TRICARE PLUS DISENROLLMENT REQUEST

(Read Agency Disclosure Notice, Privacy Act Statement, and Instructions before completing form.)

OMB No. 0720-0028
OMB approval expires August 31, 2027

AGENCY DISCLOSURE NOTICE

The public reporting burden for this collection of information is estimated to average 7 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 the burden estimate or burden reduction suggestions to the Department of Defense, Washington Headquarters Services, at whs.mc-alex.esd.mbx.dd-dod-information-collections@mail.mil (0720-0028). 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 RETURN YOUR FORM TO THE Military Treatment Facility where you are currently enrolled.

PRIVACY ACT STATEMENT

AUTHORITY: 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.

PRINCIPAL PURPOSE(S): This form collects the information necessary to process your request to disenroll from TRICARE Plus.

ROUTINE USE(S): Information collected may be used and disclosed generally as permitted under 45 CFR Parts 160 and 164, Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Rules, as implemented by DoD 6025.18-R, the DoD Health Information Privacy Regulation. In addition to those disclosures generally permitted under 5 U.S.C. 552a(b) of the Privacy Act of 1974, as amended, the DoD "Blanket Routine Uses" under 5 U.S.C. 552a(b)(3) apply to this collection. A complete listing of the routine uses permitted under 5 U.S.C. 552a(b)(3) is published at **http://dpcld.defense.gov/Privacy/SORNsIndex/BlanketRoutineUses.aspx**. Collected information may be shared with the 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.
APPLICABLE SORN: DHA-07 Military Health Information System - **http://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570672/edha-07/**

DISCLOSURE: Voluntary; however, failure to provide the requested information may result in the denial of your request to disenroll from TRICARE Plus.

INSTRUCTIONS

1. Print all information in ink. Make sure the information is complete and accurate.

2. Ensure personal information matches information in the Defense Enrollment Eligibility Reporting System (DEERS). To check your DEERS information, call the Defense Manpower Data Center Support Office at 1-800-538-9552 or log into milConnect at: https://www.dmdc.osd.mil/milconnect/ to view specific information. . The mailing address and telephone numbers you include on this form will update DEERS.

3. Sign and date the application (Section III).

4. Please keep a copy of the completed application for your records.

5. Submit your completed disenrollment application to the MTF where you are currently enrolled.

6. For information on TRICARE, visit the Defense Health Agency (DHA) Website at www.tricare.mil

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SECTION I - SPONSOR INFORMATION *(Must be completed on all applications)*

1. Sponsor Social Security Number (SSN) or DoD Benefits Number (DBN)	2. Sponsor Name *(Last, First, Middle Initial)*	3. Date of Birth *(YYYYMMDD)*

SECTION II - INDIVIDUAL(S) REQUESTING DISENROLLMENT

4.a. Name *(Last, First, Middle Initial)*	b. Date of Birth *(YYYYMMDD)*

c. Reason for Disenrollment *(X one)*	☐ Moved	☐ Loss of TRICARE Eligibility	☐ Request for Voluntary Disenrollment	☐ Death	☐ Other

(Explain)	d. Requested Disenrollment Date *(YYYYMMDD)*

e. Telephone Number *(Include area code)*	(1) Home	(2) Work	(3) Cell	f. E-mail Address

5.a. Name *(Last, First, Middle Initial)*	b. Date of Birth *(YYYYMMDD)*

c. Reason for Disenrollment *(X one)*	☐ Moved	☐ Loss of TRICARE Eligibility	☐ Request for Voluntary Disenrollment	☐ Death	☐ Other

(Explain)	d. Requested Disenrollment Date *(YYYYMMDD)*

e. Telephone Number *(Include area code)*	(1) Home	(2) Work	(3) Cell

SECTION III - SIGNATURE

6. By signing this form, I certify that the information on this form is true, accurate, and complete.

a. Signature	b. Date Signed *(YYYYMMDD)*

Return completed form to the Military Treatment Facility where you are currently enrolled. Keep a copy for your records.