*Please read Privacy Act Statement and Agency Disclosure Notice prior to completing this form.*

# APPLICATION FOR UNIFORMED SERVICES IDENTIFICATION CARD
# DEERS ENROLLMENT

*Form Approved*
*OMB No. 0704-0020*
*Expires Jul 31, 2005*

## SECTION I SPONSOR INFORMATION

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. NAME *(Last, First, Middle)* | | | 2. SEX | 3. SSN *(or SN)* | 4. STATUS | 5. BR OF SERVICE |
| 6. PAY GRADE | 7. RANK | 8. GEN. CAT | 9. TYPE OF CARD ISSUED | 10. ID NO. | 11. LAST UPDATE *(YYYYMMMDD)* | 12. V/I |
| 13. CURRENT RESIDENCE ADDRESS | | | | 14. SUPPLEMENTAL ADDRESS INFORMATION | | |
| 15. CITY | 16. STATE | 17. ZIP CODE | 18. COUNTRY | 19. UIC | 20. HOME TELEPHONE NO. *(Include Area Code)* | |
| 21. DATE OF BIRTH *(YYYYMMMDD)* | 22. BLOOD TYPE | 23. COLOR EYES | 24. COLOR HAIR | 25. HEIGHT | 26. WEIGHT | 27. MEDICARE / 28. MARITAL STATUS |
| 29. ELIG ST/MC EFF DATE *(YYYYMMMDD)* | 30. CARD EX/ELIG END DATE *(YYYYMMMDD)* | 31. PRIVILEGES AUTHORIZED *(Enter correct abbreviation AFTER privilege)* Medical Civilian; Medical Service; Commissary; Exchange Unlimited; Exchange Limited; Morale, Welfare & Recreation | | | | 32. END ELIG REASON |

## SECTION II DEPENDENT INFORMATION

| | | | | | | |
|---|---|---|---|---|---|---|
| 33. NAME *(Last, First, Middle)* | | | 34. SEX | 35. RELATIONSHIP | 36. SSN | 37. ID NO. |
| 38. LAST UPDATE *(YYYYMMMDD)* | 39. V/I | 40. CURRENT RESIDENCE ADDRESS | | | 41. SUPPLEMENTAL ADDRESS INFORMATION | |
| 42. CITY | 43. STATE | 44. ZIP CODE | 45. COUNTRY | 46. HOME TELEPHONE NO. *(Include Area Code)* | 47. DATE OF BIRTH *(YYYYMMMDD)* | |
| 48. MBI | 49. STU | 50. INCAP | 51. MEDICARE | 52. COLOR EYES | 53. COLOR HAIR | 54. HEIGHT / 55. WEIGHT / 56. MARITAL STATUS DATE *(YYYYMMMDD)* |
| 57. ELIG ST/MC EFF DATE *(YYYYMMMDD)* | 58. CARD EX/ELIG END DATE *(YYYYMMMDD)* | 59. PRIVILEGES AUTHORIZED *(Enter correct abbreviation AFTER privilege)* Medical Civilian; Medical Service; Commissary; Exchange Unlimited; Exchange Limited; Morale, Welfare & Recreation | | | | 60. END ELIG REASON |
| 61. NAME *(Last, First, Middle)* | | | 62. SEX | 63. RELATIONSHIP | 64. SSN | 65. ID NO. |
| 66. LAST UPDATE *(YYYYMMMDD)* | 67. V/I | 68. CURRENT RESIDENCE ADDRESS | | | 69. SUPPLEMENTAL ADDRESS INFORMATION | |
| 70. CITY | 71. STATE | 72. ZIP CODE | 73. COUNTRY | 74. HOME TELEPHONE NO. *(Include Area Code)* | 75. DATE OF BIRTH *(YYYYMMMDD)* | |
| 76. MBI | 77. STU | 78. INCAP | 79. MEDICARE | 80. COLOR EYES | 81. COLOR HAIR | 82. HEIGHT / 83. WEIGHT / 84. MARITAL STATUS DATE *(YYYYMMMDD)* |
| 85. ELIG ST/MC EFF DATE *(YYYYMMMDD)* | 86. CARD EX/ELIG END DATE *(YYYYMMMDD)* | 87. PRIVILEGES AUTHORIZED *(Enter correct abbreviation AFTER privilege)* Medical Civilian; Medical Service; Commissary; Exchange Unlimited; Exchange Limited; Morale, Welfare & Recreation | | | | 88. END ELIG REASON |

## SECTION III SPONSOR DECLARATION AND REMARKS

89. REMARKS *(Cite legal documentation, as applicable.)*

NOTARY SIGNATURE AND SEAL

I have read and understand the "Conditions Applicable to Sponsor or Applicant" printed in Section VIII. I certify the information provided in connection with the eligibility requirements of this form is true and accurate to the best of my knowledge.
*(If not signed in the presence of the verifying official, the signature must be notarized.)*

| | |
|---|---|
| 90. SIGNATURE | 91. DATE SIGNED *(YYYYMMMDD)* |

## SECTION IV VERIFIED BY

| | | | |
|---|---|---|---|
| 92. TYPED NAME *(Last, First, Middle)* | | 93. PAY GRADE | 94. UNIT/COMMAND NAME |
| 95. TITLE | 96. UIC | 97. DUTY PHONE NO. | 98. UNIT/COMMAND ADDRESS *(Street, City, State, ZIP Code)* |
| 99. SIGNATURE | | 100. DATE VERIFIED *(YYYYMMMDD)* | |

## SECTION V ISSUED BY

| | | | |
|---|---|---|---|
| 101. TYPED NAME *(Last, First, Middle)* | | 102. PAY GRADE | 103. UNIT/COMMAND NAME |
| 104. TITLE | 105. UIC | 106. DUTY PHONE NO. | 107. UNIT/COMMAND ADDRESS *(Street, City, State, ZIP Code)* |
| 108. SIGNATURE | | 109. DATE ISSUED *(YYYYMMMDD)* | |

## SECTION VI RECEIPT

**RECEIPT OF NEW CARD IS ACKNOWLEDGED**

| | |
|---|---|
| 110. SIGNATURE | 111. DATE ISSUED *(YYYYMMMDD)* |



PREVIOUS EDITION MAY BE USED.
*This form valid for issue of ID card 90 days from date of verification.*

Reset

The public reporting burden for this collection of information is estimated to average 10 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, Executive Services and Communications Directorate (0704-0020). Respondents 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 COMPLETED FORM TO THE ABOVE ORGANIZATION.**
**RETURN COMPLETED FORM TO THE UNIFORMED SERVICE ID CARD ISSUING FACILITY.**

## SECTION VII - PRIVACY ACT STATEMENT

**AUTHORITY:** 10 U.S.C. sections 1061 - 1065, 1072 - 1074, 1074a - 1074c, 1076, 1076a, 1077, 1095(k)(2), E.O. 9397.

**PRINCIPAL PURPOSE(S):** To apply for the Uniformed Services Identification Card and/or DEERS Enrollment.

**ROUTINE USE(S):** To appropriate business entities, individual providers of care, and others, on matters relating to claims adjudication, program abuse, utilization review, professional quality assurance, medical peer review, program integrity, third party liability, coordination of benefits, and civil and criminal litigation.

To the Department of Health and Human Services, the Department of Veterans Affairs, the Social Security Administration, and to other Federal, state, and local government agencies to identify individuals having benefit eligibility in another plan or program.

Applicant information is subject to computer matching within the Department of Defense or with other Federal or non-Federal agencies. Matching programs are conducted to assure that an individual eligible under a Federal program is not improperly receiving duplicate benefits from another program. A beneficiary or former beneficiary who has applied for privileges of a Federal Benefit Program and has received concurrent assistance under another plan will be subject to adjustment or recovery of any improper payments made or delinquent debts owed.

**DISCLOSURE:** Voluntary; however, failure to provide information may result in denial of a Uniformed Services Identification Card and/or non-enrollment in the Defense Enrollment Eligibility Reporting System. Failure to provide a beneficiary's Social Security Number renders that beneficiary ineligible for health care services in Military Treatment Facilities. However, emergency health care services will be provided to the extent furnished members of the general public.

## SECTION VIII - CONDITIONS APPLICABLE TO SPONSOR OR APPLICANT

I understand that the actions of the recipient(s) of the "Uniformed Services Identification Card" issued as a result of this application are my responsibility insofar as proper use of the card for benefits and privileges authorized; i.e., medical and dental care, exchange, commissary, and morale, welfare, and recreation programs. I will cause the recipient to surrender the card immediately upon call to do so or when appropriate under applicable regulations, and will notify an agency designated to grant authorization for privileges and facilities in event of any change in status affecting a recipient's eligibility therefor.

I am aware that medical care furnished in uniformed services facilities is subject to availability of space, facilities, and the capabilities of the medical staff to provide such care. Determinations made by the medical officer or contract surgeon, or his/her designee, as to availability of space, facilities, and the capabilities of the medical staff shall be conclusive.

Reimbursement shall be required for any unauthorized medical and dental care furnished at government expense. Copies of regulations concerning eligibility requirements are available in the Service Personnel Offices.

By signing this document, the sponsor or applicant certifies that he/she is aware that eligibility for benefits under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) terminates for all beneficiaries, except spouses and children of active duty members, and certain disabled beneficiaries under 65, when the beneficiary becomes eligible for Medicare Part A, Hospital Insurance, through the Social Security Administration.

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**PENALTY FOR PRESENTING FALSE CLAIMS OR MAKING FALSE STATEMENTS IN CONNECTION WITH CLAIMS: FINE OF UP TO $10,000 OR IMPRISONMENT FOR UP TO FIVE YEARS OR BOTH.**

*(ACT June 25, 1948, 18 U.S. Code 287, 1001)*