



# Miami Nation

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## Consent and Release for Tribal Membership Documentation Health Limited Benefit Plan Enrollment 2017-2018

Enrollment in the 2017-2018 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 |
|-------------------------------------|-----------|------|