Enrollment Exception Request

PRIVACY ACT STATEMENT

This statement serves to inform you of the purpose for collecting personal information required by Health Net Federal Services, LLC (Health Net) 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: To collect information from you in order to assess reinstatement or waiver, and manage your TRICARE enrollment if applicable.
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 the 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.

Sponsor/TRICARE Young Adult (TYA) Enrollee Information

Sponsor/TYA Enrollee Name: _____ Sponsor/TYA Enrollee SSN: _____
Last Name *First Name* *M.I.*

Address: _____
Street Address *Apartment/Unit #* *City* *State* *ZIP Code*

Email: _____

Step 1: Please specify the plan you are requesting

☐ **Select** ☐ **Prime** ☐ **TRICARE Prime Remote** ☐ **TRICARE Reserve Select** ☐ **TRICARE Retired Reserve**

☐ **TYA Prime** or ☐ **TYA Select**

Requested Effective Date _____/_____/_____

Step 2: Please provide a *detailed* explanation and attach supporting documentation (if applicable) for your enrollment exception request.

_____

_____

_____

_____

_____

Step 3: Please check the box below if you would like to include all eligible family members in the Defense Enrollment Eligibility Reporting System (DEERS) in your request. If not, please specify which family members you want to include:

☐ All eligible family members

_____

Step 4: Sign the request form.

Signature must be of sponsor, spouse, TYA enrollee, or other legal guardian of beneficiary.

Signature: _____ Date: _____

Step 5: Please mail or fax to the address below.

Health Net Federal Services, LLC
TRICARE West Region Enrollment Department
PO BOX 8458
Virginia Beach, VA 23450-8458
FAX: 1-844-388-8282

Important Information: Submission of this form does not guarantee an approved exception to policy. Please allow 10 business days for review and processing. The determination of your request will be sent via mail or email.