Enrollment Premium Allotment Authorization

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 premiums for US Family Health Plan. (When starting an allotment, you must make a one-time quarterly payment while your allotment is being set up.)

I have enclosed a payment (personal check, cashier's check, traveler's check, money order or credit card e.g., Visa/MasterCard/Discover) for the 3-month payment of TRICARE Prime enrollment premiums 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 / Discover

Card number________________________________Exp______/_____Amount_____._____Today' s date________

☐ Please **TRANSFER** my existing allotment from the ☐ North Region ☐ South Region ☐ West Region

☐ Please **CHANGE** my existing monthly allotment to US Family Health Plan effective (MM/YY) ______/______
☐ Single to Family ☐ Family to Single

☐ 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 U.S. Public Health Service. Other payments received (such as VA Benefits, Survivor Benefits or Combat Related Compensation) are not eligible.

If completing this authorization 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

JAN 2013

MAIL THIS COPY AND RETAIN COPY FOR YOUR RECORDS

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