Enrollment Fee Allotment Authorization Letter

US FAMILY HEALTH PLAN | TRICARE®

PRIVACY ACT STATEMENT

This statement serves to inform you of the purpose for collecting personal information required by Uniformed Services Family Health Plan on behalf of the TRICARE® program, and how it will be used.

AUTHORITY: 10 U.S.C. Chapter 55; 38 U.S.C. Chapter 17; 32 CFR Part 199, and E.O.9397 (SSN), as amended.

PURPOSE: This information will be used by USFHP to electronically debit or stop payment of your monthly enrollment fees from your monthly retirement pay, checking or savings account, or credit card.

ROUTINE USES: Your information may be disclosed in order to investigate waste, fraud and abuse, security, and privacy concerns. Use and disclosure of your records outside of DoD may occur in accordance with the DoD Blanket Routine Uses published at http://dpclo.defense.gov/privacy/SORNs and as permitted by ther Privacy Act of 1974 as amended (5 U.S.C. 552a(b)). Any protected health information (PHI) in your records may be used and disclosed as permitted by the HIPAA Privacy Rule (45 CFR Parts 160 and 164), and includes purposes of treatment, payment, and health care operations.

DISCLOSURE: Voluntary; if you choose not to provide your information, no penalty may be imposed, but absence of the requested information may result in administrative delays or the inability to process an individual's request.

Please type or print all entries.

Name: Last	First	M.I.	Sponsor SSN - -
Home Address: Street	Apt. No.	City	State ZIP Code

Indicate below the action you wish to take for the allotment process.

Please mark one of the three boxes and complete the requested information.

☐ Please **start** a monthly allotment to USFHP from my retirement pay for USFHP TRICARE Prime enrollment fees.

I have included a credit card payment for the three-month payment of enrollment fees payable to USFHP. I understand this payment is waived when transferring from another region and an allotment has already been set up in that region.

CARDHOLDER NAME (Please Print) _____

CARD NUMBER _____ EXP DATE (MM/YYYY) ____/____ CARD VALIDATION NUMBER _____

CARDHOLDER SIGNATURE _____

☐ Please **change** my existing monthly allotment to USFHP from:

☐ Individual to Family ☐ Family to Individual

☐ Please **stop** my existing monthly allotment USFHP effective (MM/YY) ___/____.

I hereby authorize the above action (start, change or stop) be taken by USFHP from my military retirement pay. I understand this authorization will remain in effect until I request it be changed or stopped; however, as a courtesy to me, I also hereby authorize USFHP to automatically stop this allotment at a future date if I become disenrolled from the USFHP for any reason, including transferring my enrollment to a different TRICARE region.

Sponsor Signature (Required): _____ **Date:** ____/____/____

USFHP will attempt to start the allotment from your military retirement pay by the next payment due date. You will be notified by USFHP to make alternative payment arrangements if the allotment from your retirement pay could not be started by this date. Allotments are only authorized from military retirement pay received from either DFAS, Coast Guard or Public Health. Other payments received such as VA benefits, survivor benefits or combat related compensation are not eligible.

For **New Enrollments**,
include this request with the Enrollment Form.
Please complete, sign, and mail this form and payment to:
US FAMILY HEALTH PLAN
5 Penn Plaza - 9th Floor, New York, NY 10001