



ENROLLMENT/CHANGE FORM



- New Enrollment/Re-enrollment *(complete entire form)*
Choose when a policy does not currently exist.
- Add Family Member *(complete sections A, B, E and F)*
Choose when a policy already exists for one or more family members.
- Cancel Enrollment *(complete sections A, C and F)*
Choose when an entire contract needs to be canceled.
- Change Address/Telephone # *(complete sections A, B and F)*
If the update applies only to certain family members, list in section B.
- Cancel Individual Family Member *(complete sections A, B, and F)*
Choose when one or more family members need to be canceled, but one or more will remain enrolled.

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

SECTION A	Sponsor Social Security Number		Sponsor Name (Last, First, Middle Initial)		Date of Birth (MM/DD/YY)	Sex <input type="checkbox"/> M <input type="checkbox"/> F
	Home Address				Home Phone ()	
	City	State	Zip Code	Country	E-mail Address	
	Sponsor's Military Status <input type="checkbox"/> Active Duty* <input type="checkbox"/> AGR *If Active Duty, you may only enroll eligible family members, not yourself. <input type="checkbox"/> SELRES <input type="checkbox"/> IRR			Please indicate if you intend to remain in the service for at least 12 months. <input type="checkbox"/> Yes <input type="checkbox"/> No (If No, you will not be enrolled.) <i>(See Section A on reverse side for "Notice of Intent".)</i>		
ALL ELIGIBLE FAMILY MEMBERS, AGE FOUR 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 PERTAINS.						
1. If you are a Reservist, to whom does this enrollment/change request pertain? <input type="checkbox"/> Sponsor only <input type="checkbox"/> Reserve family only <input type="checkbox"/> Reserve Sponsor and Family <i>Note: Reserve Sponsors and Reserve Family Members are separate contracts, but may enroll on a single form.</i>						
SECTION B	Last Name	First Name	Sex	Date of Birth MM / DD / YY	Address (if different than Sponsor's)	
	Spouse			/ /		
	Family Member			/ /		
	Family Member			/ /		
	Family Member			/ /		
Please list additional family member(s) on a separate sheet and attach to the enrollment form.						
C	Cancel Reason _____ (see Section C on reverse side) If other, please explain _____					
SECTION D	Amount of Initial Payment (see Section D on reverse side)			Method of Initial Payment <input type="checkbox"/> Check or Money order <input type="checkbox"/> Visa <input type="checkbox"/> Master Card		
	Credit Card Number				Expiration Date	
	Name of card holder as it appears on credit card			Authorized Signature		
SECTION E	1. Do you or your family member(s) have other Dental Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please complete the following information:					
	Policy Holder		Insurance Company		Policy Number	
	Effective Date of Policy (mm/dd/ccyy)		Please list family members covered under this policy:			
2. Is your spouse a uniformed services member? If yes, spouse's SSN: <input type="checkbox"/> Yes <input type="checkbox"/> No						
SECTION F	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 Selected Reserve 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 must remain enrolled for a minimum of 12 months. Cancellation 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 cancellation date of the policy. (See Section F on back of form for important information.)					
	Sponsor's Signature: _____			Date: _____		

Because personal information is being requested from you, we are required by the Privacy Act of 1974, to notify you of the following: This information is requested under the authority of Chapter 55, Title 10, United States Code, Section 1076a. The information will be used to determine eligibility for enrollment in the TRICARE Dental Program (TDP). Disclosure is voluntary, however, failure to provide all information may delay or prevent enrollment in the TDP.

Most of the TDP Enrollment Form is self-explanatory; however, there are certain fields to which special attention should be paid.

Section A: All information in this section refers to the Sponsor.

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

Notice of Intent - The TDP has a mandatory 12-month enrollment period. If your Expiration of Term of Service (ETS) date is less than 12 months, 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, Selected Reserve 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.** If you intend to remain in the service for at least 12 months, please check yes. **Failure to pay the premiums during the 12-month enrollment commitment will result in termination of the dental coverage and may result in the referral of the account to a collection agency.**

Section B: All information in this section refers to the family member(s).

Section C: Please indicate (with a value listed below) the reason for cancellation.

- 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 months mandatory enrollment period is completed
- 99 - Other reason not listed. Please explain in the space provided

Section D: Initial payment of one month's premium payment must be sent with the completed enrollment form in order to process your application. **The first month's premium must be included.** If enrolling a reservist and family, only one check or money order for the total premium amount should be sent. **Please include the Sponsor's SSN on the memo portion of the check or money order.** You will be charged a processing fee of \$20.00 for any check returned due to insufficient funds. Subsequent monthly payments will be either deducted from your military pay account or billed directly. Other available options are: automatic withdrawal from your checking account or a charge to your credit card. **Checks and money orders should be made payable to United Concordia/TDP.** Information regarding payment options can also be found at www.TRICAREdentalprogram.com.

Section E: 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.

Section F: The Enrollment/Change Form 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 Form.

Monthly Premiums

	Active Duty		Selected Reserve				IRR			
	Single Premium (one family member)	Family Premium (more than one family member)	Sponsor Only	Single Premium (one family member-excluding Sponsor)*	Family Premium (more than one family member-excluding Sponsor)	Sponsor & Family Premium *	Sponsor Only	Single Premium (one family member-excluding Sponsor)*	Family Premium (more than one family member-excluding Sponsor)	Sponsor & Family Premium *
Feb 1, 2006 - Jan 31, 2007	\$10.51	\$26.27	\$10.51	\$26.27	\$65.68	\$76.19	\$26.27	\$26.27	\$65.68	\$91.95
Feb 1, 2007 - Jan 31, 2008	\$11.05	\$27.63	\$11.05	\$27.63	\$69.07	\$80.12	\$27.63	\$27.63	\$69.07	\$96.70

* If both the sponsor and a single family member are enrolling, the premium due is the total of the Sponsor only and the single premium.

For help completing the enrollment form, call:

1-888-622-2256

Enrollment/Change may be faxed to:

1-888-734-1944

Send enrollment forms with payments to:

United Concordia/TDP
P.O. Box 827583
Philadelphia, PA 19182-7583

For all other enrollment changes and correspondence:

United Concordia
TDP Enrollment and Billing
PO Box 69426
Harrisburg, PA 17106-9426

Additional TDP information can be found at www.TRICAREdentalprogram.com