# TRICARE Retiree Dental Program

Enrollment application

OMB No. 0720-0015
Exp: 08/31/2015

Please PRINT CLEARLY and complete all applicable sections.

| Delta Dental Use Only | |
|---|---|
| *Spl Att/Stat:* | |
| *Eff Date:* | |
| *Client/Sub:* | |
| *Amt:* | |
| *Auth/Ck No:* | |

PRIVACY ACT STATEMENT

This statement serves to inform you of the purpose for collecting personal information required by the TRICARE Retiree Dental Program (TRDP) and how it will be used.

AUTHORITY: 10 U.S.C. Chapter 55, Medical and Dental Care; 38 U.S.C. 1781, Medical Care for Survivors and Dependents of Certain Veterans; 32 CFR 199.22, TRICARE Retiree Dental Program (TRDP); and E.O. 9397 (SSN), as amended.

PURPOSE: To obtain information from an individual for records pertaining to eligibility, claims processing, quality of care review, customer service enhancement, and payment related to the TRICARE Retiree Dental Program.

ROUTINE USES: 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, http://dpclo.defense.gov/privacy/SORNS/blanket_routine_uses.html. In addition to those disclosures generally permitted under 5 U.S.C. 552a(b) of the Privacy Act of 1974, the DoD "Blanket Routine Uses" under 5 U.S.C. 552a(b)(3) apply to this collection. Information from this system may be shared with federal, state, local, or foreign government agencies, and with private business entities, including 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.

DISCLOSURE: Voluntary. If you choose not to provide your information, no penalty may be imposed, but absence of the requested information may result in the denial of benefits.

## A Applicant

☐ Retiree
☐ Unremarried Surviving Spouse
☐ Surviving Child(ren)
☐ Family Member(s) Only—See Guidelines for specific criteria

Retiree's Social Security Number
XXX-XX-XXXX

Applicant's Date of Birth
MM/DD/YYYY

Sex
M/F

Branch of Service

Last Name First Name MI

Street Address

City, State (or if overseas, province, county, etc.), ZIP/Foreign Postal Code, Country

Home Telephone Work Telephone

*TRDP Welcome Packet delivery method (check one)*

☐ YES, I prefer to access my Welcome Packet materials online. Please send instructions to me at the following e-mail address

*E-mail Address*

☐ NO, I prefer to receive my Welcome Packet materials through the standard mail (USPS) at the street address above.

## B Family Member

| FIRST, MI, LAST (if different) | SEX | BIRTH DATE | *If child is 21 or older* FULL-TIME STUDENT | DISABLED |
|---|---|---|---|---|
| *Spouse* | M/F | MM/DD/YYYY | N/A | N/A |
| *Child* | M/F | MM/DD/YYYY | ☐ | ☐ |
| *Child* | M/F | MM/DD/YYYY | ☐ | ☐ |
| *Child* | M/F | MM/DD/YYYY | ☐ | ☐ |
| *Child* | M/F | MM/DD/YYYY | ☐ | ☐ |
| *Child* | M/F | MM/DD/YYYY | ☐ | ☐ |
| *Child* | M/F | MM/DD/YYYY | ☐ | ☐ |

*To avoid processing delays, be sure to read and sign the back of this application.*

## C Premium Prepayment

TRICARE Retiree Dental Program premiums are collected automatically through Uniformed Services retired pay deduction. The automatic deduction is directed by Title 10 of the United States Code, Section 1076c, and uses one of six discretionary allotments. If retired pay is not available or is insufficient to allow the allotment amount, you will be billed directly.

Enrollment option (check one)

☐ Single Enrollment ☐ Two-Person Enrollment ☐ Family Enrollment (3 or more)

To determine your regional premium rate and prepayment amount, visit our website at trdp.org, or call our toll-free number, 888-838-8737. Prepayment of two months of premiums is necessary for enrollment. Any unused prepayment will be returned to the enrollee during the third month of enrollment.

Two-month premium prepayment method (check one)

☐ Check/Money Order (made payable to the TRICARE Retiree Dental Program in U.S. dollars)

☐ Discover©/VISA©/MasterCard© (see Guidelines) XXXX - XXXX - XXXX - XXXX cvc/cvv XXX Exp. Date M M/ Y Y

BILLING ADDRESS (if different than mailing address)

_____

Street Address

_____

Street Address

_____

City, State (or if overseas, province, county, etc.), ZIP/Foreign Postal Code, Country

## D Enrollment Grace Period/Termination

Each new enrollee in the TRICARE Retiree Dental Program must fulfill an initial enrollment period of 12 consecutive months. This initial enrollment period starts upon the coverage effective date. There is a grace period of 30 days from the coverage effective date in which the enrollee may rescind the application without any further enrollment obligation, provided no covered services have been used during that time period. To exercise the option to rescind, the enrollee must contact Delta Dental in writing within the 30- day grace period. If the option to rescind the application within the 30-day grace period is not exercised, the enrollee must remain enrolled in the program for the duration of the initial 12-month period with only limited opportunity for voluntary termination during this time. An enrollment may be terminated involuntarily prior to the end of the 12-month time period due to loss of eligibility. After the 12-month enrollment period, enrollment renewal will continue automatically on a month-to-month basis.

## E Agency Disclosure Notice

The public reporting burden for this collection of information is estimated to average 15 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 this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to DoD/WHS/ESD Information Management Division, 4800 Mark Center Drive, Suite 02G09, Alexandria, VA 22350-3100. 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 do not return your application to the above address. Return the completed application to the following address: DELTA DENTAL OF CALIFORNIA, FEDERAL GOVERNMENT PROGRAMS, PO BOX 537008, SACRAMENTO, CA 95853-7008, UNITED STATES OF AMERICA.

## F Authorization—This section must be signed and dated.

I have read the information contained on this application and choose to enroll in the TRICARE Retiree Dental Program. I understand the benefit restrictions of the program as stated to me and/or explained in the materials provided with this application. I further acknowledge my understanding of the following:

- Deposit of my prepayment does not guarantee coverage.
- My enrollment is subject to receipt of payment and verification of funds.
- My monthly premium payment will be automatically deducted from my retired pay, and I will be billed directly only if retired pay is not available to me or is determined to be insufficient to allow the automatic monthly deduction.
- I must remain enrolled for 12 consecutive months and if I choose to continue my enrollment beyond the initial 12-month period, my enrollment will continue on a month-to-month basis.
- This program does not discriminate, or have the effect of discriminating, against anyone on the basis of health status, age, race, sex or sponsor rank.
- I certify under penalty of perjury that I, as well as any of my dependents covered under this program, meet the eligibility requirements as identified in the "Eligibility" section of the marketing brochure included with this application or on the TRDP web site.
- Notwithstanding this certification of eligibility, if I or any of my dependents do not meet the eligibility requirements of this program, coverage under the program will be cancelled immediately and any premiums previously paid prior to the effective date of cancellation of coverage will be retained by Delta Dental.
- Delta Dental may request military retirement documents from me to verify eligibility and I agree to provide them within 60 days of the request. I understand that by failing to provide the requested documents within the stated timeframe, any dental claims submitted may be delayed or ultimately denied.

*I hereby certify that the information contained on this application is true and complete.*

X _____ _____

APPLICANT SIGNATURE DATE

*The development of this piece is supported by Department of Defense Contract No. H94002-07-C-0003. The TRDP is administered and underwritten by Delta Dental of California.*