

UNITED CONCORDIA

TRICARE Dental Program

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, C and F)
Choose when a policy already exists for one or more family members.

Cancel Enrollment (complete sections A, D and F)
Choose when an entire contract needs to be canceled.

Change Address/Telephone # (complete sections A and F)

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.

Active Duty SELRES
 AGR IRR

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		
	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. (See Section A on reverse side for "Notice of Intent".)					Rank	Branch of Service
SECTION B	1. If you are a Reserve Sponsor, whom do you want to enroll? <input type="checkbox"/> Sponsor only <input type="checkbox"/> Reserve family only <input type="checkbox"/> Reserve Sponsor and Family PLEASE LIST ALL FAMILY MEMBERS TO BE COVERED BY THIS ENROLLMENT. All eligible family members, age four or older, residing at the same address, must be enrolled if any one of them is enrolled.						
	Last Name	First Name	MI	Sex	Date of Birth MM / DD / YY	Check if Geographically Separated	Address (if different than Sponsor's)
	Spouse				/ /		
	Family Member				/ /		
	Family Member				/ /		
	Family Member				/ /		
Please add additional family member(s) on a separate sheet and attach to the enrollment form.							
SECTION C	Important: 1. Do you or your family member(s) have other Dental Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If your answer to the above question is 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 Service member? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, spouse's SSN and Branch of Service							
D	Cancel Reason _____ (see Section D on reverse side) If other, please explain _____						
SECTION E	Amount of Initial Payment (see Section E 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 #				Expiration Date		
	Name on Credit Card				Authorized Signature		
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. 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 day of the month, coverage may not become effective until the first day of the second month. 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.

Instructions for completion of form on back.

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.

Notice of Intent - The TDP has a mandatory 12 month initial 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.

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

1. If you are a Reservist please indicate whom you want to enroll. For spouse and/or each family member who is to be enrolled in the TDP, please list name, sex, date of birth, geographically separated (check if the family member you are enrolling is geographically separated), and address (if different from other family members). If you are enrolling more than four family members please list additional members on a separate sheet and attach.

Section C: All information in this section pertains to other dental insurance.

2. If this is a joint service marriage, please check yes and list spouse's SSN and branch of service.

Section D: 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 E: Initial payment of one month's premium payment must be sent with the completed enrollment form in order to process your application. Please include one check or money order for all enrollments. (i.e. If a Reservist is enrolling self and family, only one check should be sent for both initial payments.) **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. Information regarding initial payments can also be accessed via United Concordia's website at www.ucci.com.

Section F: The Enrollment/Change Form must be signed by the sponsor, or an individual with a valid Power of Attorney (POA). Please submit a copy of the POA when submitting the form. If the form is two sided, please submit copies of both the front and back.

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, 2004 - Jan 31, 2005	\$9.07	\$22.66	\$9.07	\$22.68	\$56.66	\$65.73	\$22.68	\$22.68	\$56.66	\$79.34
Feb 1, 2005 - Jan 31, 2006	\$9.32	\$23.31	\$9.32	\$23.31	\$58.27	\$67.59	\$23.31	\$23.31	\$58.27	\$81.58

* 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