



Lockout Waiver Request Form



Subject: Request to Waive 12 Month TRICARE Enrollment Lockout Policy

To request the waiver of the 12-month TRICARE Enrollment Lockout Policy, please complete the form below and mail or fax the completed form to:

Humana Military Healthcare Services - TRICARE South
ATTN: PNC
1669 Phoenix Parkway, Suite 210
Atlanta, GA 30349
Fax Number: 866-836-9446

Sponsor's Name: _____

Sponsor's SSN: ____ - ____ - _____

Sponsor's Address: _____

Sponsor/Requestor's Phone Number: () ____ - _____

PCM of Family Members (check the appropriate box):

MTF/Clinic Civilian MTF and Civilian

Date of Disenrollment: ____ / ____ / _____ (MM/DD/YYYY)

Reason for Disenrollment (explain reason):

Voluntarily: _____

Involuntarily: _____

Reason for Request (justify why you think a waiver should be granted):

Signature of Requestor: _____

Date of Request: ____ / ____ / _____ (MM/DD/YYYY)

Approved

Disapproved

Reason for disapproval: _____

Signature of Approving Authority: _____