(Updated 20250509)

CONTINUED HEALTH CARE BENEFIT PROGRAM (CHCBP) APPLICATION

OMB No. 0720-0066
OMB approval expires 20261031

PLEASE DO NOT RETURN YOUR APPLICATION TO THE ABOVE ORGANIZATION. RETURN COMPLETED APPLICATION WITH PREMIUM PAYMENT TO: Humana Military Healthcare Services, Inc., Attn: CHCBP, P.O. Box 740072, Louisville, KY 40201.

PRIVACY ACT STATEMENT

This statement serves to inform you of the purpose for collecting the personal information required by DD Form 2837, Continued Health Care Benefit Program (CHCBP) Application, and how it will be used.

AUTHORITY: 10 U.S.C. 136, Under Secretary of Defense for Personnel and Readiness; 10 U.S.C. Chapter 55, Medical and Dental Care; 32 CFR Part 199, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS); and E.O. 9397 (SSN), as amended.

PURPOSE: To collect information necessary to determine eligibility for individual or family coverage under the Continued Health Care Benefit Program (CHCBP).

ROUTINE USE(S): Use and disclosure of your records outside of DoD may occur in accordance with the Privacy Act of 1974, as amended (5 U.S.C. 552a(b)). Collected information may be shared with entities including the Departments of Health and Human Services, Veterans Affairs, and other Federal, State, local, or foreign government agencies, or authorized private business entities. Additionally, information will be shared with the CHCBP contractor for determination of eligibility and to provide temporary health care coverage. Any protected health information (PHI) in your records may be used and disclosed generally as permitted by the HIPAA Privacy Rule (45 CFR Parts 160 and 164), as implemented within DoD. Permitted uses and disclosures of PHI include, but are not limited to, treatment, payment, healthcare operations, and the containment of certain communicable diseases. For a full listing of the applicable Routine Uses for this system, refer to the applicable SORN.

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

DISCLOSURE: Voluntary. However, failure to provide all requested information may result in denial of your request to enroll in or change your CHCBP health plan coverage.

SECTION I - APPLICANT INFORMATION

1. NAME *(Last, First, Middle Initial)*	**2. TELEPHONE NO.** *(Include Area Code)*
3. RESIDENCE ADDRESS *(Street, Apartment No., City, State, ZIP Code)*	**4. MAILING ADDRESS** *(If different from Residence Address)*

5. E-MAIL ADDRESS ☐ **X BOX TO RECEIVE BENEFIT RELATED E-MAILS**

SECTION II - SPONSOR INFORMATION

6. NAME *(Last, First, Middle Initial)*	**7. DOD BENEFITS NUMBER (DBN) (XXXXXXXXX-XX) OR SOCIAL SECURITY NUMBER (SSN) (XXX-XX-XXXX)**

SECTION III - PERSON(S) TO BE ENROLLED IN CHCBP *(Including Applicant)*

	8.a. NAME *(Last, First, Middle Initial)*	8.b. DBN OR SSN OF INDIVIDUAL	8.c. DATE OF BIRTH *(YYYYMMDD)*	8.d. SEX *(M or F)*
If applying for **Family** coverage, complete below. Sponsor must enroll.				
SPONSOR				☐ M ☐ F
DEPENDENTS				☐ M ☐ F
				☐ M ☐ F
				☐ M ☐ F
				☐ M ☐ F
				☐ M ☐ F
				☐ M ☐ F
				☐ M ☐ F
If applying for **Individual** coverage, complete appropriate line below:				
SPONSOR				☐ M ☐ F
SPOUSE				☐ M ☐ F
FORMER SPOUSE *(Submit copy of final divorce decree)*				☐ M ☐ F
CHILD				☐ M ☐ F
OTHER				☐ M ☐ F

9 . TOTAL THREE-MONTH PREMIUM ENCLOSED: *(See www.tricare.mil/chcbp)*

$ _____ **PREMIUM PAID IS FOR:** ☐ **INDIVIDUAL COVERAGE** ☐ **FAMILY COVERAGE**

PAID BY: ☐ **CHECK** ☐ **MONEY ORDER** *(Check/money order payable to the United States Treasury)* ☐ **Credit/Debit Card**

10. APPLICANT'S SIGNATURE AND DATE: By signing this form, the applicant is certifying that the information provided 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.

a. SIGNATURE	**b. DATE SIGNED** *(YYYYMMDD)*

CONTINUED HEALTH CARE BENEFIT PROGRAM (CHCBP) APPLICATION INSTRUCTIONS

Section I – APPLICANT INFORMATION:

1. Name: (Last, First, Middle Initial) (Must match what's in the Defense Enrollment Eligibility Reporting System (DEERS).
2. Phone Number: Enter your complete phone number(s) (home, work, mobile), with area code.
3. Residence Address (Street, apartment number, city, state, ZIP code, country). CHCBP sends mail to this address, unless you put something different in item #4.
4. Mailing Address: Fill this out only if it's different from your residence address (Item #3).
5. E-Mail: Enter your e-mail address(es). Mark the box if you agree to receive benefit related e-mails.

SECTION II - SPONSOR INFORMATION:

6. Sponsor's Name: (Last, First, Middle Initial) (Must match what's in DEERS).
7. DoD BENEFITS NUMBER (DBN) (XXXXXXXXX-XX) or SOCIAL SECURITY NUMBER (SSN) (XXX-XX-XXXX) of the sponsor.

SECTION III - PERSON(S) APPLYING FOR CHCBP (Including yourself):

Fill in the boxes under "Family Coverage" for yourself and other family members. Note: For family coverage, the Sponsor must apply for coverage.

Fill in the box under "Individual Coverage" if you're the only one applying for CHCBP.

8a. Name (Last, First, Middle Initial): Each person's full name.
8b. DBN or SSN: Each person's DBN or SSN (see above for sponsor for example). DBN is preferred.
8c. Date of Birth: Each person's full date of birth.
8d. Sex: Mark each person's sex: "M" for Male; "F" for Female.
9. Total Three-Month Premium: You have to submit a full 3-month premium with this application. Go to www.tricare.mil/chcbp for current rates. Enter the full amount you owe. Mark the box for "Individual Coverage" OR "Family Coverage." Mark the "Paid by" box for your "Check" OR "Money Order," payable to the "United States Treasury."

10. Signature and Date: This should be your signature (as the sponsor for the family or as the single person applying). You signature reflects your agreement that the information on the application is correct. Enter the date you signed the application.

10a. Signature: Here is where you (the sponsor's or single applicant) sign.
10b. Date signed: The date you signed the form (Year, month, day—YYYYMMDD).

TO PURCHASE OR CHANGE COVERAGE: You may mail or fax this form to the CHCBP contractor. Mailing address is listed on page 1. Fax: 502-322-8108. You use this same form to apply for coverage or change your CHCBP plan (for example, family to individual if a child ages out). The contractor will notify you about your coverage status by e-mail or U.S. mail. For any questions call 1-800-444-5445..