Verification of Receipt

I have read and acknowledge the attached

Tribal Health Fund Policy.

_____

Please print your name here.

_____

Signature

_____

Date

Please be sure to keep a copy of all documents that you sign for your own records.

Please make changes if applicable

and return to us as soon as possible.

Name: _____

Maiden Name: _____

Birth date: _____ Social Security #: _____ Enrollment #: _____

Address/Street: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Work Number: _____

DO YOU HAVE INSURANCE COVERAGE? YES OR NO (Please circle one)

TYPE OF COVERAGE: (Circle all that apply)

MEDICAL, HOSPITAL, DENTAL

OPTICAL, ORTHODONTIC, PHARMACY

INSURANCE COMPANY NAME: _____

INSURANCE COMPANY ADDRESS: _____

_____

INSURANCE COMPANY PHONE #: _____

POLICY HOLDER NAME: _____ POLICY #: _____

IF YOU HAVE A SECONDARY INSURANCE CARRIER, PLEASE INCLUDE THIS INFORMATION ON THE BACK OF THIS FORM.

***** PLEASE INCLUDE A COPY OF THE FRONT AND BACK OF YOUR TRIBAL ID AND INSURANCE CARDS*****