Army Reserve Health Counseling and Insurance Verification Form

[The proponent agency is the Surgeon's Office.]

PRIVACY ACT STATEMENT

AUTHORITY: Title 10, U.S. Code, 1076d and E.O. 9397

PRINCIPAL PURPOSE(S): This form is used by Reserve Component Service Members to validate their health insurance coverage and to counsel those who choose to remain uninsured. Please see 32 CFR 199.24(c) for a list of eligible beneficiaries.

ROUTINE USE(S): In addition to those disclosures generally permitted under 5 U.S.C. 552a(b) of the Privacy Act, disclosures may be made to Federal, State, local and foreign government agencies, private business entities, and individual providers of care on matters relating to entitlement, fraud, program abuse, program integrity, or civil and criminal litigation related to the operation of the TRS program.

DISCLOSURE: Voluntary; however, failure to furnish all requested information will result in the applicant being unable to obtain TRICARE Reserve Select coverage.

Last Name	First Name	Middle Name	Rank, Title or Grade	Social Security Number

Unit	Current Duty Assignment

SECTION I. COMMANDER'S COUNSELING

It is your responsibility IAW AR 40-501, paragraph 9-3, to maintain your medical and dental fitness. This includes correcting remedial defects, avoiding harmful habits, and controlling weight. You are responsible for seeking medical advice and treatment quickly when you believe your physical well-being is in question. You must report to your unit commander, any change in your health status that impacts your readiness status. You are also responsible for providing your unit commander all medical documentation, including civilian health records, and completing the annual physical health assessment. The Army must maintain a healthy force in order to maintain its overall mission readiness. Failure to maintain your health and fitness could result in administrative separation or discharge.

Soldier's Initials _____

Commander's Signature	Date

SECTION II. HEALTH INSURANCE VERIFICATION

Do you currently have health insurance?

☐ **Yes** *(Continue to Section V: Validation and Signature)*

☐ **No** *(Continue to Section III: Federal Employee Health Benefit (FEHB) Program)*

SECTION III. FEDERAL EMPLOYEE HEALTH BENEFIT (FEHB) PROGRAM

1. Are you a Federal Employee eligible to enroll in the Federal Employee Health Benefit (FEHB) Program?

☐ **Yes** *(Continue to question 2)*

☐ **No** *(Continue to Section IV: TRICARE Reserve Select)*

☐ **I'm not sure** *(Read eligibility criteria http://www.opm.gov/insure/health/eligibility/index.asp)*

2. Do you wish to enroll in the FEHB?

☐ **Yes** *(Complete enrollment instructions at: http://www.opm.gov/insure/health/enrollment/index.asp, then proceed to Section V)*

☐ **No** *(Continue to Section VI: Declination of Health Insurance)*

SECTION IV. TRICARE RESERVE SELECT

TRS is a premium-based health plan available worldwide to Selected Reserve members of the Ready Reserve (and their families) who are not eligible for or enrolled in the Federal Employee Health Benefits (FEHB) program (as defined in Chapter 89 of Title 5 U.S.C) or currently covered under FEHB, either under their own eligibility or through a family member.

Do you wish to enroll in TRS?

☐ **Yes** *(Complete enrollment at: http://www.tricare.mil/mybenefit/, then proceed to Section V: Validation and Signature)*

☐ **No** *(Continue to Section VI: Declination of Health Insurance)*

SECTION V. VALIDATION AND SIGNATURE

I verify that I currently have or recently enrolled to have health insurance and understand that maintaining health insurance may protect me from financial harm resulting from injury or illness. I also understand it is my responsibility to maintain my medical and dental readiness at all times and that health insurance will assist me in maintaining my medical and dental readiness.

Signature	Date

SECTION VI. DECLINATION OF HEALTH INSURANCE

I understand by declining health insurance coverage and not being covered by any other health insurance places my physical readiness is at risk. Additionally, I am at increased risk of incurring a fiduciary responsibility resulting from an unexpected illness or accident. I understand it is my responsibility to maintain my physical readiness and failure to maintain my health and fitness could result in administrative separation or discharge.

Signature	Date