Date of Arrival in Country:

SPONSOR'S SSN/DBN:

TRICARE PRIME OPTION DESIRED:

☐ **TRICARE Prime:** Active duty service members have to enroll in TRICARE Prime. (Enrollment is not automatic.)

☐ **TRICARE Prime Remote:** If eligible, you may be enrolled in TRICARE Prime Remote or TRICARE Prime Remote for Active Duty Family Members.

☒ **TRICARE Overseas Program Prime:** Family members must be command sponsored and meet specific enrollment criteria of the overseas area. If eligible, you may be enrolled in TRICARE Overseas Program Prime Remote. Retirees are not eligible for TRICARE Overseas Program Prime.

☐ **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 ☐ Deceased *(Go to Section II.)* ☐ Unremarried Former Spouse

4. SPONSOR'S TELEPHONE NUMBER *(Include Area Code)*
a. WORK: 314-452-_____ c. CELL:
b. HOME:

5. SPONSOR'S E-MAIL ADDRESS

6. SPONSOR'S DATE OF BIRTH *(YYYYMMDD)*

7. SPONSOR'S RESIDENCE ADDRESS *(Street, Apartment No., City, State, ZIP Code, Country)* ☐ New

8. SPONSOR'S MAILING ADDRESS *(Provide APO or FPO if stationed overseas)* ☐ Same as residence ☐ New

PSC 9 BOX _____
APO AE 09123

9. SPONSOR'S MILITARY ASSIGNMENT

a. UNIT

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

c. STATE, ZIP CODE AND COUNTRY OF WORK ADDRESS

Please circle IF applicable:
PRP -- FLYING STATUS -- EOD -- AUoF

10. SPONSOR'S REQUESTED ACTION *(X one)*

☐ None *(go to Section II)* ☒ Enroll ☐ Transfer Enrollment ☐ PCM Change ☐ Disenroll (Non-AD only)

Effective Date Requested: _____

11. SPONSOR'S PCM PREFERENCE *(Please list your first and second choices below. PCM assignment depends upon availability and your uniformed service guidelines. Review PCM options online or call your Regional Contractor, preferred MTF, or USFHP member services (non-active duty only) for availability of PCMs.)*

a. 1st CHOICE ☐ MTF ☐ PRP (ADSM) ☐ Civilian	FULL NAME or MTF/CLINIC
b. 2nd CHOICE ☐ MTF ☐ Civilian	FULL NAME or MTF/CLINIC

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

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

SPONSOR'S SSN/DBN:

SECTION II - ENROLLING FAMILY MEMBER INFORMATION OR PCM CHANGE *(Use additional copies of this page as necessary)*

DEPENDENT 1

12.a. FAMILY MEMBER NAME *(Last, First, Middle Initial) (Must match DEERS)* | **b. DATE OF BIRTH** *(YYYYMMDD)*

c. REQUESTED ACTION: [X] Enroll [ ] Transfer Enrollment [ ] PCM Change [ ] Disenroll Effective Date Requested: _____

d. RESIDENCE AND MAILING ADDRESS
(Provide address, with ZIP Code and Country, if different from Sponsor)

Child's Age (if applicable): _____

[X] Same as Sponsor [ ] New

e. TELEPHONE NUMBER *(Include Area Code)*
(1) WORK: (2) HOME: (3) CELL:

f. E-MAIL ADDRESS

g. PCM PREFERENCE *(Please list your first and second choices below. PCM assignment depends upon availability and uniformed service guidelines. Review PCM options online or call your Regional Contractor or USFHP customer services for availability of PCMs.)*

(1) 1st CHOICE [ ] MTF [ ] Civilian [ ] Same as Sponsor — FULL NAME or MTF/CLINIC

(2) 2nd CHOICE [ ] MTF [ ] Civilian [ ] Same as Sponsor — FULL NAME or MTF/CLINIC

h. PCM SPECIALTY [ ] No Preference [ ] Family/General Practice [ ] Internal Medicine [ ] Pediatrics [ ] Flight Medicine

i. PREFERRED PCM GENDER [ ] No Preference [ ] Male [ ] Female

DEPENDENT 2

13.a. FAMILY MEMBER NAME *(Last, First, Middle Initial) (Must match DEERS)* | **b. DATE OF BIRTH** *(YYYYMMDD)*

c. REQUESTED ACTION: [X] Enroll [ ] Transfer Enrollment [ ] PCM Change [ ] Disenroll Effective Date Requested: _____

d. RESIDENCE AND MAILING ADDRESS
(Provide address, with ZIP Code and Country, if different from Sponsor)

Child's Age (if applicable): _____

[X] Same as Sponsor [ ] New

e. TELEPHONE NUMBER *(Include Area Code)*
(1) WORK: (2) HOME: (3) CELL:

f. E-MAIL ADDRESS

g. PCM PREFERENCE *(Please list your first and second choices below. PCM assignment depends upon availability and uniformed service guidelines. Review PCM options online or call your Regional Contractor or USFHP customer services for availability of PCMs.)*

(1) 1st CHOICE [ ] MTF [ ] Civilian [ ] Same as Sponsor — FULL NAME or MTF/CLINIC

(2) 2nd CHOICE [ ] MTF [ ] Civilian [ ] Same as Sponsor — FULL NAME or MTF/CLINIC

h. PCM SPECIALTY [ ] No Preference [ ] Family/General Practice [ ] Internal Medicine [ ] Pediatrics [ ] Flight Medicine

i. PREFERRED PCM GENDER [ ] No Preference [ ] Male [ ] Female

DEPENDENT 3

14.a. FAMILY MEMBER NAME *(Last, First, Middle Initial) (Must match DEERS)* | **b. DATE OF BIRTH** *(YYYYMMDD)*

c. REQUESTED ACTION: [X] Enroll [ ] Transfer Enrollment [ ] PCM Change [ ] Disenroll Effective Date Requested: _____

d. RESIDENCE AND MAILING ADDRESS
(Provide address, with ZIP Code and Country, if different from Sponsor)

Child's Age (if applicable): _____

[X] Same as Sponsor [ ] New

e. TELEPHONE NUMBER *(Include Area Code)*
(1) WORK: (2) HOME: (3) CELL:

f. E-MAIL ADDRESS

g. PCM PREFERENCE *(Please list your first and second choices below. PCM assignment depends upon availability and uniformed service guidelines. Review PCM options online or call your Regional Contractor or USFHP customer services for availability of PCMs.)*

(1) 1st CHOICE [ ] MTF [ ] Civilian [ ] Same as Sponsor — FULL NAME or MTF/CLINIC

(2) 2nd CHOICE [ ] MTF [ ] Civilian [ ] Same as Sponsor — FULL NAME or MTF/CLINIC

h. PCM SPECIALTY [ ] No Preference [ ] Family/General Practice [ ] Internal Medicine [ ] Pediatrics [ ] Flight Medicine

i. PREFERRED PCM GENDER [ ] No Preference [ ] Male [ ] Female

SPONSOR'S SSN/DBN:

SECTION III - REASON FOR DISENROLLMENT OR PCM CHANGE

(Complete if disenrolling or making a PCM change)

Name of Family Member:	☐ Relocation ☐ Dissatisfied ☐ PCS ☐ Other:
Name of Family Member:	☐ Relocation ☐ Dissatisfied ☐ PCS ☐ Other:
Name of Family Member:	☐ Relocation ☐ Dissatisfied ☐ PCS ☐ Other:
Name of Family Member:	☐ Relocation ☐ Dissatisfied ☐ PCS ☐ Other:

SECTION IV - OTHER HEALTH INSURANCE

PLEASE IDENTIFY IF ANYONE IS 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 V - ACCESS WAIVER AND SIGNATURE (REQUIRED)

☒ ***(X if waiving drive time)*** If my selected or assigned Primary Care Manager (PCM) is greater than a 30 minute drive-time from my residence, or if I reside outside the Prime Service Area, I hereby waive the drive time standards of thirty minutes for primary care and one hour for specialty care

I understand if I selected a PCM by name, team, or location (MTF or civilian), TRICARE will enroll me with that PCM subject to PCM availability and uniformed services policy. I understand that it is my responsibility to comply with all TRICARE Prime, TRICARE Prime Remote, TRICARE Overseas Program Prime, and/or USFHP 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.

1. **SIGNATURE OF SPONSOR, SPOUSE, OR OTHER LEGAL GUARDIAN OF BENEFICIARY**	2. **RELATIONSHIP TO SPONSOR**	3. **DATE SIGNED** *(YYYYMMDD)*

ENROLLMENT NOTE: Prime enrollment start dates are based primarily on the 20th of the month rule (applications received on/before the 20th of the month are effective the first calendar day of the next month). You should confirm enrollment and PCM assignment before obtaining routine medical care. (Note: This does not apply to TRICARE Overseas Prime or to active duty service members.)

DISENROLLMENT NOTE: In some cases, you may not be able to re-enroll in TRICARE Prime for a 12-month period from the date of the disenrollment. This one year period does not apply to any family member whose sponsor is in grade E-1 to E-4.

PAYMENT OPTIONS: See Section VI on next page.