TRIBAL HEALTH PARTNERS T.P.A., L.L.C.
P.O. BOX 71490, Phoenix, AZ 85050
Phone: 1-888-419-6139 Fax: 623-889-7299

Instructions page 1: Complete the enrollment form in full in ink. Please print or type.

Section 1

Type of coverage: **□ TRIBAL MEMBER ONLY □ TRIBAL MEMBER + SPOUSE □ TRIBAL MEMBER+CHILD(REN) □ FULL FAMILY**

Section 2

EMPLOYED BY: DATE OF HIRE TITLE

LAST NAME FIRST INITIAL DATE OF BIRTH

ADDRESS CITY STATE ZIP CODE

PHONE NUMBER SOCIAL SECURITY NUMBER

Please check one: π Native π Non Native

SEX: o Male o Female
MARITAL STATUS: o Single o Married
Date of Marriage or Divorce _____Number of dependent children **under** Age 26: _____and if spouse is 65 or Older (yes) or (no)?

NAME OF DEPENDENT	RELATIONSHIP	DATE OF BIRTH
* _____	***spouse***	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

*** SSN# if 45 years of age or older**_____
(Required by Medicare)

Section 3

Home Office Use Only Effective Date_____ Group Number_____ Coverage Class _____
(Life Insurance Information) Amount of Insurance _____Life _____AD&D_____

Section 4

Other Coverage Information

Do you and your family members have any additional group health coverage (including Medicare)? θ YES θ NO
If yes, please provide Carrier Name, Policy#, Effective date and who is covered under the Plan:

Section 5

To Refuse or Cancel Coverage
I do NOT wish to apply for, or wish to cancel θ Employee θ Family

Reason for refusing coverage: **θ Other coverage** **θ Covered by Spouse** **θ Medicare/Medicaid**

θ Other _____

PLEASE COMPLETE BOTH SIDES OF THIS FORM

Instructions page 2 continued: Complete the form in full in ink. Please print/type (except for signature).

Section 6

Beneficiary's Full Name (s) _____

Relationship _____

Section 7

To Add Coverage To An Existing Plan: If change is due to marriage, birth, expected birth, show date and reason

I wish to add: θ Employee θ Dependent θ Full Family

Reason for Change: _____

Section 8

I authorize payroll deductions for my share, if any, of the cost of the coverage(s) applied for.

I represent that all statements and answers made in this application and on any attached papers, are complete and true to the best of my knowledge and belief. Please supply Certificate of Creditable Coverage when applying.

I agree that:

(1) No coverage will be effective until the effective date assigned by the plan administrators following its approval of this application;

(2) No agent has authority to waive any requirement or a complete answer to any question;

(3) My employer shall represent me when receiving notices (including contribution and termination notices), when transmitting change requests and other information and when paying my contribution for this coverage.

I certify that all statements are complete and true to the best of my knowledge, that any contract which may be issued to me shall be binding only if each statement included in this application is complete and true.

In accordance with HIPAA regulations concerning Protected Health Information (PHI), I authorize any physician, medical facility, insurer, employer having information as to employment, medical coverage, or medical care, treatment or advice for any physical or mental condition of me, my spouse, or my children, or any other non-medical information, to release such information to its administrators to determine eligibility for coverage.

I agree that the company may release such information to its representatives or reinsurers or as permitted by law.

I understand that any charge involved for the cost of these records will be my responsibility.

A copy is valid as the original.

Signature _____ Date _____