



**TRICARE LATIN AMERICA & CANADA (TLAC) PRIME ENROLLMENT APPLICATION (GTMO Version)**

**SPONSOR INFORMATION**

CAN BE COMPLETED BY ANY ADULT BENEFICIARY. SEE REVERSE FOR DIRECTIONS. PLEASE PRINT CLEARLY.

<b>1. Sponsor Name (last, first, middle initial)</b>			<b>2. Sponsor Social Security Number</b>		<b>3. Sex</b>	<b>4. Date of Birth (dd/mmm/yyyy)</b>	<b>5. Rank</b>	<b>6. Telephone Numbers</b>	
								Duty: 011-5399-	
								Home: 011-5399-	
<b>7. Duty Address (Unit, Office Symbol, Station, APO/FPO, (Country))</b>					<b>8. DEROS/PRD (*required*)</b>		<b>9. Mailing Address (Box Number, APO/FPO, Zip Code)</b>		
PSC							SAME AS BLOCK # 7		
FPO, AE									
<b>10. Sponsor Branch of Service (Must be Active Duty)</b>			<b>11. E-Mail Address (if exists)</b>			<b>12. Primary Care Manager (PCM) Selection for Sponsor</b>			
Army	Air Force	Navy							
Marines	USCG	NOAA/PHS							

**FAMILY MEMBER INFORMATION**

LIST ALL FAMILY MEMBERS WHO ACCOMPANIED THE SPONSOR TO CUBA AND ARE APPLYING FOR ENROLLMENT. PLEASE PRINT CLEARLY.

<b>13. Family Member Name (last, first, middle initial)</b>	<b>14. Family Member Social Security Number</b>	<b>15. Sex (M or F)</b>	<b>16. Relationship to Sponsor</b>	<b>17. Date of Birth (dd/mmm/yyyy)</b>	<b>18. Currently Residing In GTMO</b>	<b>19. Select a PCM for each Family Member</b>
					YES NO	
					YES NO	
					YES NO	
					YES NO	
					YES NO	
					YES NO	
					YES NO	

<b>20. SIGNATURE:</b> "I have read the instructions on the reverse side of this form and understand the Privacy Act Statement listed there. I further request enrollment for my listed family members in TRICARE Latin America & Canada Prime."	SIGNATURE	DATE
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## INSTRUCTIONS

1. SPONSOR NAME. Last name, first name, middle initial.
2. SPONSOR SOCIAL SECURITY NUMBER. This is the SSN of the active duty member
3. SEX. M or F.
4. DATE OF BIRTH. Enter DOB of sponsor. List by dd/mmm/yyyy (example: 11 Oct 1962).
5. RANK. List rank of sponsor (not pay grade). (example: Army 0-4 should be MAJ).
6. TELEPHONE NUMBER. Sponsor's work & home phone numbers including country code.
7. DUTY ADDRESS. Please list Unit, Office Symbol, Installation, APO/FPO, Zip Code.
8. DEROS/PRD: Enter the sponsor's date of estimated return from overseas/projected rotation date.
9. MAILING ADDRESS. This is the mailing address where you currently reside. Include PSC, Box Number, APO and Zip Code. In most cases this is the same as information in Block 7.
10. SPONSOR BRANCH OF SERVICE: Circle the appropriate selection.  
**Note: Currently, only Active Duty and their accompanied family members are authorized to enroll in TLAC Prime.**
11. E-MAIL ADDRESS: Please provide if one exists for work, home or both. (This will provide another avenue for important medical benefit information to be distributed)
12. PRIMARY CARE MANAGER (PCM) SELECTION. If you have any questions please contact the TLAC Support Office
13. FAMILY MEMBER NAME. List each family member (last name, first name, middle initial) who accompanied the sponsor to Cuba, is listed on the sponsor's original orders, and who will reside in Cuba with the sponsor.
14. FAMILY MEMBER SOCIAL SECURITY NUMBER. Please list the Social Security Numbers for each family member. If the family member has not yet been issued a SSN,

write that in this section. If you do not know the number, please write that in the appropriate block.

15. SEX. Please enter the Family Member's Sex (M for male or F for female)
16. RELATIONSHIP TO SPONSOR: Please enter the appropriate response using the samples below (For questions please contact the TLAC Support Office):  
- SPOUSE  
- DAUGHTER  
- SON  
**\*\* IF SPOUSE IS ALSO ON ACTIVE DUTY, PLEASE INDICATE IT IN THIS BLOCK\*\***
17. DATE OF BIRTH. List the date of birth for each family member. (dd/mmm/yyyy)
18. Currently Residing In GTMO: Circle the appropriate response.
19. Select a Primary Care Manager for each family member. If you have questions contact your TLAC Support Office.
20. SIGNATURE. Either adult beneficiary must sign and date the form. The signature of the sponsor or the sponsor's spouse is required.

Mail completed form to: TRICARE Service Center,  
US Naval Hospital GTMO  
Attn: Ginger  
PSC 1005, Box 36  
FPO, AE 09593-0136

OR FAX completed form to 706.787.3024 (DSN 773)

OR PHONE GINGER at (7)-2017

OR E-mail completed form (as attached file) to [tricare@gan10.med.navy.mil](mailto:tricare@gan10.med.navy.mil)

### PRIVACY ACT STATEMENT

AUTHORITY: Title 10, USC, Sec. 1095 and 1099; EO 9397  
 PRINCIPAL PURPOSE(S): Information will be used to enroll the beneficiary(ies) in TRICARE Latin America & Canada Prime, and to assign Primary Care Managers (PCMs) to each enrollee. Information will also be used by military treatment facility (MTF) staff and TRICARE contractors to determine eligibility for care and payment of claims.  
 ROUTINE USE(S): The information on this form will be released to the MTF staff, TRICARE contractors, and providers of health care.

**DISCLOSURE:**

Is voluntary, however, failure to provide the information requested may preclude your enrollment in TRICARE Latin America & Canada Prime.