NAVY SPONSOR NOTIFICATION
NAVPERS 1330/2 (2-73) S/N 0106-LF-063-7020

FROM:

TO:

THE SERVICE MEMBER LISTED HEREON HAS BEEN ORDERED TO YOUR COMMAND

<table>
<thead>
<tr>
<th>NAME</th>
<th>RANK/RATE</th>
<th>SSN</th>
</tr>
</thead>
</table>

MARITAL STATUS | WILL DEPENDENT ACCOMPANY SERVICE MEMBER | SEX AND AGES OF DEPENDENT CHILDREN (F for female, M for male) |
<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>NO</td>
<td>SEX</td>
</tr>
</tbody>
</table>

CURRENT MAILING ADDRESS

LEAVE ADDRESS

ESTIMATED DETACHMENT DATE | ESTIMATED ARRIVAL DATE YOUR COMMAND | MODE OF TRAVEL | INITIAL PERMANENT ASSIGNMENT |
<table>
<thead>
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<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>YES</td>
</tr>
</tbody>
</table>

SPONSOR

OTHER INFORMATION

REQUIRED | DESIRED | NOT DESIRED

---
To: (insert name)
From: NROTC Purdue Officer Candidates
Subject: Welcome Aboard
Date: (insert date)

Congratulations on being accepted into the Seaman-to-Admiral 21 program. You have joined the ranks of the Navy's most elite officer ascension program. You are about to embark on one of the greatest opportunities of your Naval career.

Your choice of Purdue University shows that you are committed to excellence and maintaining the highest academic standards in the country. For the last 150 years, Purdue has produced some of the finest officers in the United States Navy. Purdue graduates rank among some of the highest positions in the Naval Service.

As your fellow Officer Candidates, we are eager to provide all of the help that we can in order to make your transition as smooth as possible. In this packet you will find information regarding TRICARE Prime Remote medical and dental benefits as well as information detailing many of the apartment and housing opportunities in Lafayette and West Lafayette.

We hope to see you soon and if you have any questions feel free to contact me at (insert Phone Number).

Very respectfully,

(insert name don't forget to sign)
Active Duty Checklist Before Reporting to Purdue

**Uniforms:**

**Navy**
- Khaki Uniforms
- Service Dress Blues Uniform
- Summer White Uniform
- Choker White Uniform
- Ribbons
- Mini-Medals-Optional
- 2 sets of Official Navy PT Gear
- Cold weather PT gear (watch cap, gloves, sweats, etc.)
- Running Shoes
- NWU Uniforms (trousers, blouse, blue under shirt, boot bands, leather steel toe boots)
- NWU Parka (optional, but recommended as West Lafayette does experience cold and snowy winters)
- Eisenhower Jacket

**Marine Corps**
- Name Tag
- Tanker Jacket
- Service Dress A
- Service Dress C
- Blue Dress A/B
- Cammies- Woodland and Desert
- Green sweats
- Green PT shorts
- Ribbons
- Medals
- Running Shoes
Medical:

- Register for Tricare Prime Remote. We are in the Tricare North Region and the link is below for registration.
  http://www.tricare.mil/mybenefit/home/overview/LearnAboutPlansAndCosts/TRICAREPrimeRemote

  Cusack, John P MD
  Southside Family Practice
  (765) 471-9146
  3554 Promenade Pky, #F
  Lafayette, IN 47909

- Register for Tricare Dental Program through Concordia Dental.
  https://secure.ucci.com/tdptie/secure/home/home.jsp

  Dentist List, most people use Aspen Dental:
  https://secure.addp-ucci.com/tp2fad/?network=016

  Aspen Dental Group, P.C.
  3725 Rome Dr.
  Ste A
  Lafayette, IN 47905
  (765) 447-2725

Admin:

- Apply early and ask questions frequently if there is any confusion
- Nuclear Option OC’s contact OC Faulter (716-949-4539), and all other OC’s contact either OC Faulter or OC Houston (207-522-7342) regarding any question you may have.
- Register for Classes
  https://wl.mypurdue.purdue.edu/cp/home/displaylogin
    o Make sure you are registered for NS 202. This is the required Naval Leadership Lab that is taken every semester
    o STAR is not required and should be waived by your respective major
- Set up Purdue Webmail account
• OC’s wanting to become Nuclear Engineers, the Nuclear Engineering Assistant information is below to get in contact with. Nuclear Engineering has a 3-year degree plan that will work with no transfer credit. Contact Chrystal Randler and work with her and First Year Engineering if First Year Engineering is not cooperating with a 3-year plan.

Chrystal Randler  
Academic Program Assistant  
Nuclear Engineering  
NUCL 127  
crandler@purdue.edu  
Tel: 765-494-5749  
Fax: 765-494-9570

• Active Duty Persons wanting to use the GI Bill: [http://www.gibill.va.gov/](http://www.gibill.va.gov/)

• Purdue GI Bill contact information:
  
  Teresa Harris  
  regvet@purdue.edu; harri262@purdue.edu  
  (765) 494-7638

**Additional Information:**
-Campus Map Printable PDF: [http://www.purdue.edu/campus_map/CampusMap111111.pdf](http://www.purdue.edu/campus_map/CampusMap111111.pdf)  
-Parking Permit Information: [http://www.purdue.edu/pat/mainnav/parking/students.htm](http://www.purdue.edu/pat/mainnav/parking/students.htm). OCs and MECEPS are not eligible for “A” passes.

**Housing**

**Apartment Complexes / Rental Communities**
The following apartment complexes and Rental Communities are places that OC’s have lived in before and would recommend to incoming officer candidates.

**Purchasing/Renting a House**
Most married OC’s have been purchasing houses instead of living in apartment complexes. Information on local realtors, real estate companies, and neighborhoods can be obtained from your sponsor.

**Foxfire at Valley Lakes**
www.foxfireapartments.com  
2121 Kyra Dr  
Lafayette, IN 47909-8028  
(765) 447-2121  
Nice, newer apartment complex and rental community with available garages, a common area,
gym, and outdoor running track. Internet and television have to be purchased through the
apartment
front office. 15 minutes from campus.

Pheasant Run
http://www.roseresidents.com/pheasantrun/
3090 Pheasant Run Drive
Lafayette, IN 47909-3303
(765) 474-0512
Affordable apartments with good maintenance. Amenities include a dog park, pool, gym,
basketball and tennis courts, and a fishing pond. Internet and television purchased through front
office. Leases include a military clause and a discount for service members. 15 minutes from
campus, also on the bus route.

Bay Pointe
http://www.roseresidents.com/baypointe/
3331 Mystic Lane
Lafayette, IN 47909-5337
(765) 474-3779
Run by the same company as Pheasant Run (next door) witch access to same facilities. Also has
a separate pool.

Blackbird Farms Apartments
http://www.apartments-lafayette-wlh.com/
2411 Kestral Boulevard
West Lafayette, IN 47906
(765) 588-3921
Apartment complex allowing pets up to 25 lbs. Amenities include a pool, gym, and basketball
and tennis courts. Approximately 5 minutes from campus, also on a bus route.

Prime Campus Housing
http://www.primecampushousing.com/
103 Northwestern St
West Lafayette, IN 47906
(765) 743-7700
Apartment Management Company with many
buildings within walking distance of campus.
Caters primarily to students, with many locations available.

The Fairway
http://www.thefairwaypurdue.com
1304 Palmer Dr
West Lafayette, IN 47906
(765) 463-3232

Housing- More geared toward college students.
**Willowbrook West**  
http://www.willowbrookwestlafayette.com/  
2053 Willowbrook Drive  
West Lafayette, IN 47906  
(765) 464-3800

**Campus Suites on the Lake**  
http://www.campussuites.com/purdue-west-lafayette-in/  
3800 Campus Suites Blvd  
West Lafayette, IN 47906  
765-463-9999

**Copper Beech Townhomes**  
http://cbeech.com/westlafayette.htm  
2900 Snowdrop Drive  
West Lafayette, IN 47906  
Phone: (765) 497-5600  
E-Mail: purdue@cbeech.com
TRICARE PRIME ENROLLMENT APPLICATION AND
PCM CHANGE FORM
(Please read Agency Disclosure Notice, Privacy Act Statement, and Instructions before completing this form.)

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 the Department of Defense, Executive Services and Communications Directorate (0720-0008). 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 ORGANIZATION.
SEND YOUR APPLICATION TO THE ADDRESS SHOWN ON THE APPLICATION INSTRUCTION SHEET.

PRIVACY ACT STATEMENT


PRINCIPAL PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources to Military Health Services System beneficiaries applying for coverage under the TRICARE Program (32 CFR 199.17).

ROUTINE USE(S): Information from application forms and related documents may be given to the Department of Health and Human Services, and/or the Department of Transportation consistent with their statutory administrative responsibilities under TRICARE; to the Department of Justice for representation of the Secretary of Defense in civil actions. Appropriate disclosures may be made to other Federal, State, local, and foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, fraud, program abuse, program integrity, and civil and criminal litigation related to the operation of the TRICARE Program.

DISCLOSURE: Voluntary; however, failure to provide information will result in the denial of enrollment.
TRICARE PRIME ENROLLMENT APPLICATION AND PCM CHANGE FORM

This form is for the following:
- Eligible beneficiaries who want to enroll in TRICARE Prime, TRICARE Prime Remote (TPR),
or US Family Health Plan.
- Portability transfers to a new region for the TRICARE program listed above.
- Address changes within the same region for the TRICARE program listed above.
- Primary Care Manager (PCM) changes as follows: Within the same Military Treatment
  Facility (MTF)/Clinic, to an MTF/Clinic, or to a civilian PCM.

### ELIGIBLE CATEGORIES

<table>
<thead>
<tr>
<th>SECTION I Sponsor Information</th>
<th>SECTION II Enrolling Family Members</th>
<th>SECTION III Other Health Insurance</th>
<th>SECTION IV Reason for PCM Change</th>
<th>SECTION V Signature</th>
<th>SECTION VI Enrollment Fee Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Active Duty Members, Reserve Component Members called or ordered to active duty for 30 days or more.</td>
<td>X</td>
<td></td>
<td>Complete if changing PCM</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Active Duty Family Members (ADFMs) and Survivors of Active Duty (first three years in survivor status).</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>Complete if changing PCM</td>
<td>X</td>
</tr>
<tr>
<td>3. Active Duty Family Members of Reserve Component Members called or ordered to active duty for 31 days or more. Must be eligible in DEERS.</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>Complete if changing PCM</td>
<td>X</td>
</tr>
<tr>
<td>4. Retirees, retiree family members, survivors, and eligible former spouses under 65 years of age who reside within the 50 United States or the District of Columbia. This excludes beneficiaries over the age of 65 who are eligible for TRICARE Prime.</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>Complete if changing PCM</td>
<td>X (Must include required payment)</td>
</tr>
<tr>
<td>5. ADFMs, Retirees, retired family members, survivors and eligible former spouses 65 years or older and entitled to Medicare Part A. (Applicable only to US Family Health Plan.)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>Complete if changing PCM</td>
<td>X (If not enrolled in Medicare Part B)</td>
</tr>
</tbody>
</table>

DD FORM 2876, APR 2007
GENERAL INSTRUCTIONS

1. TRICARE Prime - Active duty service members are required to enroll in Prime. Active
duty family members, retirees and their family members are encouraged, but not required,
to enroll in Prime.

2. TRICARE Prime Remote (TPR) is a program for active duty service members and their
family members when the sponsor lives and works over 50 miles or one hour drive from a
Military Treatment Facility (MTF) and the family member lives with the sponsor.

3. Families with more than three members need multiple copies of page 6.

4. Print all information in ink. Make sure the information is complete and accurate.

5. Ensure personal and family information matches information in the Defense Enrollment
Eligibility Reporting System (DEERS). To check your DEERS information, call the Defense
Manpower Data Center (DMDC) Support Office at 1-800-538-9552 and refer to your name
as printed on your military ID card.

If you are an unremarried former spouse, please remember to use your personal SSN as the
sponsor number.

6. There are two address fields for the sponsor and each family member. The Residence
address block should be completed if it is known. If you haven’t established a residence at
the time you are completing this form, insert “To be determined.” in the Residence address
block and complete the Mailing address block. The Mailing address block is only to be
completed if mail is to be sent to an address other than the Residence address. If the
Mailing address block is blank, all mail will be sent to the Residence address. The addresses
and telephone numbers you include on this form will update DEERS.

It is very important that you update your personal information in DEERS whenever your
residence address, mailing address, telephone number, or Medicare status changes. Please
see instruction 5 above.

7. Sign and date the application (Section VI).

8. Please keep a copy of the completed TRICARE Prime Application/PCM Change Form for
your records.

Enrollment in TRICARE Prime requires that all services, except for emergencies, must be
coordinated through the PCM. If not, the beneficiary will be responsible for payment of
charges in accordance with the Point-of-Service (POS) option as described in the TRICARE
Beneficiary Handbook.
9. **US Family Health Plan** is a TRICARE Prime enrollment option for eligible individuals and families who live in seven specific parts of the country: Seattle, Washington; Cleveland, Ohio; Portland, Maine; Brighton, Massachusetts; Staten Island, New York; Baltimore, Maryland; and Houston, Texas. The primary difference between other TRICARE options and the US Family Health Plan is that US Family Health Plan may be used by uniformed service retirees and their eligible family members who are age 65 or older.

10. For enrollment or PCM changes in the **US Family Health Plan**, submit the completed Application/PCM Change Form to the US Family Health Plan address listed below. For questions regarding enrollment/PCM changes in the US Family Health Plan, contact the US Family Health Plan member services at:

<table>
<thead>
<tr>
<th>Area</th>
<th>Address</th>
<th>Phone Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>ME and NH</td>
<td>US Family Health Plan at Martin’s Point Health Care</td>
<td>PO Box 9746 Portland, ME 04104-5040 1-888-241-4556</td>
</tr>
<tr>
<td>MD, PA, VA and WV</td>
<td>US Family Health Plan at Johns Hopkins Medicine</td>
<td>PO Box 815 Glen Burnie, MD 21060 1-800-801-9322</td>
</tr>
<tr>
<td>MA &amp; RI</td>
<td>US Family Health Plan at Brighton Marine</td>
<td>PO Box 9195 Watertown, MA 02471-9900 1-800-818-8589</td>
</tr>
<tr>
<td>NY, NJ, PA and CT</td>
<td>US Family Health Plan at St. Vincent NYC</td>
<td>450 West 33rd Street, 12th Floor New York, NY 10001 1-800-241-4848</td>
</tr>
</tbody>
</table>

**MAILING INSTRUCTIONS**

1. Submit the completed Application/PCM Change Form to the address below. For enrollment or PCM changes in the US Family Health Plan please see instruction 10 above.

   **Health Net Federal Services, LLC**
   PO Box 870143
   Surfside Beach, SC 29587-9743

   Applications can be mailed to the contractor identified above or dropped off at a TRICARE Service Center (TSC). Contact the local TSC in person or call the telephone number listed below in instruction 3 to determine when your new or transferred enrollment will begin.

2. For additional information on TRICARE, contact the local TRICARE Service Center (TSC) or visit the TMA website at www.tricare.osd.mil.

3. For enrollment assistance, please call **Health Net Federal Services, LLC** at 1-877-TRICARE (1-877-874-2273).

**PAY INSTRUCTIONS**

1. If you have elected monthly allotment from retired pay as the payment method for your TRICARE Prime enrollment fees, you must complete an allotment authorization letter provided. If you select this type of payment, you must make the first quarterly payment by check or credit card at the time of application.

2. If you elected electronic funds transfer (EFT) as the payment method for your TRICARE Prime enrollment fees, ensure you provide your banking information in Section VI, Part B of the enrollment application form. If you select this type of payment, you must make the first quarterly payment by check or credit card at the time of application.

3. If you elected credit card as the method for your TRICARE Prime enrollment, ensure you provide your credit card information in Section VI, Part C of the enrollment application form. If you select this type of payment, these payments are made either quarterly or annually.
TRICARE PRIME ENROLLMENT APPLICATION AND
PCM CHANGE FORM
(Please read Agency Disclosure Notice, Privacy Act Statement, and Instructions before completing this form.)

<table>
<thead>
<tr>
<th>Action (X one)</th>
<th>Prime Enrollment</th>
<th>Prime Remote Enrollment</th>
<th>US Family Health Plan Enrollment</th>
<th>PCM Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. SPONSOR SOCIAL SECURITY NUMBER (SSN)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. SPONSOR NAME (Last, First, Middle Initial) (Must match DEERS)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. SPONSOR DATE OF BIRTH (YYYYMMDD)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. SPONSOR IS: (X one)</td>
<td>Active Duty</td>
<td>Retired</td>
<td>Deceased (Go to Section II.)</td>
<td>Former Spouse</td>
</tr>
<tr>
<td>5. RESIDENCE ADDRESS (Street/P.O. Box, Apartment No., City, State, ZIP Code)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. MAILING ADDRESS (If different from residence address)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. SPONSOR TELEPHONE NUMBERS (Include Area Code)</td>
<td>a. HOME</td>
<td>b. WORK</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. CITY AND COUNTRY OF MILITARY ASSIGNMENT (OCONUS only)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. MEMBER'S UNIT AND UNIT IDENTIFICATION CODE (UIC) (If known)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. ZIP CODE OF WORK ADDRESS</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. E-MAIL ADDRESS</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. SPONSOR'S ACTION (X one)</td>
<td>New Enrollment</td>
<td>PCM Change</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>13. SPONSOR PRIMARY CARE MANAGER (PCM) PREFERENCE (Honoring your preference depends upon availability and local Military Treatment Facility (MTF) policy. Contact your TRICARE Service Center, preferred MTF, or US Family Health Plan Member Services for availability of PCMs.) (Complete all that apply.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. PCM NAME MTF/CLINIC (If known)</td>
<td>1st CHOICE</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. PCM SPECIALTY</td>
<td>No Preference</td>
<td>Flight Medicine</td>
<td>Family/General Practice</td>
<td>Internal Medicine</td>
</tr>
<tr>
<td>c. PREFERRED PCM GENDER</td>
<td>No Preference</td>
<td>Male</td>
<td>Female</td>
<td></td>
</tr>
</tbody>
</table>

DD FORM 2876. APR 2007

ORIGINAL: DETACH AND MAIL THIS COPY.
<table>
<thead>
<tr>
<th>Field</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SPONSOR SOCIAL SECURITY NUMBER</strong></td>
<td></td>
</tr>
<tr>
<td><strong>SPONSOR NAME</strong></td>
<td>(Last, First, Middle Initial) (Must match DEERS)</td>
</tr>
<tr>
<td>a. FAMILY MEMBER NAME</td>
<td>(Last, First, Middle Initial) (Must match DEERS)</td>
</tr>
<tr>
<td>b. DATE OF BIRTH</td>
<td>(YYYYMMDD)</td>
</tr>
<tr>
<td>c. RESIDENCE ADDRESS</td>
<td>(Street/P.O. Box, Apartment No., City, State, ZIP Code)</td>
</tr>
<tr>
<td>d. MAILING ADDRESS</td>
<td>(If different from residence address)</td>
</tr>
<tr>
<td>e. RELATIONSHIP TO SPONSOR</td>
<td>Spouse, Former Spouse, Child</td>
</tr>
<tr>
<td>f. TELEPHONE NUMBERS</td>
<td>(1) HOME, (2) WORK</td>
</tr>
<tr>
<td>g. PRIMARY CARE MANAGER (PCM) PREFERENCE</td>
<td>(Honoring your preferences depends upon availability and local MTF policy. Contact your TRICARE Service Center, preferred MTF or US Family Health Plan Member service for availability of PCMs.)</td>
</tr>
</tbody>
</table>

**SECTION II - ENROLLING FAMILY MEMBER INFORMATION**

(Use additional copies of this page to continue as necessary.)

| (1) PCM NAME MTF/CLINIC | 1st CHOICE | Same as Sponsor |
| (2) PCM SPECIALTY | No Preference, Flight Medicine, Pediatrics |
| (3) PREFERRED PCM GENDER | No Preference, Male, Female |

DD FORM 2876, APR 2007  ORIGINAL: DETACH AND MAIL THIS COPY.
**SPONSOR SOCIAL SECURITY NUMBER**

**SPONSOR NAME (Last, First, Middle Initial) (Must match DEERS)**

<table>
<thead>
<tr>
<th>1. IS THE RETIREE OR ARE ANY RETIREE FAMILY MEMBERS ELIGIBLE FOR MEDICARE BASED ON DISABILITY OR END STAGE RENAL DISEASE?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
</tr>
</tbody>
</table>

If Yes, provide a copy of the Medicare card for each family member that is under the age of 65 and entitled to Medicare.

<table>
<thead>
<tr>
<th>2. ARE ANY ENROLLING FAMILY MEMBERS OR IS THE RETIREE CURRENTLY COVERED BY OTHER HEALTH INSURANCE (not a TRICARE Supplement)?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
</tr>
</tbody>
</table>

If Yes, provide the name of the other health insurance and the insurance identification number:

**REASON FOR CHANGE (X one per affected family member)**

<table>
<thead>
<tr>
<th>Name</th>
<th>Move</th>
<th>Other (Explain)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please read and sign only if you are outside the service area.

Your enrollment application indicates that your current address is outside the service area. You may travel to a location where there is a provider network and enroll at that location. However, since you live outside the service area, by signing below, you indicate that your travel time to the network of primary care delivery sites may exceed 30 minutes from your home to the delivery site and your travel time for specialty care may exceed one hour.

**SIGNATURE OF SPONSOR, SPOUSE, OR OTHER LEGAL GUARDIAN OF BENEFICIARY**

<table>
<thead>
<tr>
<th>DATE SIGNED (YYYYMMDD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(YYYYMMDD)</td>
</tr>
</tbody>
</table>

**I understand that it is my responsibility to comply with all TRICARE Prime procedures. By signing the form, I certify that the information on this form 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 imprisonment under applicable Federal law.**

**SIGNATURE OF SPONSOR, SPOUSE, OR OTHER LEGAL GUARDIAN OF BENEFICIARY**

<table>
<thead>
<tr>
<th>DATE SIGNED (YYYYMMDD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(YYYYMMDD)</td>
</tr>
</tbody>
</table>
SECTION VII - PAYMENT OF TRICARE PRIME ENROLLMENT FEES

NOTE: This section is only for retirees, retiree family members, survivors and eligible former spouses.

1. Retired beneficiaries and retiree family members entitled to Medicare Part A and Medicare Part B must be enrolled in Medicare Part B to be eligible for enrollment in TRICARE Prime. TRICARE enrollment fees are waived for these retirees and retiree family members if they provide a copy of their Medicare card as proof of entitlement to Medicare Part A and B and DEERS reflects their entitlement to Medicare Part A and B.

2. Explain all split enrollments (retiree family enrollment in more than one TRICARE Region) on a separate sheet of paper.

<table>
<thead>
<tr>
<th>PAYMENT FEE OPTIONS</th>
<th>MONTHLY</th>
<th>QUARTERLY</th>
<th>ANNUAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. PLAN SELECTION</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
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<tr>
<td>(X one) a. Allotment From Retired Pay (Complete A below)</td>
<td>a. Check/Cashiers Check/Money Order*</td>
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</tr>
<tr>
<td>b. Electronic Funds Transfer (Complete B below)</td>
<td>b. VISA or Master Card (Complete C below)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If you have elected a monthly payment option (Allotment or Electronic Funds Transfer) please see Pay Instructions on Page 4 for further details regarding establishing monthly payments.

If you have elected Monthly Allotment or Electronic Funds Transfer, the first quarterly payment is due at the time of application.

NOTE: Quarterly and annual bills will be sent on a quarterly and annual basis, respectively. Monthly bills will not be sent.

*Make check payable to Health Net Federal Services

---

**A**

I, ____________________________ (Signature of sponsor) choose to have my enrollment fees paid by monthly allotment from my Uniformed Services retired pay.

**B**

I, ____________________________ (Signature of account holder) choose to have my enrollment fees paid by electronic funds transfer.

**C**

I, ____________________________ (Signature of card holder) choose to have my initial enrollment fees billed to my credit card. (Annual and Quarterly initial payments only)

**E**

(1) NAME AND ADDRESS OF FINANCIAL INSTITUTION

(2) TELEPHONE NUMBER OF FINANCIAL INSTITUTION (Include Area Code)

(3) ACCOUNT INFORMATION (X) Savings Checking (Attach voided check)

(4) ACCOUNT NUMBER

(5) BANK OR ABA ROUTING NUMBER

(6) NAME ON ACCOUNT

**C**

I, ____________________________ (Signature of card holder) choose to have my initial enrollment fees billed to my credit card. (Annual and Quarterly initial payments only)

(1) NAME ON CREDIT CARD

(2) CREDIT CARD NUMBER AND EXPIRATION DATE (MMYY)

(3) TYPE OF CARD (X) VISA Master Card
You searched for providers who are within 40 miles from the center of ZIP Code 47905 who meet the following criteria:
Beneficiary Category: TPR
Provider Type: PRIMARY CARE MANAGERS (PCMs)
The closest 10 providers to your location have been returned.

To narrow your results, please search again.

MTF Clinics Providers Printer Friendly Directory
Currently displaying: Providers. Click on the MTF Clinics tab to display the MTF Clinics results.

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https://www.hnfs.net/ProviderDirectory/SearchResults.aspx?searchnow=true

5/7/2007
Valley Lakes Family Medicine
1803 E 350 S Ste 1
Lafayette, IN 47909
(765) 471-9146

John Cusack
For Active Duty Family Members and National Guard and Reserve Members and Their Families

www.TRICAREdentalprogram.com

TRICARE Dental Program

At a Glance

For Active Duty Family Members and National Guard and Reserve Members and Their Families
The TRICARE Dental Program—
the Dental Plan for You

United Concordia Companies, Inc. (United Concordia) has been selected by the Department of Defense to continue offering the TRICARE Dental Program (TDP) to family members of active duty uniformed services personnel and to National Guard and Reserve members and their families.

The TRICARE Dental Program is ...

... **Affordable**
Government-shared premiums and cost-shares ensure you get the most coverage for minimal out-of-pocket costs.

... **Portable**
Active duty families move often. The TDP offers coverage worldwide, so when your sponsor changes duty stations, you don’t have to change dental plans.

... **Flexible**
Coverage for National Guard and Reserve members and their families changes as the sponsors’ status changes from inactive to active duty. The TDP guarantees continuous dental coverage when you need it.

Join the TDP today to enjoy a nationwide network of participating dentists, high-quality customer service, and comprehensive dental coverage designed specifically with you in mind!

---

**An Important Note about TRICARE Dental Program Information**

At the time of printing, the information in this publication is current. It is important to remember that TRICARE policies and benefits are governed by public law. Changes to TRICARE programs are continually made as public law is amended. For the most recent information, contact United Concordia at 1-800-866-8499 (CONUS) or 1-888-418-0466 (OCONUS) or visit them online at www.TRICAREdentalprogram.com.
Who Is Eligible?

The TDP is available to:

• Family members of active duty uniformed services personnel*
• Family members of National Guard and Reserve service members
• National Guard and Reserve service members who are not on active duty

Family members include spouses and unmarried children (including stepchildren, adopted children, and court-appointed wards) under the age of 21. Unmarried children are eligible up to the end of the month in which they turn 21 and may be eligible up to age 23 in certain circumstances.

To be eligible to enroll in the TDP, the sponsor must have at least 12 months remaining on his or her service commitment at the time of enrollment. This service commitment will be based on the time remaining in any single status or in any uninterrupted combination of active duty, National Guard, or Reserve status.

In some circumstances, the 12-month minimum enrollment requirement may be waived for National Guard and Reserve family members and for sponsors who are activated in support of certain contingency operations. Contact United Concordia Enrollment and Billing at 1-888-622-2256 to determine your eligibility for this waiver.

* The uniformed services include the U.S. Air Force, U.S. Army, U.S. Navy, U.S. Marine Corps, U.S. Coast Guard, the Commissioned Corps of the U.S. Public Health Service (USPHS), and the Commissioned Corps of the National Oceanic and Atmospheric Administration (NOAA).

Who Is Not Eligible?

The following individuals are not eligible to enroll in the TDP:

• Active duty service members, including National Guard and Reserve members called or ordered to active duty for more than 30 consecutive days
• Retired service members and their families
• Former spouses
• Parents and parents-in-law
• Disabled veterans
• Foreign military personnel
Verifying Eligibility

Eligibility will be verified in the Defense Enrollment Eligibility Reporting System (DEERS) by United Concordia. Please ensure your personal information is updated in DEERS. If eligibility cannot be confirmed, enrollment will be denied.

DEERS information may be verified by contacting the nearest uniformed services personnel office (where military ID cards are issued). Sponsors or registered family members may make address and contact information changes; however, only the sponsor can add or delete family members from DEERS. The sponsor must provide proper documentation, such as a marriage certificate, divorce decree, and/or birth certificate.

You may update your DEERS information in one of the following ways:

- Visit the Web site at https://www.dmdc.osd.mil/appj/address/index.jsp. This is the quick and easy way to update your information (address and contact information only).
- Visit a local personnel office that has a uniformed services ID card facility or a Real-Time Automated Personnel Identification System (RAPIDS) office. To locate the nearest RAPIDS office, visit www.dmdc.osd.mil/rsl. Call ahead for hours of operation and for instructions.
- Fax changes of address and contact information to the Defense Manpower Data Center Support Office at 1-831-655-8317.
- Call the Defense Manpower Data Center Support Office at 1-800-538-9552 or 1-866-363-2883 (TTY/TDD). Hours of operation: Monday–Friday, 6 a.m. to 3:30 p.m. Pacific Time, except Federal holidays.
- Mail the changed address and contact information to:
  Defense Manpower Data Center
  Support Office
  Attn: COA
  400 Gigling Road
  Seaside, CA 93955-6771
Living Overseas?

The TDP Has You Covered

The CONUS (inside the Continental United States) service area includes the 50 United States, the District of Columbia, Puerto Rico, Guam, and the U.S. Virgin Islands. The OCONUS (outside of the Continental United States) service area includes all other countries, island masses, and territorial waters not in the CONUS service area. Covered services provided on a ship or vessel that is outside the territorial waters of the CONUS service area are covered under the OCONUS service area, regardless of the dentist’s office location.

All enrollees are eligible for dental care in both the CONUS and OCONUS service areas. The family member does not have to be command-sponsored or listed on the sponsor’s change of assignment orders to receive dental care in the OCONUS service area. However, there is a difference between the cost-share amounts paid by command-sponsored and non-command-sponsored family members. Command-sponsored family members enjoy reduced cost-shares when care is received OCONUS. Family members who are not command-sponsored are responsible for the applicable cost-share portion when care is received in both the CONUS and OCONUS service areas.

The OCONUS service area is further categorized into non-remote and remote locations.

Non-Remote OCONUS Locations

Non-remote OCONUS locations are those countries in which the uniformed services have a fixed overseas dental treatment facility (ODTF). Non-remote countries include:

- Azores
- Bahrain
- Belgium
- Diego Garcia
- Germany
- Iceland
- Italy/Sardinia
- Japan
- Portugal
- South Korea
- Spain
- Turkey
- United Kingdom

Remote OCONUS Locations

Remote OCONUS locations are those countries that do not have a fixed uniformed services ODTF. This includes countries with “part-time” ODTFs. All OCONUS countries not listed on the above Non-remote OCONUS Locations list are considered remote locations.

Policies and procedures vary in OCONUS service areas. Contact your local ODTF or overseas TRICARE Area Office (TAO) before receiving any care. Staff from these facilities will inform you about local dentists, referral procedures, and claims submission.

For additional information about the OCONUS program:

- Contact United Concordia’s TDP OCONUS Dental Unit, 24 hours a day, Monday–Friday, toll-free at 1-888-418-0466.*

* From the OCONUS service area, you must first dial your local access code.
National Guard and Reserve Members and Their Families

Why the TDP Is the Perfect Dental Plan for You

The TDP is perfectly designed for National Guard and Reserve sponsors and their families because it uniquely changes as a National Guard or Reserve sponsor’s status changes. The TDP offers continuous coverage to family members and only covers National Guard and Reserve sponsors when they need it—when they are not on active duty.

National Guard and Reserve Sponsor Coverage

National Guard and Reserve sponsors are eligible to enroll in the TDP when they are not on active duty—in other words, while on inactive duty or drilling status. If a TDP-enrolled National Guard or Reserve sponsor is called or ordered to active duty for more than 30 consecutive days, he or she will be automatically disenrolled from the program during the period of activation and automatically re-enrolled upon deactivation.

A National Guard or Reserve sponsor’s enrollment is separate from his or her family’s enrollment and will have a separate monthly premium. The sponsor can be enrolled even if the family is not enrolled.

National Guard and Reserve Family Member Coverage

National Guard and Reserve family members can enroll in the TDP at any time, even if their sponsor does not enroll. The plan offers continuous dental coverage throughout the sponsor’s changing status—from inactive to active and back again. In fact, if a National Guard or Reserve sponsor is activated, family members will enjoy reduced monthly premiums when their sponsor is activated, because they are considered “active duty family members” during that period of activation.

The TDP coverage available to National Guard and Reserve members and their families changes depending on the sponsor’s status—active or inactive. To see specific information about enrollment eligibility, length of a TDP commitment, monthly premiums, and benefits, visit the TDP Web site at www.TRICAREdentalprogram.com.
Enrolling Is Easy

The active duty, National Guard, or Reserve sponsor must sign the TDP Enrollment/Change Form. Family members cannot enroll without the sponsor's signature on the enrollment form. If the sponsor is unavailable, an individual with Power of Attorney (POA) may sign the form, and a copy of the POA must be provided with the form. Failure to provide this documentation will result in denial of the enrollment.

Enrollment in the TDP may be through a single plan or a family plan.

<table>
<thead>
<tr>
<th>Single Plan</th>
<th>Family Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who can enroll?</td>
<td>• One National Guard or Reserve member • One eligible family member</td>
</tr>
<tr>
<td></td>
<td>• Two or more eligible family members</td>
</tr>
<tr>
<td>How much will it cost?</td>
<td>• Premiums vary depending on the number of members enrolled and the sponsor’s status (active vs. inactive). For current premium amounts, visit <a href="http://www.TRICAREdentalprogram.com">www.TRICAREdentalprogram.com</a> or call 1-888-622-2256.</td>
</tr>
</tbody>
</table>

1. Children under the age of 4 can be voluntarily enrolled at any time. They are automatically enrolled on the first day of the month following the month they reach age 4, if an existing contract is in effect. If the existing contract is for a single family member only, the premium will change from the single plan rate to the family plan rate.

All new enrollees must remain enrolled in the TDP for at least 12 months regardless of any previous enrollment. After completing the 12-month minimum enrollment period, enrollment may be continued on a month-to-month basis. If a National Guard or Reserve sponsor is called or ordered to active duty, that active duty period does not count toward fulfillment of the 12-month enrollment period.

Three Convenient Ways to Enroll

**OPTION 1**

**Online**
Go to www.TRICAREdentalprogram.com, complete the online TDP Enrollment/Change Form, and use a credit card (Visa® or MasterCard®) to make your initial premium payment. Upon completion of the online enrollment process, a transaction number is provided, which you should keep for future reference. If you include your e-mail address on the form, you will receive an e-mail confirmation of your online enrollment.

**OPTION 2**

**Mail**
Fill out the TDP Enrollment/Change Form and mail it along with your initial premium payment to United Concordia at the following address:

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

**OPTION 3**

**Fax**
Fax your TDP Enrollment/Change Form and initial payment (credit card only) to 1-888-734-1944.

You must include an initial payment equal to one month's premium with your enrollment application.

If you need a copy of the enrollment form, you can download it at www.TRICAREdentalprogram.com or call United Concordia at 1-888-622-2256. Forms also are available at local dental treatment facilities.

To ensure your coverage begins as soon as possible, fill out the enrollment form completely. An incomplete application may delay your enrollment or result in denial.
Enrollment Deadlines

If your application is received by the 20th of the month, enrollment will begin the first day of the following month. If your application is received after the 20th of the month, enrollment will begin the first day of the second month. For example, if the enrollment application and initial premium payment are received by February 20, coverage will be effective March 1. If the enrollment application and initial premium payment are received February 21, coverage will be effective April 1. Enrollment is processed according to the date of receipt, not by a postmark date or the date on the application.

Your enrollment in the TDP is confirmed when you receive your dental enrollment card(s) in the mail. You will also receive a TRICARE Dental Program Benefit Booklet. The effective date of your coverage will be shown on the enrollment card(s). United Concordia will not consider payment for services provided prior to the effective date of the policy.

Please contact United Concordia at 1-888-622-2256 if you have questions about completing your enrollment application or to confirm the effective date of your TDP coverage.

Monthly Premiums

United Concordia will collect your monthly premiums from your payroll account if sufficient funds are available. If there are insufficient funds or no payroll account is available at the time of billing, United Concordia will bill the sponsor directly for the premium amount by issuing a monthly invoice.

TDP-enrolled sponsors and family members who are both receiving bills directly will receive two monthly invoices. United Concordia will automatically direct-bill for premiums due from Individual Ready Reserve (IRR) service members and from Selected Reserve and IRR family members.

Premiums are paid for a full month of coverage. There are no circumstances when a partial premium can be paid. Payments can be made by check or money order. Electronic billing (eBill) also is available at www.TRICAREdentalprogram.com, and payments can be made with Visa, MasterCard, or electronic checking (ACH). Through eBill, you can pay your balance immediately, schedule payment for a future date, or set up automatic monthly payments.
Costs and Coverage

The following chart provides an overview of enrollee cost-shares for covered services.

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<td>0%</td>
<td>0%</td>
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<td>Preventive (except sealants)</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
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<tr>
<td>Sealants</td>
<td>20%</td>
<td>20%</td>
<td>0%</td>
</tr>
<tr>
<td>Consultation/Office Visit</td>
<td>20%</td>
<td>20%</td>
<td>0%</td>
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<tr>
<td>Basic Restorative</td>
<td>20%</td>
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<tr>
<td>General Anesthesia</td>
<td>40%</td>
<td>40%</td>
<td>0%</td>
</tr>
<tr>
<td>Intravenous Sedation</td>
<td>50%</td>
<td>50%</td>
<td>0%</td>
</tr>
<tr>
<td>Miscellaneous Services</td>
<td>50%</td>
<td>50%</td>
<td>0%</td>
</tr>
<tr>
<td>Orthodontic Diagnosis Services</td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Other Restorative</td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Implant Services</td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Prosthodontic</td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Orthodontic²</td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
</tr>
</tbody>
</table>

1. Selected Reserve and IRR family members and IRR (other than Special Mobilization Category) sponsors are responsible for the applicable cost-share portion regardless of where the treatment is received.

2. Age limitations apply to orthodontic services.

Maximums

The TDP limits how much can be paid for dental services per enrollee. The following table outlines the TDP maximum amounts.

<table>
<thead>
<tr>
<th>Maximum Benefit Type</th>
<th>Maximum Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental Program Annual Maximum Benefit</td>
<td>$1,200 per enrollee per contract year (February 1–January 31 each year) for non-orthodontic services</td>
</tr>
<tr>
<td>Orthodontic Lifetime Maximum Benefit¹</td>
<td>$1,500 per enrollee for orthodontic treatment. If an enrollee receives orthodontic services, payments for these services will not exceed $1,500 during the enrollee's eligibility lifetime. Orthodontic diagnostic services will be applied to the $1,200 dental program annual maximum.</td>
</tr>
</tbody>
</table>

¹. Age limitations apply to orthodontic services.

For more information, including a complete list of TDP-covered services, visit www.TRICAREdentalprogram.com or contact United Concordia at 1-800-866-8499.
Choosing a Dentist

Participating Dentists
While you may receive dental care from any licensed/authorized dentist, you can save money and time by choosing a United Concordia participating dentist. Participating dentists have agreed to accept United Concordia's allowances for covered services. They do not require full payment at the time of service—only the applicable cost-share. Additionally, they will submit your claims for you.

To find a participating dentist, call United Concordia at 1-800-866-8499 or visit the Web site at www.TRICAREdentalprogram.com and click on “Find a Dentist” under the Enrollees tab. You can search for a dentist by last name, specialty, city, county, or ZIP code. The online directory is updated weekly.

You also can contact your local Beneficiary Counseling and Assistance Coordinator (BCAC) for assistance in finding a participating dentist. Visit the BCAC directory online at www.tricare.mil/bcacdcao.

United Concordia participating dentists are available only in the CONUS service area.

Nonparticipating Dentists
You also can access care from nonparticipating dentists. However, nonparticipating dentists may require payment at the time services are received. In addition, you will pay any difference between United Concordia’s allowance and the dentist’s usual charge, as well as the applicable cost-shares. You also may be required to file your own claims.

OCONUS Dentists
United Concordia maintains a list of dental providers in the OCONUS service area on the Web site at www.TRICAREdentalprogram.com. Click on “Find an Overseas Host Nation Provider” under the Enrollees tab. The ODTFs and TRICARE Area Offices (TAOs) can provide a list of host nation dentists from the TDP Web site.

Included in this directory are TRICARE OCONUS Preferred Dentists (TOPDs). TOPDs have agreed to the following:

- TOPDs will not require you to pay their full charge at the time of service—only your applicable cost-share, if any.
- TOPDs will complete and submit your claim forms.
- TOPDs will submit predeterminations for complex and costly services prior to rendering treatment.

The TOPD program is a new initiative that began in 2007 and is not currently available in all OCONUS non-remote locations. Check the TDP Web site for availability in your area.

You do not have to utilize a TOPD to receive TOP OCONUS benefits; however, with a non-TOPD provider, you may be required to pay for services before you receive care. You may also be required to submit your own claim and other required documentation.

See the “Living Overseas?” section of this brochure for information on obtaining dental care in the OCONUS service area.
For Information and Assistance

Customer Service

Customer Service (CONUS Service Area)
United Concordia
TDP Customer Service
P.O. Box 69410
Harrisburg, PA 17106-9410
1-800-866-8499 (toll-free)
24 hours per day, Monday–Friday
1-800-891-1854 (toll-free TDD)
E-mail: conus@ucci.com

Customer Service (OCONUS Service Area)
United Concordia
TDP OCONUS Dental Unit
P.O. Box 69418
Harrisburg, PA 17106-9418
1-888-418-0466* (toll-free)
24 hours per day, Monday–Friday
E-mail: oconus@ucci.com

* From the OCONUS service area, you must first dial your local access code. Representatives are available to assist members in English, German, Italian, Japanese, Korean, and Spanish.

Enrollment and Billing

TDP Enrollment/Change Form
and Initial Payment
United Concordia/TDP
P.O. Box 827583
Philadelphia, PA 19182-7583
Fax (credit card enrollments only):
1-888-734-1944 (toll-free)

Enrollment and Billing Customer Service
1-888-622-2256 (toll-free)
8 a.m.–8 p.m. Eastern Time, Monday–Friday

General Correspondence
United Concordia
TDP Enrollment and Billing
P.O. Box 69426
Harrisburg, PA 17106-9426
E-mail: eabem@ucci.com

UNITED CONCORDIA
TDP 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, C 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.

Sponsor Social Security Number

Sponsor Name (Last, First, Middle Initial)

Date of Birth (mm/dd/yy)

Sex □ M □ F

SECTION A

Home Address:

City State Zip Code Country

Home Phone:

SECTION B

Sponsor’s Military Status

☐ Active Duty ☐ AGR

☐ SELRES ☐ IRR

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

Please indicate if you intend to remain in the service for at least 12 months.

☐ Yes ☐ No (If no, you will not be enrolled.)

(See Section A on reverse side for "Notice of intent."

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

Note: Reserve Sponsors and Reserve family members are separate contracts, but may enroll on a single form.

SECTION 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

☐ Check or money order ☐ Visa* ☐ MasterCard*

Credit Card Number ____________________________ Expiration Date __/____

Name of card holder as it appears on credit card

Authorized Signature

SECTION E

Effective Date of Policy (mm/dd/yy)

Please list family members covered under this policy:

Policy Holder

Insurance Company

Policy Number

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.

5579 F 11/09 Instructions for completion of form on back.
Most of the TDP Enrollment/Change 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 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, 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-month 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 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 TDP 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 TDP Enrollment/Change Form.

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### Monthly Premiums

<table>
<thead>
<tr>
<th>Active Duty</th>
<th>Selected Reserve</th>
<th>Individual Ready Reserve</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Single Premium</strong></td>
<td><strong>Family Premium</strong></td>
<td><strong>Sponsor-Only Premium</strong></td>
</tr>
<tr>
<td>(one family member)</td>
<td>(more than one family member)</td>
<td>(one family member, excluding Sponsor)</td>
</tr>
<tr>
<td><strong>Feb 1, 2009– Jan 31, 2010</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$12.12</td>
<td>$30.29</td>
<td>$12.12</td>
</tr>
<tr>
<td><strong>Feb 1, 2010– Jan 31, 2011</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$12.69</td>
<td>$31.72</td>
<td>$12.69</td>
</tr>
</tbody>
</table>

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

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For help completing the TDP Enrollment/Change Form, call: 1-888-622-2256 United Concordia/TDP 1-888-734-1944

For all other enrollment changes and correspondence:
The TDP Enrollment/Change Form may be faxed to: P.O. Box 827583 Philadelphia, PA 19182-7583

Send TDP Enrollment/Change Forms with payments to: United Concordia/TDP P.O. Box 69426 Harrisburg, PA 17106-9426

Additional TDP information can be found at www.TRICAREdentalprogram.com.
Completing the TDP Claim Form

AGENCY DISCLOSURE STATEMENT - 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 the Department of Defense, Washington Headquarters Services, Executive Services Directorate, Information Management Division. 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 COMPLETED FORM TO THE ABOVE ADDRESS.
The completed form should be sent to United Concordia, TDP CONUS Dental Unit, P.O. Box 69411, Harrisburg, PA 17106-9411

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

- Upper left corner. **Dentist's Claim Form**: Check the appropriate box to indicate if your claim is for predetermination (estimate of services to be performed) or for services actually received.

- **Box 2. Relationship to sponsor**: For example, self, spouse, or child.

- **Box 7. Sponsor's Social Security number (SSN)**: The sponsor's nine-digit SSN must appear on every claim form.

- **Box 8. Patient mailing address**: Be sure to provide the current and complete mailing address to include APO/FPO and/or street, city, state, country, and postal mailing code.

- **Box 10. Release of Information**

- **Box 13. Is patient covered by another dental plan?**: Check "No" if the family member has no other dental insurance. If the family member has additional dental insurance, please check "Yes" and include the plan name, insured name and Social Security number, group number, and address of the other carrier.

- **Box 14. Assignment of Benefits**: Sign if the family member, parent, or guardian wants to assign payment of benefits to the dentist; if signed, United Concordia will send payment to the dentist directly.

- **Box 15. Dentist name; 15a. Provider no.**: The provider number represents the provider number assigned by United Concordia.

- **Box 16. Mailing address**: Include street, city, state, country, and postal mailing code.

- **Box 30. Examination and treatment plan**: Provide a detailed description of the services performed, including applicable tooth numbers, dates of service, and the fee charged.

**General Instructions**

- Submit a separate claim form for each family member who receives treatment.

- **All claim forms should be submitted to United Concordia as soon as possible after the service date**, preferably within 60 days of the date of service. Claims postmarked more than 12 months after the date of service will be denied.

- The member must sign the appropriate sections of the claim form. If the family member is under 18 years of age, the parent or guardian must sign the form.

- The dentist must sign the appropriate sections of the claim form.
DENTIST'S CLAIM FORM

Check □ Dentist's pre-treatment estimate
□ Dentist's statement of actual services

UNITED CONCORDIA
TRICARE Dental Program
P.O. Box 69411
Harrisburg, PA 17106-9411

OMB No. 0720-0035
Expires Jan. 31, 2009
Harrisburg, PA 17106-9411

Claims Processing
P.O. Box 69411

1. Patient name

2. Relationship to sponsor
   self spouse child other

3. Sex
   m f

4. Patient birth date
   day month year

5. If part-time student
   school city

6. Sponsor's name
   First Middle Last

7. Sponsor's Social Security number (SSN)

8. Patient mailing address
   City, State, Zip

9. Telephone number

10. I have reviewed the following treatment plan.
    I authorize release of any
    information relating to this claim.

   Signature (patient or parent if minor) Date

11. Branch of service

12. Group name

TRICARE Dental Program

13. Is patient covered by
    another dental plan?

   Yes □ No □

    Insured name and Subscriber Identifier (SSN or ID#)

    Name and address of carrier

14. I hereby authorize payment of my group insurance benefits, otherwise payable to me, to
    the dentist listed below.

   Signature (insured person) Date

15. Dentist name

15a. Provider no.

16. Mailing address—street address
   City, State, Zip

17. Dentist SSN or TIN

18. Dentist license no.

19. Dentist phone no.

20. First visit date

21. Place of treatment
   Office Hosp E/C Other

22. Radiographs and/or
    documentation enclosed

23. Is treatment result of
    occupational illness or injury?

   Yes □ No □

24. Is treatment result of
    auto accident?

25. Other accident?

26. If prosthesis, is
    this initial
    placement?

   (If no, reason for replacement) Date

27. Date of prior
    placement

28. Is treatment for
    orthodontics?

29. Transfer patient?

   Yes □ No □

   Starting date of
   treatment

30. Examination and treatment plan—list in order from Tooth No. 1 through Tooth No 32—Use charting system shown.

31. Missing teeth information

   Permanent Primary

   Place an 'X' on each missing tooth

   ARCD E FGH I J K L M N O P S T U V W X Y

   Remarks for unusual services

32. Total fee charged

   $0.00

34. Payment or copay of
    other plan

5876 G 9/05