Miami Nation

P.O. Box 1326
Miami, OK 74355
Phone: 918.541.1300
FAX: 918.542.7260

Health Limited Benefit Plan

Re-Enrollment Request for 2015-2016
Tribal Member – Individual

Instructions – Plan Sponsor: Miami Nation – RE-ENROLLMENT for Tribal Member Individual

1. If you are enrolled as a member of the Miami Nation, please complete this form. Please print and use ink.
2. Mail or FAX ALL completed forms in your packet and a copy of your Tribal Membership card to Miami Nation (address and FAX number above).

TRIBAL MEMBER

Name (Last, First)	Birthdate (MM/DD/YYYY)	Tribal Membership Enrollment No. **(REQUIRED-NOT CDIB)**
Home Address (Street, City, State, Zip)	Gender ☐ Male ☐ Female	**Please check ALL that apply:** ☐ Age 65 or over ☐ Permanent Disability (documented) ☐ Veteran (must provide discharge papers)
Email address		Daytime Phone

AUTHORIZATION

I am electing to participate in the Miami Nation Health Limited Benefit Plan for the year of 2015-2016. I understand my enrollment in the Miami Nation Health Limited Benefit Plan for 2015-2016 will end on September 30, 2016.

As a Miami Tribal Member and Health Limited Benefit Plan participant, I certify that any expense paid with the debit card has not been reimbursed by any other health plan and I will not seek reimbursement under any other plan covering health benefits. I also agree to acquire and retain sufficient documentation of all claims and provide pertinent documentation to HealthSmart Benefit Solutions when requested. If I should purchase items using my debit card that are not eligible expenses, I authorize the Miami Nation to collect the improper payment from my Limited Health Benefit Plan money remaining in my account. If this option is unsuccessful, I understand that I will be denied access to the card's usage until the debt is paid by me.

Tribal Member Signature	Date

Incomplete forms will be returned and the processing of your re-enrollment will be delayed.
If you have any questions concerning your account please contact our office at 800-825-3540 Extension 252543.

PLEASE READ - IMPORTANT INFORMATION

Once you've re-enrolled for this plan year 2015-2016, the benefit of $500 will be added to your Debit Card. If you are a tribal member over 65 **and** a Veteran **OR** disabled **and** a Veteran $750 will be added to your debit card. These funds are for your use to purchase items shown on the List of Eligible Expenses.

Keep your Debit Card.
Please keep this card after using all of your available funds for the year. When you re-enroll for the following year, 2016-2017, this same card will be re-loaded with additional funds.

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Consent and Release for Tribal Membership Documentation
Health Limited Benefit Plan Enrollment 2015-2016

Enrollment in the 2015-2016 Miami Nation Health Limited Benefit Plan (the Plan) requires documentation to verify Miami Nation Tribal membership AND attainment of age 65, and/or permanent disability. By signing this form I, the undersigned, agree to the following:

I authorize the Miami Nation (the Nation) to grant HealthSmart access to documentation via the Nation's Membership/CDIB Department for the purpose of determining my eligibility to participate in the Plan. This information is limited to:

- full name
- mailing address, email address
- date of birth
- Tribal membership enrollment number
- copy of CDIB/Tribal Membership Card
- documentation of permanent disability, if applicable

I also understand and agree that:

- HealthSmart will have access to personal and sensitive information currently held by the Nation under its own laws and the policies and procedures of the Executive Branch.
- the information obtained by HealthSmart, through consultation with the Nation, will only be used to determine that I am a Tribal member of the Miami Nation who is eligible to receive benefits under the Plan.
- this Consent and Release is valid and in effect for the duration of my participation in the Plan.
- no additional personal information may be released to HealthSmart by the Nation without my express written consent.
- my signature on this form is required to received benefits under the Plan.

By signing this form, I am releasing the Nation and HealthSmart from any and all liability as a result of the disclosure of my personal information.

Print Name	Signature*	Date	Tribal Enrollment No.

*If you are completing the enrollment form on behalf of an individual who is permanently disabled or legally determined incompetent and unable to sign, please provide the following:

Print Name (Person Completing Form)	Signature	Date