



# Enrollment Fee Allotment Authorization

TRICARE Prime Enrollments Before October 1, 2011



Please type or print all entries.

Name: Last	First	M.I.	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 **US Family Health Plan** from my retirement pay for TRICARE Prime enrollment fees for **US Family Health Plan** in the amount of: \$ (Single \$19.17 or Family \$38.34).  
*I have enclosed a payment (personal check, cashier's check, traveler's check, money order or credit card e.g., Visa/MasterCard) for the 3-month payment (\$57.50 individual or \$115.00 family) of TRICARE Prime enrollment fees payable to **US Family Health Plan**. I understand that this payment is waived when transferring from another region and an allotment has already been set up in that region.*

Please charge my card for the 3 month payment. Please circle card type: Visa / Mastercard

Card number \_\_\_\_\_ Exp \_\_\_\_\_ / \_\_\_\_\_ Amount \_\_\_\_\_ Today's date \_\_\_\_\_

Please **CHANGE** my existing monthly allotment to **US Family Health Plan** from \$ \_\_\_\_\_ to \$ \_\_\_\_\_.  
 Effective (MM/YY) \_\_\_\_\_ / \_\_\_\_\_  
 Single to Family (\$19.17 to \$38.34)  
 Family to Single (\$38.34 to \$19.17)

Please **STOP** my existing allotment to **US Family Health Plan** effective (MM/YY) \_\_\_\_\_ / \_\_\_\_\_

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

Sponsor Signature (Required): \_\_\_\_\_ Date: \_\_\_\_\_

**US Family Health Plan** will attempt to start the allotment from your military retirement pay by the next payment due date. You will be notified by **US Family Health Plan** 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.

If completing this form as part of your Enrollment Form, please include with the Enrollment Form.  
**Please complete, sign, and mail this form and payment to:**

**US Family Health Plan**  
 P.O. Box 84985  
 Seattle, WA 98124  
 (800) 585-5883