

SPONSOR SOCIAL SECURITY NUMBER										
SPONSOR NAME <i>(Last, First, Middle Initial) (Must match DEERS)</i>										
SECTION II - ENROLLING FAMILY MEMBER INFORMATION <i>(Use additional copies of this page to continue as necessary)</i>	a. FAMILY MEMBER NAME <i>(Last, First, Middle Initial) (Must match DEERS)</i>									
	b. DATE OF BIRTH <i>(YYYYMMDD)</i>									
	c. RESIDENCE ADDRESS <i>(Street/P.O. Box, Apartment No., City, State, ZIP Code)</i>									
	Same as Sponsor									
	d. MAILING ADDRESS <i>(If different from residence address)</i>									
	Same as Sponsor									
	e. RELATIONSHIP TO SPONSOR			<input type="checkbox"/> Spouse		<input type="checkbox"/> Former Spouse		<input type="checkbox"/> Child		
	f. TELEPHONE NUMBERS <i>(Include Area Code)</i>			(1) HOME			(2) WORK			
	g. PRIMARY CARE MANAGER (PCM) PREFERENCE <i>(Honoring your preferences depends upon availability and local MTF policy. Contact your TRICARE Service Center, preferred MTF or US Family Health Plan Member service for availability of PCMs.) (Complete all that apply.)</i>									
	(1) PCM NAME MTF/CLINIC <i>(If known)</i>		1st CHOICE							
			<input type="checkbox"/> Same as Sponsor							
	(2) PCM SPECIALTY		2nd CHOICE							
			<input type="checkbox"/> Same as Sponsor							
	(3) PREFERRED PCM GENDER		No Preference		Flight Medicine		Pediatrics			
			Family/General Practice		Internal Medicine					
	(3) PREFERRED PCM GENDER		No Preference		Male		Female			
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		Family/General Practice		Internal Medicine						
(3) PREFERRED PCM GENDER		No Preference		Male		Female				