UNITED CONCORDIA®
Protecting More Than Just Your Smile®

OMB No. xxxx-xxxx
OMB approval expires
XX-XX-XXXX

TRICARE® Dental Program Enrollment/Change Authorization Form

Privacy Act Statement	
This statement serves to inform you of the purpose for collecting personal information required by the TRICARE Dental Program (TDP) and how it will be used. http://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570707/edtma-04/	
AUTHORITY:	10 U.S.C. Chapter 55, Medical and Dental Care; 32 CFR 199.13, TRICARE Dental Program; and E.O. 9397 (SSN), as amended.
PURPOSE:	To collect information from you to manage your enrollment in the TDP, administer your benefits, and pay for the services you receive.
ROUTINE USES:	Your records may be disclosed to providers of care and other business entities on matters relating to eligibility, claims pricing and payment, fraud, quality assurance, program integrity, and the coordination of benefits. Your records may also be disclosed outside of the Department of Defense (DoD) in accordance with the DoD Blanket Routine Uses published at Caution- http://dpcld.defense.gov/Privacy/SORNsIndex/Blanket-Routine-Uses/ and as permitted by the Privacy Act of 1974, as amended (5 U.S.C. 552a(b)). Any protected health information (PHI) in your records may be used and disclosed generally as permitted by the Health Insurance Portability and Accountability Act 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, and healthcare operations.
DISCLOSURE:	Voluntary. If you choose not to provide this information, no penalty may be imposed, but absence of the requested information may delay or prevent your receipt of TDP services.

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FOR TRICARE® DENTAL PROGRAM

ENROLLMENT/CHANGE AUTHORIZATION -

☐ **New Enrollment/Re-enrollment** (complete entire authorization) Choose when a contract does not currently exist.
☐ **Add Family Member** (complete sections I, II, V, and VI) Choose when a contract already exists for one or more family members.
☐ **Terminate Enrollment** (complete sections I, III, and VI) Choose when an entire contract needs to be terminated.
☐ **Change Address/Telephone** (complete sections I, II, and VI) If the update applies only to certain family members, list in section II.
☐ **Terminate Individual Family Member** (complete sections I, II, III, and VI) Choose when one or more family members need to be terminated, but one or more will remain enrolled.

SECTION I

NOTE: Incomplete information on this authorization will delay your enrollment.

Sponsor Name – Last Name, MI, First Name _____

Sponsor Social Security Number _____ -or- DBN _____

Date of Birth (mm/dd/yy) _____ Gender M ☐ F ☐ Home Address _____

City _____ State _____ Zip Code _____ Country _____ Home Phone _____

Sponsor's Military Status - Active Duty* ☐ AGR* ☐ SELRES ☐ IRR ☐

*If Active Duty or AGR, you may only enroll eligible family members, not yourself.

SECTION II

NOTE: National Guard and Reserve sponsors and their family members will be enrolled to separate contracts, but may enroll on a single Enrollment/Change Authorization.

ALL ELIGIBLE FAMILY MEMBERS, AGE 1 OR OLDER, RESIDING AT THE SAME ADDRESS MUST BE ENROLLED IF ANY ONE OF THEM IS ENROLLED. PLEASE LIST ALL FAMILY MEMBERS TO WHOM THIS ENROLLMENT/CHANGE AUTHORIZATION PERTAINS.

If you are a National Guard and Reserve sponsor, to whom does this Enrollment/Change Authorization request pertain?

☐ Sponsor only ☐ Reserve family only ☐ Reserve Sponsor and family

Spouse – Last Name	First Name	Gender	Date of Birth (mm/dd/yy)	Address (if different than Sponsor's)
		M ☐ F ☐		
Family Member – Last Name	First Name	Gender	Date of Birth (mm/dd/yy)	Address (if different than Sponsor's)
		M ☐ F ☐		
		M ☐ F ☐		
		M ☐ F ☐		
		M ☐ F ☐		

Please list additional family member(s) on a separate sheet and attach to the Enrollment/Change Authorization.

SECTION III

Desired End Date _____ Reason for Termination _____ (see values listed in Section III on page 3)

If other, please explain _____

SECTION IV

Amount of Initial Payment (see Section IV on page 3) _____

Method of Initial Payment

☐ Check or money order ☐ Visa® ☐ MasterCard® ☐ American Express® ☐ Discover®

Credit Card Number _____ Expiration Date (mm/yy) _____ Security Code _____

➤ Authorized Signature _____

Name of Cardholder (as it appears on credit card) _____

SECTION IV *(continued)*

Recurring Payments Note: Payroll allotment is required for active duty service members and will be automatically established.

☐ Payroll Allotment *(for other than active duty, when coverage and pay duty status permits)*

☐ EFT

Routing Number _____ Account Number _____

Name(s) on Account _____

Bank Name _____

➤ Signature(s) from all account holders _____

Visa® ☐ MasterCard® ☐ American Express® ☐ Discover® ☐

Credit Card Number _____ Expiration Date (mm/yy) _____ Security Code _____

➤ Authorized Signature _____

Name of Cardholder *(as it appears on credit card)*

SECTION V

1. Do you or your family member(s) have other dental insurance? Yes ☐ No ☐

If yes, please complete the following information:

Policyholder _____ Effective Date of Policy (mm/dd/yy) _____

Insurance Company _____ Policy Number _____

Please List Family Members Covered Under This Policy _____

Group Plan Name _____

Group Employer Name _____ Group Employer Phone _____

Insurance Company Contact Name _____ Contact Phone Number _____

Insurance Company Address _____

Company Phone Number _____

2. Is your spouse a uniformed services member? Yes ☐ No ☐ If yes, spouse's SSN or DBN _____

SECTION VI

This is my application for coverage, or change to coverage, under the TRICARE Dental Program. I authorize monthly deductions of required premiums from my earnings if my coverage and pay status permit payroll deduction. I understand and agree that IRR sponsors and SELRES and IRR family members will be billed directly for the cost of coverage. I understand that enrollment is subject to verification of eligibility and receipt of one month's premium payment. I understand that coverage does not begin upon deposit of my initial premium payment. For applications received by the 20th of each month, coverage will become effective the first day of the next month. For applications received after the 20th of each month, coverage will not become effective until the first day of the second month. I understand and agree to remain enrolled for a minimum of 12 months and to any premium rate changes that occur during this period. Termination is not automatic upon fulfillment of this period and must be initiated by the sponsor. I understand that I am responsible for full payment of any dental services provided prior to the effective date or after the termination date of the policy.

➤ Sponsor's Signature: _____ Date: _____

	Active Duty		Selected Reserve				Individual Ready Reserve			
	Single Premium (one family member)	**Family Premium** (more than one family member)	**Sponsor-Only Premium**	**Single Premium*** (one family member, excluding Sponsor)	**Family Premium** (more than one family member, excluding Sponsor)	**Sponsor Premium plus Family Premium**	**Sponsor-Only Premium**	**Single Premium*** (one family member, excluding Sponsor)	**Family Premium** (more than one family member, excluding Sponsor)	**Sponsor Premium plus Family Premium**
May 1, 2017 – April 30, 2018	$11.10	$28.87	$11.10	$27.76	$72.18	$83.28	$27.76	$27.76	$72.18	$99.94

Please review these instructions before submitting the Enrollment/Change Authorization. For help completing the Enrollment/ Change Authorization call:

CONUS: 844-653-4061

OCONUS: UCCI: 844-653-4060

Send Enrollment/Change Authorization with payments to: UCCI TRICARE Dental Program, P.O. Box 645547, Pittsburgh, PA 15264-5253

SECTION I

All information in this section refers to the sponsor.

AGR = Active Guard/Reserve; SELRES = Selected Reserve; IRR = Individual Ready Reserve

SECTION II

Information in this section refers to the family member(s).

SECTION III

Please indicate (with a value listed below) the reason for termination.

G – Transfer to duty station where space-available dental care is readily available in the military dental treatment facility

J – Moved to an OCONUS location

N – Voluntary disenrollment by sponsor

O – Voluntary disenrollment by family member (sponsor signature required)

P – Dissatisfied with program after 12-month mandatory enrollment period was completed

99 – Other reason not listed. Please explain in the space provided.

SECTION IV

Initial payment of one month's premium must be sent with the completed Enrollment/Change Authorization. If enrolling a National Guard or Reserve member and family members, only one check or money order for the total premium amount should be sent. Please include the sponsor's Social Security number (SSN) or Department of Defense Benefits Number (DBN) on the memo portion of the check or money order. **Recurring payment** – By setting up a recurring payment, you have the flexibility to pay your premium by payroll allotment (required method if coverage and pay status permits), electronic funds transfer (EFT) from your savings or checking account, or by credit card. **If paying by EFT from your savings or checking account, please attach a voided check to the Enrollment/ Change Authorization.** Signatures are required from all account holders. This authorization is to remain in full force and effect until you notify your bank or notify the payee of its termination by canceling any pending payments and recurring payment instructions at least three banking days before your account is scheduled to be debited. **Checks and money orders should be made payable to United Concordia.**

Note: *In the event that a payment is returned for insufficient funds for either initial or recurring payments, you authorize United Concordia to electronically debit your bank account for the original amount of the transaction, as well as a returned fee, up to the maximum amount allowed by law. Additional information can be found at* www.tricare.mil.

SECTION V

All information in this section pertains to other dental insurance.

For question 2, if this is a joint service marriage, please check yes and list spouse's SSN or DBN..

SECTION VI

The Enrollment/Change Authorization must be signed by the sponsor. An individual with power of attorney (POA) may sign for the sponsor; however, the entire copy of the valid POA must be submitted with the Enrollment/Change Authorization.

Notice of Intent –The TRICARE Dental Program (TDP) has a mandatory 12-month enrollment period. If your Expiration of Term of Service (ETS) date is less than 12 months away, you are not eligible for the TDP unless you intend to continue your service commitment for at least 12 months. This service commitment is calculated based on the time remaining in your current status (active duty, SELRES or IRR), plus any uninterrupted combination thereof. **By applying for this program, you are agreeing to a minimum 12-month enrollment and to any premium rate changes that occur during this period. Failure to pay the premiums during the 12-month enrollment commitment will result in termination of dental coverage and a 12-month lockout from the TDP.**