TRICARE YOUNG ADULT APPLICATION

OMB No. 0720-0049
OMB approval expires April 30, 2028

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

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 below.

Sponsor Status	TRICARE Prime *(1)*	TRICARE Prime Remote *(1)*	TRICARE Select	Uniformed Services Family Health Plan *(1)*	TRICARE Overseas Prime *(1)*	TRICARE Overseas Prime Remote *(1)*	TRICARE Overseas Select
Active Duty	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Retired	Yes	No	Yes	Yes	No	No	Yes
Selected Reserve *(2)*	No	No	Yes	No	No	No	Yes
Retired Reserve *(2)*	No	No	Yes	No	No	No	Yes

(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

ONLINE:
You may electronically complete, submit and print a copy of your enrollment, disenrollment, transfer to another TYA plan, or request a change in an assigned Primary Care Manager (PCM) by logging into the Beneficiary Web Enrollment (BWE) website at http://milconnect.dmdc.osd.mil.

MAILING THE FORM:
For manual enrollment, disenrollment, or PCM changes in a TRICARE Young Adult plan, complete and submit the form to the address below.
Forms may be mailed to the contractor identified below. Call your Contractor to determine when your new or transferred enrollment will begin.

Contractor for actions effective on/after January 1, 2025:
TriWest Healthcare Alliance

Address:
TriWest Healthcare Alliance
PO Box 8890
Virginia Beach, VA 23450

Phone Number: 1-888-TRIWEST (874-9378)

Fax Number: 1-866-566-9915

Website: www.tricare.mil/West

Uniformed Services Family Health Plan (USFHP) *(Include locations, addresses and telephone numbers.)* Website: **www.tricare.mil/usfhp**

USFHP	*Pacific Medical Centers*
PO Box 169001, *Irving, TX 75016*	*PO Box 84985* *Seattle, WA 98124*
Phone: 1-800-678-7347	*Phone: 1-888-958-7347 option 1*
FAX: 1-210-766-8854	*FAX: 1-206-326-2458*

YOUNG ADULT SSN/DBN:

TRICARE YOUNG ADULT OPTION DESIRED:

☐ **TRICARE Select:** Includes dependents of sponsors enrolled in the TRICARE Reserve Select and TRICARE Retired Reserve health plans.

☐ **TRICARE Prime:** Where available. Enrollment is not automatic. If eligible, active duty family members may be enrolled in TRICARE Prime Remote for Active Duty Family Members (TPRADFM).

☐ **Uniformed Services Family Health Plan (USFHP):** Available in six locations. Submit the completed Enrollment Application to the USFHP 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 (SSN) *(XXX-XX-XXXX)* **or DOD BENEFITS NUMBER (DBN)** *(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. UNIT

b. UNIT IDENTIFICATION CODE (UIC) *(If known)*

c. STATE, ZIP CODE AND COUNTY OF WORK ADDRESS

SECTION II - ENROLLING TRICARE YOUNG ADULT FAMILY MEMBER INFORMATION OR PCM CHANGE

9. FAMILY MEMBER NAME *(Last, First, Middle Initial) (Must match DEERS)*

10. DATE OF BIRTH *(YYYYMMDD)*

11. REQUESTED ACTION: ☐ Enroll ☐ Transfer Enrollment ☐ PCM Change ☐ Disenroll Effective Date

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. TELEPHONE NUMBER *(Include Area Code)*

a. WORK:

b. RESIDENTIAL:

15. E-MAIL ADDRESS ☐ *(X box to receive TRICARE e-mails)*

16. PRIMARY CARE MANAGER (PCM) PREFERENCE *(Complete only if selecting a Prime or USFHP plan, or requesting a PCM change. Please list your first and second choices below. Honoring your preference depends upon availability and local Military Treatment Facility (MTF) policy. Contact your preferred MTF, or US Family Health Plan Member Services for availability of PCMs. If no PCM preference is indicated, one will be assigned.)*

a. 1st CHOICE ☐ MTF ☐ Civilian ☐ Same as Sponsor — FULL NAME or MTF/CLINIC

b. 2nd CHOICE ☐ MTF ☐ Civilian ☐ Same as Sponsor — FULL NAME or MTF/CLINIC

c. PCM SPECIALTY ☐ No Preference ☐ Family/General Practice ☐ Internal Medicine ☐ Pediatrics ☐ Flight Medicine

d. PREFERRED PCM SEX ☐ No Preference ☐ Male ☐ Female

17. REASON FOR DISENROLLMENT OR PCM CHANGE ☐ Relocation ☐ Dissatisfied with PCM ☐ PCS

☐ Have employer-sponsored health care coverage ☐ Marriage ☐ Other:

YOUNG ADULT SSN/DBN:

SECTION III - OTHER HEALTH INSURANCE

18. PLEASE IDENTIFY IF YOU ARE 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:

☐ Dental Insurance: Person(s) Covered:

Policy Holder Name: Carrier Name:

Policy Number: Policy Effective Date:

☐ Vision Insurance: Person(s) Covered:

Policy Holder Name: Carrier Name:

Policy Number: Policy Effective Date:

☐ Prescription Insurance: Person(s) Covered:

Policy Holder Name: Carrier Name:

Policy Number: Policy Effective Date:

SECTION IV - ACCESS WAIVER, ATTESTATIONS, AND SIGNATURE (REQUIRED)

I understand that if I selected a Primary Care Manager (PCM) by name, team, or location (MTF or civilian), the TRICARE program will enroll me with that PCM if capacity exists. If my selected or assigned PCM is greater than a 30 minute drive-time from my residence, or if I reside outside the Prime Service Area, I understand that my Drive time access standards will be automatically waived unless indicated otherwise below, in order to manage PCM assignment and maintain enrollments. Drive time access standards are thirty minutes for primary care and one hour for specialty care from residence.

☐ *(X if NOT waiving drive time)* I do NOT agree to waive the drive time access to care standards. I request that my PCM and specialty care are within the access standard from my residence.

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.

19. SIGNATURE OF YOUNG ADULT DEPENDENT APPLICATION	**20. DATE SIGNED** *(YYYYMMDD)*

ENROLLMENT NOTE: Your regional or USFHP contractor will process your enrollment, disenrollment, or change request 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 PCM assignment for Prime plans) or PCM changes before obtaining care by calling your Regional or USFHP contractor, 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.

YOUNG ADULT SSN/DBN:

SECTION V - PAYMENT OF TRICARE YOUNG ADULT PREMIUMS

21. PREMIUM PAYMENT METHOD *(X and complete as applicable.) (See www.tricare.mil/costs for current 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
(Enclose applicable premium payable to contractor on first page.)

PAYMENT AMOUNT: **$** _____

☐ Visa/MasterCard Credit or Debit Card:

CARD NUMBER: _____ EXPIRATION DATE *(MM/YYYY)* _____

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: _____ EXPIRATION DATE *(MM/YYYY)* _____

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 servicing Contractor 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 cancelled 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.