



TRICARE OVERSEAS PROGRAM PRIME ENROLLMENT APPLICATION

SPONSOR INFORMATION

CAN BE COMPLETED BY ANY ADULT BENEFICIARY. SEE REVERSE FOR DIRECTIONS. PLEASE PRINT CLEARLY.

Overseas Area (Circle One) TRICARE Europe TRICARE Pacific TRICARE Latin America and Canada

1. Sponsor Name (last, first, middle initial)		2. Sponsor Social Security Number		3. Sex	4. City and Country		5. Date of Birth (dd/mmm/yy)		6. Rank	7. Telephone Numbers	
										Home:	
										Duty:	
8. Duty Address (Unit, Office Symbol, Station, APO/FPO)			9. DEROS/PRD (*required*)		10. Mailing Address				11. Sponsor Branch of Service (Must be Active Duty)		
									Army	Air Force	Navy
									Marines	USCG	NOAA/PHS
12. E-Mail Address (if available) Please Print Clearly		13. Sponsor Status (circle One)				14. Preferred Military Treatment Facility Site/ PCM (if applicable)					
		Active Component		Activated Guard/Reserve		Flyer/PRP					
		Transitional Survivor		Other _____							

FAMILY MEMBER INFORMATION

LIST ALL FAMILY MEMBERS WHO ARE EITHER COMMAND SPONSORED, OR RESIDED WITH THE SPONSOR IN COUNTRY AT THE TIME OF ACTIVATION, WHO ARE APPLYING FOR ENROLLMENT IN A TRICARE OVERSEAS PRIME OPTION. PLEASE PRINT CLEARLY. (Please do not list members not physically residing with you.)

15. Family Member Name (last, first, middle initial)	16. Date of Birth (dd/mmm/yy)	17. Relation to Sponsor	18. Date of Arrival in Country	19. Current City & Country of Residence	20. Military Treatment Facility (if applicable)	21. PCM Selection

COPY OF ORDERS REQUIRED

22. SIGNATURE: "I have read the instructions on the reverse side of this form and understand the Privacy Act Statement listed there. I further request enrollment for myself and my listed family members in the TRICARE Overseas Program Prime option."			SIGNATURE		DATE	
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Other Health Insurance Information

Name of Insurance Carrier	Plan Option	Insurance Account Number	Effective Date
I hereby certify that my other health information provided in this section is complete and correct. I understand that my other health insurance will be first payer on all TRICARE medical claims.		Signature	Date

INSTRUCTIONS

TOP – Please circle applicable overseas location. Note: TRICARE Europe also includes the Middle East and Africa. TRICARE Latin America also includes Caribbean nations.

1. SPONSOR NAME - Last name, first name, middle initial.
2. SPONSOR SOCIAL SECURITY NUMBER - This is the SSN of the active duty member
3. SEX – M for male or F for female.
4. CITY AND COUNTRY - Where the sponsor is stationed.
5. DATE OF BIRTH - Enter DOB of sponsor. List by dd/mmm/yy (example: 11 Oct 62).
6. RANK - List sponsor's rank (not pay grade; e.g. Army 0-4 should be MAJ).
7. TELEPHONE NUMBER - Sponsor's work & home phone numbers to include country code or foreign DSN prefix.
8. DUTY ADDRESS - Please list Unit, Office Symbol, Installation, APO/FPO, Zip Code. (If attached or remotely assigned to a subordinate unit, please use your actual unit assignment and duty location rather than that of the parent unit.)
9. DEROS/PRD - Enter the sponsor's date of estimated return from overseas or the projected rotation date.
10. MAILING ADDRESS - This is the mailing address where you currently reside. Please include PSC, Box Number, APO and Zip Code.
11. SPONSOR BRANCH OF SERVICE: Circle the appropriate selection.
12. E-MAIL ADDRESS: Please provide if one exists for work, home or both. (This will provide another avenue for important medical benefit information to be distributed)
13. SPONSOR STATUS. Circle the appropriate selection
14. PREFERRED MILITARY TREATMENT FACILITY SITE. Choose the military treatment facility where you would prefer to be enrolled. If you are in an area with overlapping military treatment facility service areas, choose the facility most convenient to your duty or residence. If you are located in a remote area outside of a military treatment facility service area, this block will not be applicable. (Note: The enrollment specialist may request that a primary care manager also be entered in this block.)

15. FAMILY MEMBER NAME. List each family member (last name, first name, middle initial) who accompanied the sponsor overseas and is listed on the sponsor's original orders. **Please note: Currently, active duty family members who accompany their sponsor from the U.S. must be listed on the sponsor's travel orders in order to enroll in TRICARE Overseas Program Prime Options.**
16. DATE OF BIRTH. List the DOB for each family member. List by dd/mmm/yy (example: 01Jan 60).
17. RELATIONSHIP TO SPONSOR: Please enter spouse, son, daughter, as appropriate. **IF SPOUSE IS ALSO AN ACTIVE DUTY SERVICE MEMBER, PLEASE COMPLETE A SEPARATE ENROLLMENT FORM** (Family members should only be listed on the form for the active duty service member whose DEERS information reflects family member dependence.)
18. DATE OF ARRIVAL IN COUNTRY. Provide date family arrived in country using the following format dd/mmm/yy (e.g. 01 Jan 07)
19. CURRENT CITY AND COUNTRY OF RESIDENCE – Family members of activated reservists must reside with the sponsor in an overseas location at the time of activation to be eligible for TRICARE Overseas Program Prime options.
20. MILITARY TREATMENT FACILITY – Select the preferred Military Treatment Facility, if applicable (see #14).
21. SELECT A PCM FOR EACH FAMILY MEMBER. If you have questions, contact the TRICARE Service Center supporting the military treatment facility where you would like to have family members enrolled. (This may not be applicable depending on overseas area and TRICARE Overseas Program Prime option.)
22. SIGNATURE. Either adult beneficiary must sign and date the form. The signature of the sponsor or the sponsor's spouse is required.
23. OTHER HEALTH INSURANCE INFORMATION – Please provide the carrier, plan account number, and effective date of any health insurance policy that currently covers any of your TRICARE-eligible family members. **Please Note:** National health insurance that covers a TRICARE beneficiary is considered other health insurance and should be reported.

PRIVACY ACT STATEMENT

AUTHORITY: Title 10, USC, Sec. 1095 and 1099; EO 9397

PRINCIPAL PURPOSE(S): Information will be used to enroll the beneficiary(ies) in TRICARE Overseas Prime programs, and to assign Primary Care Managers (PCMs) to each enrollee. Information will also be used by military treatment facility (MTF) staff and TRICARE contractors to determine eligibility for care and payment of claims.

ROUTINE USE(S): The information on this form will be released to the MTF staff, TRICARE contractors, and providers of health care.

DISCLOSURE: Is voluntary, however, failure to provide the information requested may preclude your enrollment in TRICARE Overseas Prime programs.