

# Osage Nation Health Limited Benefit Plan

## RE-ENROLLMENT REQUEST FORM FOR 2011

### **Plan Sponsor: Osage Nation – Tribal Member**

If you are currently enrolled as a member of the Osage Nation and participated in the Osage Nation Health Limited Benefit Plan for 2010 and would like to continue coverage for 2011 please read and complete information below. You will need to complete this form for each dependent in your family who was also enrolled in the plan for the year of 2010 and elects to continue coverage.

### **Mail this completed form to:**

Mutual Assurance Administrators

Attn: Monica McKaughan

P.O. Box 42096

Oklahoma City, OK 73123

*If you have received this form and were not enrolled in the Osage Nation Health Limited Benefit Plan for 2010, please contact the Osage Nation Constituent Services at 918-287-5662 and request an initial enrollment form.*

Name: Please Print (Last) (First) (Middle Initial)

Tribal Membership Enrollment Number: (REQUIRED)

**You will only need to complete the address section below if there have been any changes since your 2010 enrollment.**

**If there are no changes proceed with your election.**

**Address:**

**City:**

**State:**

**Zip Code:**

**Enrollment Acknowledgement/Authorization:** I am electing to participate in the Osage Nation Health Limited Benefit Plan for the year of 2011. I certify that, except for any change in address noted above, the information provided in my initial enrollment for this plan in 2010 is still valid and true to the best of my knowledge. I understand my enrollment in the Osage Nation Health Limited Benefit Plan for 2011 will end on December 31, 2011.

As an Osage 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 Mutual Assurance Administrators when it is requested. If I should purchase items using my debit card that are not eligible expenses, I authorize the Osage 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.

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Parent or Guardian's Name:** \_\_\_\_\_

**Relationship:** \_\_\_\_\_

**Contact Phone Number:** \_\_\_\_\_