

## TRICARE - ACTIVE DUTY FAMILY MEMBER DENTAL PLAN (FMDP) ENROLLMENT ELECTION

### PRIVACY ACT STATEMENT

**AUTHORITY:** 10 USC 55, 1076A (Dental Plan), 5 USC 552a and EO 9397.  
**PRINCIPAL PURPOSE:** Used by applicant to apply for dental insurance coverage of family members.  
**ROUTINE USES:** None.  
**DISCLOSURE:** Voluntary; however, failure to furnish all information could delay or prevent enrollment in the FMDP.

### INSTRUCTIONS

**IMPORTANT:** FMDP ENROLLMENT AND CLAIMS PAYMENT IS BASED UPON DEERS ELIGIBILITY FOR CHAMPUS. WHEN ENROLLING OR CHANGING FMDP ENROLLMENT, MAKE SURE YOUR DEERS INFORMATION IS CORRECT. EXPIRED ID CARDS WILL AFFECT YOUR CHAMPUS (and Dental) ELIGIBILITY. CHECK YOUR FAMILY MEMBERS' ID CARD.

**NOTE:** CHANGES IN FAMILY STATUS (*gains and losses*) THAT AFFECT YOUR DENTAL PREMIUM MUST BE REPORTED TO DEERS USING DD FORM 1172, "Application for Uniformed Services Identification Card - DEERS Enrollment."

FMDP Enrollment is for a minimum of two (2) years, unless:

- (1) Family members lose their CHAMPUS eligibility in DEERS; or
- (2) Sponsor and family members transfer OCONUS to an area where FMDP is not available and the sponsor voluntarily elects to disenroll all enrolled family members; or
- (3) Sponsor and enrolled family members transfer to a uniformed services installation that offers space available family member dental care; or
- (4) Sponsor and family members are returning from an overseas location where FMDP is not available and the sponsor has between 12 and 23 months remaining in the uniformed service.

All family members must be enrolled if any members are enrolled, except:

- (1) Sponsors with one (1) family member age 4 or older and one (1) family member under 4 may elect to enroll as a single premium with only the family member age 4 or older being eligible for the FMDP; or
- (2) Family members residing in two or more physically separate locations, and only the family members in one or more locations are to be enrolled. Those family members may be enrolled in the FMDP using DD Form 2494-1, "Supplemental TRICARE - Active Duty Family Member Dental Plan (FMDP) Enrollment Election."

**REMINDER:** The FMDP is a "prepaid" plan, which means deductions from your pay must be made in advance of coverage. Coverage for enrolled CHAMPUS eligible family members shall begin the first day of the month following receipt of this form by your personnel activity. For example, if the form is completed in January, coverage begins February 1. However, it is important to note that processing of the enrollment information may take 30 days or more. This means that even though family members are eligible for coverage, a premium deduction may not appear on your LES during the first or second month of enrollment. Premium deductions will be made retroactive to the month the form was completed. It also means that the contractor may not be able to confirm eligibility if family members visit a dentist soon after they are enrolled.

Claims for enrolled family members cannot be paid by the contractor until enrollment information is received from the government. If a claim is denied because the contractor cannot verify eligibility, that does not necessarily mean these services will not be covered. Once eligibility verification has been received, the family member or dentist can request reprocessing of the denied claim by calling or writing the contractor.

### SECTION I - ACTIVE DUTY MEMBER ELIGIBILITY INFORMATION

1. SPONSOR'S NAME (LAST, First, Middle Initial)	2. SPONSOR'S SOCIAL SECURITY NUMBER	3. SPONSOR'S GRADE
4. SPONSOR'S UNIT		5. DATE OF EXPIRATION OF SERVICE OR CONTRACT (As extended) (YYMMDD)

### SECTION II - COVERAGE INFORMATION

<b>6. ELECTION OF COVERAGE</b> (Enrollment activity must do a DEERS check of family member(s) records and also verify the information below.)			
a. SINGLE PREMIUMS (X the block that describes your enrollment election.)		b. FAMILY PREMIUMS (X this block if you have more than one family member eligible regardless of the family members' ages.)	
1		I have a sole (1) family member age four (4) or older for whom I am electing coverage. I have no other family members.	
2		I have more than one (1) family member for whom I am electing coverage.	
3		I have a sole (1) family member under age four (4) for whom I am electing coverage. I have no other family members.	
1		I have a sole (1) family member age four (4) or older for whom I am electing coverage and one (1) or more family members under age four (4) for whom I am not electing coverage.	
			<b>NOTE:</b> If the above block is marked, all eligible family members regardless of age will be enrolled.

**SECTION II - COVERAGE INFORMATION** *(Continued)*

6.c. SPONSORS WITH 12 TO 23 MONTHS RETENTION RETURNING FROM AN OCONUS AREA WHERE FMDP WAS NOT AVAILABLE:

**NOTE:** The following enrollment codes may only be used for sponsors enrolling family members returning from an OCONUS area where FMDP was not available. If the family members did not accompany the sponsor on the OCONUS tour, the sponsor may not enroll the family members.

<b>R</b>		OCONUS Returnee. I have a sole (1) family member for whom I am electing coverage. I have no other family members age four (4) or older.
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<b>S</b>		OCONUS Returnee. I have more than one (1) family member for whom I am electing coverage.
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**7. TERMINATION OF COVERAGE** *(Service enrolling activity must cite appropriate documentation to ensure termination conditions are understood and met.)*

All terminations due to changes in eligibility for benefits as determined by DEERS will be processed automatically through the system. This type of change will not require action on the part of the sponsor except to ensure the accuracy of his/her DEERS record.

Place an X in the block describing your reason for disenrollment.

a. MY FAMILY MEMBERS HAVE BEEN ENROLLED IN THE FAMILY MEMBER DENTAL PLAN FOR AT LEAST TWO YEARS *(Verified by DEERS, Personnel or Finance file).*

<b>A</b>		(1) I am dissatisfied with the benefits package.
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<b>B</b>		(2) I am dissatisfied with claims processing.
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<b>C</b>		(3) I am dissatisfied with the quality of dental treatment received.
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<b>D</b>		(4) I am dissatisfied with the premium amount I pay.
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<b>E</b>		(5) I am satisfied, but wish to disenroll for personal reasons.
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b. I HAVE CHANGED MY DUTY STATION:

<b>F</b>		(6) OCONUS to areas where FMDP is not available.
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<b>G</b>		(7) To an installation with space available family member dental care.
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**8. STATEMENT OF UNDERSTANDING**

I have checked my family member information in DEERS and verified the accuracy of the DEERS information. I understand that changes in family size from one to two or more eligible family members *(or the reverse)* will result in an automatic change in enrollment status and an automatic change in premium. I also understand I may not terminate enrollment based on a change in family size. If my DEERS record indicates a family member is no longer eligible, a change will occur automatically with no action on my part. I further understand that the premium rate for this program is subject to change. I also understand that during the two year minimum enrollment period I cannot disenroll due to a change in premium rate. I understand that enrollment in FMDP automatically terminates the last day of the month of active duty or upon termination of basic pay. I authorize payroll deductions to be taken from my pay based upon the information in DEERS.

a. SPONSOR SIGNATURE	b. DATE SIGNED (YYMMDD)
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**9. WITNESSING OFFICIAL** *(Give the sponsor a signed copy of this form.)*

a. NAME <i>(Last, First, Middle Initial)</i>	b. GRADE
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c. SIGNATURE	d. DATE SIGNED (YYMMDD)
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**10. REMARKS**