRIMARY CARE MANAGER (PCM) PREFERENCE <i>(Honoring your preferences depends upon availability and local MTF policy. Contact your TRICARE Service Center, preferred MTF or US Family Health Plan Member service for availability of PCMs.) (Complete all that apply.)</i>										
(1) PCM NAME MTF/CLINIC <i>(If known)</i>		1st CHOICE								
		<input type="checkbox"/> Same as Sponsor								
(2) PCM SPECIALTY		2nd CHOICE								
		<input type="checkbox"/> Same as Sponsor								
(3) PREFERRED PCM GENDER		<input type="checkbox"/> No Preference		<input type="checkbox"/> Flight Medicine		<input type="checkbox"/> Pediatrics				
		<input type="checkbox"/> Family/General Practice		<input type="checkbox"/> Internal Medicine						
(3) PREFERRED PCM GENDER		<input type="checkbox"/> No Preference		<input type="checkbox"/> Male		<input type="checkbox"/> Female				



SPONSOR SOCIAL SECURITY NUMBER

SPONSOR NAME *(Last, First, Middle Initial) (Must match DEERS)*

<b>SECTION III</b>	1. IS THE RETIREE OR ARE ANY RETIREE FAMILY MEMBERS ELIGIBLE FOR MEDICARE BASED ON DISABILITY OR END STAGE RENAL DISEASE?	<input type="checkbox"/>	Yes
		<input type="checkbox"/>	No
	If Yes, provide a copy of the Medicare card for each family member that is under the age of 65 and entitled to Medicare.		
	2. ARE ANY ENROLLING FAMILY MEMBERS OR IS THE RETIREE CURRENTLY COVERED BY OTHER HEALTH INSURANCE <i>(not a TRICARE Supplement)?</i>	<input type="checkbox"/>	Yes
	<input type="checkbox"/>	No	
If Yes, provide the name of the other health insurance and the insurance identification number:			

<b>SECTION IV - REASON FOR PCM CHANGE</b>	REASON FOR CHANGE <i>(X one per affected family member)</i>		
	Name	<input type="checkbox"/>	Move
		<input type="checkbox"/>	Other <i>(Explain)</i>
	Name	<input type="checkbox"/>	Move
		<input type="checkbox"/>	Other <i>(Explain)</i>
Name	<input type="checkbox"/>	Move	
	<input type="checkbox"/>	Other <i>(Explain)</i>	
Name	<input type="checkbox"/>	Move	
	<input type="checkbox"/>	Other <i>(Explain)</i>	

**SECTION V - ACCESS WAIVER**

**Please read and sign only if you are outside the service area.**  
 Your enrollment application indicates that your current address is outside the service area. You may travel to a location where there is a provider network and enroll at that location. However, since you live outside the service area, by signing below, you indicate that your travel time to the network of primary care delivery sites may exceed 30 minutes from your home to the delivery site and your travel time for specialty care may exceed one hour.

<b>SECTION V - ACCESS WAIVER</b>	SIGNATURE OF SPONSOR, SPOUSE, OR OTHER LEGAL GUARDIAN OF BENEFICIARY	DATE SIGNED (YYYYMMDD)

**SECTION VI - SIGNATURE**

I understand that it is my responsibility to comply with all TRICARE Prime procedures. By signing the 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.

<b>SECTION VI - SIGNATURE</b>	SIGNATURE OF SPONSOR, SPOUSE, OR OTHER LEGAL GUARDIAN OF BENEFICIARY	DATE SIGNED (YYYYMMDD)

SPONSOR SOCIAL SECURITY NUMBER					
SPONSOR NAME <i>(Last, First, Middle Initial) (Must match DEERS)</i>					
SECTION III	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 85%; padding: 5px;">1. IS THE RETIREE OR ARE ANY RETIREE FAMILY MEMBERS ELIGIBLE FOR MEDICARE BASED ON DISABILITY OR END STAGE RENAL DISEASE?</td> <td style="width: 15%; text-align: center; padding: 5px;"><input type="checkbox"/> Yes</td> </tr> <tr> <td style="padding: 5px;"></td> <td style="text-align: center; padding: 5px;"><input type="checkbox"/> No</td> </tr> </table> <p style="padding: 5px;">If Yes, provide a copy of the Medicare card for each family member that is under the age of 65 and entitled to Medicare.</p>	1. IS THE RETIREE OR ARE ANY RETIREE FAMILY MEMBERS ELIGIBLE FOR MEDICARE BASED ON DISABILITY OR END STAGE RENAL DISEASE?	<input type="checkbox"/> Yes		<input type="checkbox"/> No
	1. IS THE RETIREE OR ARE ANY RETIREE FAMILY MEMBERS ELIGIBLE FOR MEDICARE BASED ON DISABILITY OR END STAGE RENAL DISEASE?	<input type="checkbox"/> Yes			
		<input type="checkbox"/> No			
	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 85%; padding: 5px;">2. ARE ANY ENROLLING FAMILY MEMBERS OR IS THE RETIREE CURRENTLY COVERED BY OTHER HEALTH INSURANCE <i>(not a TRICARE Supplement)</i>?</td> <td style="width: 15%; text-align: center; padding: 5px;"><input type="checkbox"/> Yes</td> </tr> <tr> <td style="padding: 5px;"></td> <td style="text-align: center; padding: 5px;"><input type="checkbox"/> No</td> </tr> </table> <p style="padding: 5px;">If Yes, provide the name of the other health insurance and the insurance identification number:</p>	2. ARE ANY ENROLLING FAMILY MEMBERS OR IS THE RETIREE CURRENTLY COVERED BY OTHER HEALTH INSURANCE <i>(not a TRICARE Supplement)</i> ?	<input type="checkbox"/> Yes		<input type="checkbox"/> No
2. ARE ANY ENROLLING FAMILY MEMBERS OR IS THE RETIREE CURRENTLY COVERED BY OTHER HEALTH INSURANCE <i>(not a TRICARE Supplement)</i> ?	<input type="checkbox"/> Yes				
	<input type="checkbox"/> No				
SECTION IV – REASON FOR PCM CHANGE	REASON FOR CHANGE <i>(X one per affected family member)</i>				
	Name <input type="checkbox"/> Move <input type="checkbox"/> Other <i>(Explain)</i>				
	Name <input type="checkbox"/> Move <input type="checkbox"/> Other <i>(Explain)</i>				
	Name <input type="checkbox"/> Move <input type="checkbox"/> Other <i>(Explain)</i>				
	Name <input type="checkbox"/> Move <input type="checkbox"/> Other <i>(Explain)</i>				
SECTION V – ACCESS WAIVER	<p><b>Please read and sign only if you are outside the service area.</b> Your enrollment application indicates that your current address is outside the service area. You may travel to a location where there is a provider network and enroll at that location. However, since you live outside the service area, by signing below, you indicate that your travel time to the network of primary care delivery sites may exceed 30 minutes from your home to the delivery site and your travel time for specialty care may exceed one hour.</p>				
	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 70%; padding: 5px;">SIGNATURE OF SPONSOR, SPOUSE, OR OTHER LEGAL GUARDIAN OF BENEFICIARY</td> <td style="width: 30%; padding: 5px;">DATE SIGNED <i>(YYYYMMDD)</i></td> </tr> </table>	SIGNATURE OF SPONSOR, SPOUSE, OR OTHER LEGAL GUARDIAN OF BENEFICIARY	DATE SIGNED <i>(YYYYMMDD)</i>		
SIGNATURE OF SPONSOR, SPOUSE, OR OTHER LEGAL GUARDIAN OF BENEFICIARY	DATE SIGNED <i>(YYYYMMDD)</i>				
SECTION VI – SIGNATURE	<p>I understand that it is my responsibility to comply with all TRICARE Prime procedures. By signing the 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.</p>				
	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 70%; padding: 5px;">SIGNATURE OF SPONSOR, SPOUSE, OR OTHER LEGAL GUARDIAN OF BENEFICIARY</td> <td style="width: 30%; padding: 5px;">DATE SIGNED <i>(YYYYMMDD)</i></td> </tr> </table>	SIGNATURE OF SPONSOR, SPOUSE, OR OTHER LEGAL GUARDIAN OF BENEFICIARY	DATE SIGNED <i>(YYYYMMDD)</i>		
SIGNATURE OF SPONSOR, SPOUSE, OR OTHER LEGAL GUARDIAN OF BENEFICIARY	DATE SIGNED <i>(YYYYMMDD)</i>				

SPONSOR SOCIAL SECURITY NUMBER

SPONSOR NAME (Last, First, Middle Initial) (Must match DEERS)

**SECTION VII - PAYMENT OF TRICARE PRIME ENROLLMENT FEES**

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

1. Retired beneficiaries and retiree family members entitled to Medicare Part A and Medicare Part B must be enrolled in Medicare Part B to be eligible for enrollment in TRICARE prime. TRICARE enrollment fees are waived for these retirees and retiree family members if they provide a copy of their Medicare card as proof of entitlement to Medicare Part A and B and DEERS reflects their entitlement to Medicare Part A and B.

2. Explain all split enrollments (retiree family enrollment in more than one TRICARE Region) on a separate sheet of paper.

1. PAYMENT FEE OPTIONS	MONTHLY	QUARTERLY	ANNUAL
2. PLAN SELECTION (X one)	Single \$19.17	Single \$57.50	Single \$230.00
	Family \$38.34	Family \$115.00	Family \$460.00
3. PAYMENT METHOD (X one)	a. Allotment From Retired Pay (Complete A below)	a. Check/Cashiers Check/Money Order*	a. Check/Cashiers Check/Money Order*
	b. Electronic Funds Transfer (Complete B below)	b. VISA or Master Card (Complete C below)	b. VISA or Master Card (Complete C below)

If you have elected a monthly payment option (Allotment or Electronic Funds Transfer) please see Pay Instructions on Page 4 for further details regarding establishing monthly payments. If you have elected Monthly Allotment or Electronic Funds Transfer, the first quarterly payment is due at the time of application.

**NOTE: Quarterly and annual bills will be sent on a quarterly and annual basis, respectively. Monthly bills will not be sent.**

\*Make check payable to TriWest

<b>MONTHLY ALLOTMENT</b>	A	I, _____ choose to have my enrollment fees paid by monthly allotment from my Uniformed Services retired pay. <i>(Signature of sponsor)</i>
	<b>NOTE: Only retired Uniformed Services members may establish an allotment from their retired pay. Follow instructions on Premium Allotment Authorization letter and submit as directed.</b>	

<b>ELECTRONIC FUNDS TRANSFER</b>	B	I, _____ choose to have my enrollment fees paid by electronic funds transfer. <i>(Signature of account holder)</i>
	(1) NAME AND ADDRESS OF FINANCIAL INSTITUTION	
	(2) TELEPHONE NUMBER OF FINANCIAL INSTITUTION <i>(Include Area Code)</i>	
	(3) ACCOUNT INFORMATION (X)	Savings <input type="checkbox"/> Checking <input type="checkbox"/> <i>(Attach voided check)</i>
	(4) ACCOUNT NUMBER	
	(5) BANK OR ABA ROUTING NUMBER	
(6) NAME ON ACCOUNT		

<b>CREDIT CARD</b>	C	I, _____ choose to have my initial enrollment fees billed to my credit card. <i>(Annual and Quarterly initial payments only)</i> <i>(Signature of card holder)</i>
	(1) NAME ON CREDIT CARD	
	(2) CREDIT CARD NUMBER AND EXPIRATION DATE (MMYY)	
	(3) TYPE OF CARD (X)	VISA <input type="checkbox"/> Master Card <input type="checkbox"/>

SPONSOR SOCIAL SECURITY NUMBER

SPONSOR NAME (Last, First, Middle Initial) (Must match DEERS)

SECTION VII - PAYMENT OF TRICARE PRIME ENROLLMENT FEES

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

1. Retired beneficiaries and retiree family members entitled to Medicare Part A and Medicare Part B must be enrolled in Medicare Part B to be eligible for enrollment in TRICARE prime. TRICARE enrollment fees are waived for these retirees and retiree family members if they provide a copy of their Medicare card as proof of entitlement to Medicare Part A and B and DEERS reflects their entitlement to Medicare Part A and B.

2. Explain all split enrollments (retiree family enrollment in more than one TRICARE Region) on a separate sheet of paper.

Table with 4 columns: 1. PAYMENT FEE OPTIONS, MONTHLY, QUARTERLY, ANNUAL. Rows include PLAN SELECTION (Single/Family) and PAYMENT METHOD (Allotment/Check/Money Order/VISA/Master Card).

If you have elected a monthly payment option (Allotment or Electronic Funds Transfer) please see Pay Instructions on Page 4 for further details regarding establishing monthly payments. If you have elected Monthly Allotment or Electronic Funds Transfer, the first quarterly payment is due at the time of application.

NOTE: Quarterly and annual bills will be sent on a quarterly and annual basis, respectively. Monthly bills will not be sent.

\*Make check payable to the (Contractor's Name)

Section A: MONTHLY ALLOTMENT. Includes signature line for sponsor and a note: NOTE: Only retired Uniformed Services members may establish an allotment from their retired pay. Follow instructions on Premium Allotment Authorization letter and submit as directed.

Section B: ELECTRONIC FUNDS TRANSFER. Includes signature line for account holder and numbered fields for financial institution name, telephone number, account information, account number, bank routing number, and name on account.

Section C: CREDIT CARD. Includes signature line for card holder and numbered fields for name on credit card, credit card number and expiration date, and type of card (VISA or Master Card).