TRICARE® Retiree Dental Program
Enrollment Application Guidelines

Read this before completing the TRDP Enrollment Application:

• Your DEERS record must state “retired” – Your TRDP eligibility will be verified through the Defense Enrollment Eligibility Reporting System (DEERS). Before you enroll, check with DEERS to make sure your record shows your eligibility status as ‘retired.’ Call DEERS at 800-538-9552 or go online to tricare.mil/DEERS to confirm.

• Coverage Effective Date – Your coverage is effective the first day of the month following acceptance of your enrollment application and receipt of your two-month premium prepayment.
  
  • If you are enrolling in the first month of your retirement and would like us to make your coverage effective date retroactive to your month of retirement in order to avoid a lapse in coverage, please write ‘Requesting retroactive effective date to (insert date)’ at the top of page 1 of your enrollment application.

• Enroll Online – You can also enroll online! Visit trdp.org for details to enroll through the Beneficiary Web Enrollment (BWE) website. Watch our “Enrolling is Easy” video to learn more about enrolling online.

• Electronic Funds Transfer (EFT) or Recurring Credit Card (RCC) Payments – If we are unable to establish the mandatory monthly premium allotment from your retirement pay, you must make arrangements to pay your monthly premiums through electronic funds transfer (EFT) or recurring credit card (RCC) payment. You can obtain an EFT/RCC form online at trdp.org or by calling our toll-free Customer Service number once you are enrolled.

• Requesting a 12-Month Waiting Period Waiver – As described in the TRDP Enrollment Brochure, you may qualify for a waiver of the 12-month waiting period for major services. Please note, however, that the waiver does not happen automatically when you enroll. To obtain the waiver, first check with DEERS to make sure your record has been updated with your correct retirement date. Then, complete an Online Inquiry Form, available at trdp.org, to let us know you have enrolled within the four-month timeframe, and we will update your account accordingly. If your DEERS record does not reflect your correct retirement information, we may require a copy of your retirement orders to verify your eligibility for the waiver.

Tips for completing the TRDP Enrollment Application:

• Fill out the application using black ink.

• Complete all applicable areas of the application and sign and date the application in Section F. Incomplete, illegible, damaged or unsigned applications cannot be accepted and will be returned.

• Mail this application, your premium prepayment if paying by check/money order (must be in U.S. dollars), and all required documentation to: Delta Dental of California, Federal Government Programs, PO Box 537007, Sacramento, California, 95853-7007, United States of America.

(continued on reverse)
• In Section A:
  • Check the appropriate box for the primary person who is applying for enrollment in the TRDP.
  • Provide the retiree’s Social Security number (SSN) or DoD Benefits Number (DBN) in the “Retiree’s Social Security Number” box. This number must always be that of the retiree, even if deceased.
  • To enroll as an unremarried surviving spouse, complete Section A with your name, address and the deceased retiree’s subscriber identification number. In Section B, list the eligible surviving child(ren) who is/are enrolling.
  • For Family Member(s) Only enrollment of a spouse and/or eligible child(ren), the retired member must meet one of the criteria as described in the “Eligibility” section of the TRDP Enrollment Brochure. Depending on your circumstance, include a copy of the correspondence from Veterans Affairs (VA) identifying the service-connected disability rating that allows dental care at the VA, documentation from your employer stating coverage does not extend to family members, or documentation from your treating physician along with your enrollment application.
  • Applicants for overseas enrollment must list their full address, including the foreign postal code and name of the country in which they reside. For overseas applicants, DEERS records must reflect the overseas address.
  • Enter the applicant’s date of birth in MM/DD/YYYY format.
  • Be sure to include your email address if you would like to receive your Welcome Letter electronically. The TRDP Benefits Booklet is available at trdp.org.

• In Section B:
  • Enter the birth dates of each family member in MM/DD/YYYY format.
  • If you are enrolling a child who is 21 years or older, DEERS records must indicate the child is a full-time student and/or disabled.

• In Section C:
  • Check the appropriate enrollment option for a Single Enrollment, Two-Person Enrollment, or Family Enrollment (three or more persons).
  • Check the appropriate box to indicate if you are enclosing a check/money order or are using your Discover®, VISA® or MasterCard® to pay your two months’ premium prepayment. The premium prepayment must be made in U.S. dollars.
  • If you are paying by one of the credit cards listed above, use the spaces provided to enter the card number, CV/CVV security code (last three numbers located on the signature strip of your card), and the card expiration date.
  • Please read Section D and Section E carefully. Note that Section E provides the address for mailing your enrollment application to Delta Dental.
  • After reading Section F, please sign and date the application. Your signature is your acknowledgement and acceptance of the statements therein and your certification that the information you provided in the application is complete and accurate. Your enrollment application cannot be processed without your signature.

Before mailing the TRDP Enrollment Application, did you remember to:
• Enclose necessary documentation for Family Member(s) Only enrollment, if applicable?
• List the retiree’s SSN or DBN?
• Provide your email address on the enrollment application?
• Include your check/money order or credit card information for your initial premium prepayment?
• Sign and date the application?
**A**  Applicant

**Primary Subscriber Information (check one)**
- [ ] Retiree
- [ ] Unremarried Surviving Spouse
- [ ] Surviving Child(ren)
- [ ] Family Member(s) Only—See Guidelines (section B) for specific criteria

**Enrollment Option (check one)**
- [ ] Individual
- [ ] Two-Person
- [ ] Family (3 or more)

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<th>Residence Address of Primary Enrollee</th>
<th>City, State (or if overseas, province, county, etc.), ZIP/Foreign Postal Code, Country</th>
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**Mailing Address**
- [ ] check box for “Same as above”

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**TRDP Welcome Packet electronic delivery option**
- [ ] YES, I would like to receive my Explanation of Benefits (EOB) electronically.

**Email Address**

**Retiree’s Social Security Number or DBN**

**Applicant’s Date of Birth**  MM/DD/YYYY

**Sex**  M/F

**Branch of Service**

**Retiree Retirement Date**

**B**  Family Member to be Enrolled

**If child is 21 or older**  BIRTH DATE

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**Mail your completed application to the following address:**
**Delta Dental of California,**
**Federal Government Programs,**
**PO Box 537007,**
**Sacramento, California, 95853-7007**

**IMPORTANT - This application is two pages. To avoid processing delays, all sections must be complete.**
I hereby certify that the information contained on this application is true and complete.

• Delta Dental may request military retirement documents to assist in verifying eligibility. I agree to provide them within a timely manner as requested in

• Notwithstanding this certification of eligibility, if I or any of my dependents do not meet the eligibility requirements of this program, coverage under

• I certify under penalty of perjury that I, as well as any of my dependents covered under this program, meet the eligibility requirements as identified

• This program does not discriminate, or have the effect of discriminating, against anyone on the basis of health status, age, race, sex or sponsor rank.

• I must remain enrolled for 12 consecutive months and if I choose to continue my enrollment beyond the initial 12-month period, my enrollment will

• My monthly premium payment will be automatically deducted from my retired pay. If retired pay is not available or is insufficient to allow the

• Two-month premium prepayment method (check one)

• Check/Money Order (made payable to the TRICARE Retiree Dental Program in U.S. dollars)

• Discover/VISA/MasterCard (see Guidelines) ___________________________ cvc/cvv _____________ Exp. Date ___ / ___

• BILLING ADDRESS (if different than mailing address)

Street Address

Street Address

D Enrollment Grace Period/Termination

Each new enrollee in the TRICARE Retiree Dental Program must fulfill an initial enrollment period of 12 consecutive months. This initial enrollment period

starts upon the coverage effective date. There is a grace period of 30 days from the coverage effective date in which the enrollee may rescind the

application without any further enrollment obligation, provided no covered services have been used during that time period. To exercise the option to

rescind, the enrollee must contact Delta Dental in writing within the 30-day grace period. If the option to rescind the application within the 30-day grace

period is not exercised, the enrollee must remain enrolled in the program for the duration of the initial 12-month period with only limited opportunity

for voluntary termination during this time. An enrollment may be terminated involuntarily prior to the end of the 12-month time period due to loss of

eligibility. After the 12-month enrollment period, enrollment renewal will continue automatically on a month-to-month basis.

E 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, Washington Headquarters Services, Executive Services Directorate, Information Management Division, 4800 Mark Center Drive, Suite 02G09, Alexandria, VA 22350-3100 (OMB 0072-0015). Respondents (applicants) 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 RESPONSE (APPLICATION) TO THE ABOVE ADDRESS. Responses (applications) should be sent to: Delta Dental of California, Federal Government Programs, PO Box 537007, Sacramento, CA 95853-7007, United States of America.

F Authorization–This section must be signed and dated

I have read the information contained on this application and choose to enroll in the TRICARE Retiree Dental Program. I understand the benefit

restrictions of the program as stated to me and/or explained in the materials provided with this application. I further acknowledge my understanding of the

following:

• Deposit of my prepayment does not guarantee coverage.

• My enrollment is subject to receipt of payment and verification of funds.

• My monthly premium payment will be automatically deducted from my retired pay. If retired pay is not available or is insufficient to allow the

• Two-month premium prepayment method (check one)

• Check/Money Order (made payable to the TRICARE Retiree Dental Program in U.S. dollars)

• Discover/VISA/MasterCard (see Guidelines) ___________________________ cvc/cvv _____________ Exp. Date ___ / ___

• BILLING ADDRESS (if different than mailing address)

Street Address

Street Address

X _____________________________________________________________    ____________________________

APPLICANT SIGNATURE     (Retiree, Surviving Unmarried Spouse or Surviving Children*)                                   DATE

*All other signatures must be accompanied by Power of Attorney.

The development of this piece is supported by Department of Defense Contract No. HT9402-15-C-0006. TRICARE is a registered trademark of the Department of Defense, Defense Health Agency. All

rights reserved. The TRDP is administered and underwritten by Delta Dental of California.

TRDP Enrollment Application #103241 1/17