



Miami Nation

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

Consent and Release for Tribal Membership Documentation Health Limited Benefit Plan Enrollment 2018-2019

Enrollment in the 2018-2019 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.
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*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
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Health Limited Benefit Plan

Initial Enrollment Request for 2018-2019 Tribal Member – Individual

Instructions – Plan Sponsor: Miami Nation – NEW 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).
3. **You must include a copy of your Tribal Membership Card in order to be eligible for the Limited Benefit Plan.**

TRIBAL MEMBER

Name (Last, First)	Birthdate (MM/DD/YYYY)	Tribal Membership Enrollment No. (REQUIRED-NOT CDIB)
Home Address (Street, City, State, Zip)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Please check <u>ALL</u> that apply: <input type="checkbox"/> Age 65 or over <input type="checkbox"/> Permanent Disability (documented) <input type="checkbox"/> 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 2018-2019. I understand my enrollment in the Miami Nation Health Limited Benefit Plan for 2018-2019 will end on September 30, 2019.

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
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Please make sure all forms, i.e. "Consent and Release" are complete and you have included all the requested information. Incomplete forms will be returned and the processing of your benefit card will be delayed.

Remember to enclose a copy of your Tribal Membership Card.

Once you've enrolled should you have any questions concerning your account, please contact the HealthSmart Member Service Team at 844-516-3658

PLEASE READ - IMPORTANT INFORMATION**Look for your Debit Card in the Mail.**

Once enrolled for this plan year 2018-2019, you will receive a debit card for your use to purchase items shown on the List of Eligible Expenses. If you are a tribal member over 65, disabled or a veteran the benefit amount on your debit card will be \$500. If you are over 65 or disabled **and** a Veteran, the amount on your debit card will be \$750.00. Your Debit Card will be mailed directly to your address entered on this form.

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, 2019-2020, this same card will be re-loaded with additional funds.