

# 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](http://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](http://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](http://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](http://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.**

- **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?

# TRICARE® Retiree Dental Program

OMB No. 0720-0015

Exp: 12/31/2019

Enrollment application  
trdp.org

Delta Dental Use Only

**PRINT CLEARLY** and complete all applicable sections.

To process this application, payment information and signature are required.

## PRIVACY ACT STATEMENT

This statement serves to inform you of the purpose for collecting personal information required by the TRICARE Retiree Dental Program (TRDP) and how it will be used.

AUTHORITY: 10 U.S.C. Chapter 55, Medical and Dental Care; 38 U.S.C. 1781, Medical Care for Survivors and Dependents of Certain Veterans; 32 CFR 199.22, TRICARE Retiree Dental Program (TRDP); and E.O. 9397 (SSN), as amended.

PURPOSE: To obtain your information for records pertaining to eligibility, claims processing, quality of care review, customer service enhancement, and payment related to the TRDP.

ROUTINE USES: Your records may be disclosed outside of DoD to federal, state, local, or foreign government agencies, and with private business entities, including individual providers of care, on matters relating to eligibility, claims pricing and payment, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation. Use and disclosure of your records may also occur in accordance with the DoD Blanket Routine Uses published at HYPERLINK "http://dpcl.dod.mil/Privacy/SORNsIndex/BlanketRoutineUses.aspx" http://dpcl.dod.mil/Privacy/SORNsIndex/BlanketRoutineUses.aspx and as permitted by the Privacy Act of 1974, as amended (5 U.S.C. 552a(b)).

DISCLOSURE: Voluntary. If you chose not to provide your information, no penalty may be imposed, but absence of the requested information may result in denial of TRDP or delays in processing claims and benefits.

## 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)

Retiree's Social Security Number or DBN

Applicant's Date of Birth

MM/DD/YYYY

Sex

M/F

Branch of Service

Retiree Retirement Date

Last Name First Name MI

Residence Address of Primary Enrollee City, State (or if overseas, province, county, etc.), ZIP/Foreign Postal Code, Country

Mailing Address  check box for "Same as above"

Primary Telephone Secondary Telephone

TRDP Welcome Packet electronic delivery option

- YES, I would like to receive my Explanation of Benefits (EOB) electronically.

Email Address

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

## B Family Member to be Enrolled

FIRST, MI, LAST (if different)

If child is 21 or older

BIRTH DATE

FIRST, MI, LAST (if different)	BIRTH DATE
Spouse	MM/DD/YYYY
Child	MM/DD/YYYY
Child	MM/DD/YYYY
Child	MM/DD/YYYY
Child	MM/DD/YYYY

**IMPORTANT - This application is two pages. To avoid processing delays, all sections must be complete.**

## C Premium Prepayment

"If retired pay is not available or is insufficient to allow the allotment amount, an electronic payment method must be established to continue enrollment. Your electronic payment must be one of two payment options: (1) Electronic Funds Transfer (EFT) directly from a checking or savings account each month; (2) Recurring Credit Card (RCC) payment authorization from a credit card each month.

To determine your regional premium rate and prepayment amount, visit our website at trdp.org, or call our automated toll-free IVR at 888-838-8737 (select Option 2, then enter the information as prompted to find your premium rates). Prepayment of two months of premiums is necessary for enrollment. Any unused prepayment will be returned to the enrollee during the third month of enrollment.

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 O2G09, 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 allotment amount, an electronic payment method must be established to continue enrollment. Your electronic payment must be one of two payment options: (1) Electronic Funds Transfer (EFT) directly from a checking or savings account each month; (2) Recurring Credit Card (RCC) payment authorization from a credit card each month.
- 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 continue on a month-to-month basis.
- 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 certify under penalty of perjury that I, as well as any of my dependents covered under this program, meet the eligibility requirements as identified in the "Eligibility" section of the guidelines included with this application or on the TRDP website. Eligibility for the TRDP will be verified with the Defense Enrollment Eligibility System (DEERS).
- Notwithstanding this certification of eligibility, if I or any of my dependents do not meet the eligibility requirements of this program, coverage under the program will be cancelled immediately and any premiums previously paid prior to the effective date of cancellation of coverage will be retained by Delta Dental.
- Delta Dental may request military retirement documents to assist in verifying eligibility. I agree to provide them within a timely manner as requested in order to avoid delays in processing my enrollment.

I hereby certify that the information contained on this application is true and complete.

X \_\_\_\_\_  
APPLICANT SIGNATURE (Retiree, Surviving Unmarried Spouse or Surviving Children\*)

\_\_\_\_\_  
DATE

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

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