



TRICARE PRIME PCM CHANGE AND DISENROLLMENT REQUEST

Sponsor Information *(Must Be Completed)*

Sponsor name	Last	First	MI	SSN
Street or PO Box	Apt. No.	City	State	Zip Code
Date of Birth	(Day Mo Yr)	Sponsor Home Phone No.	Work No.	Unit

PCM Change Request

Sponsor PCM Choice (only if sponsor changing PCM):					
List Family Members affected by the PCM change					
Last Name	First	MI	SSN	DOB	PCM Requested:
Last Name	First	MI	SSN	DOB	PCM Requested:
Last Name	First	MI	SSN	DOB	PCM Requested:
Last Name	First	MI	SSN	DOB	PCM Requested:
Last Name	First	MI	SSN	DOB	PCM Requested:
Reason for Request:					
Please make the above listed changes effective the date of my signature.					
Signature		Relationship To Sponsor		Date	

Disenrollment Request *(Active Duty Personnel May Not Disenroll)*

Last Name	First	MI	Reason for Disenrollment:
Last Name	First	MI	
Last Name	First	MI	
Last Name	First	MI	
<p>"I understand I am disenrolling my Family Member(s) from TRICARE Prime. I also understand by disenrolling from TRICARE Prime that my Family Member(s) will be covered by TRICARE Standard and will be locked out of TRICARE Prime for one year."</p> <p style="text-align: right;">Counseled by: _____</p>			
Signature		Relationship To Sponsor	
		Date	