HEALTH BENEFITS
REGISTRATION FORM

Today's date:	Tribal Enrollment #:	HB Staff Initials:

MEMBER INFORMATION

Please provide your legal name as it appears on your social security card:

Last name:	First:	Middle:	Marital status (circle one) Single / Mar / Div / Sep / Wid

Former/Maiden name:	Birth date:	Age:	Sex: ☐ M ☐ F

SSN:	Primary phone no.:	Alternate phone no:

Physical address:

Mailing address:

County:	Email:
Employer:	Occupation:

Other IHS Eligibility:

☐ Dependent Child of Tribal Member

Father's Name:____Tribe:____

Mother's Name:____Tribe:____

☐ Pregnant Spouse of Tribal Member, Tribal Member Name____ Due Date____________

Did you retire from the Military? ☐ Yes ☐ No	Are you a US Veteran? ☐ Yes ☐ No (If yes, please provide a copy of your VA/Military ID)

Do you pay a premium for your Medicare?☐ Yes ☐ No *If yes, are you being reimbursed for the premiums? ☐ Yes ☐ No

***If you are not being reimbursed please bring your current Social Security Award letter in for reimbursement**.

Do you have any unpaid Medical Bills? ☐ Yes ☐ No

IN CASE OF EMERGENCY

Name of Local friend or relative:	Relationship to Member:
Phone Number:	Alternate phone number:

INSURANCE INFORMATION		
(Please provide your insurance card(s).)		
Are you currently employed? ☐ Yes ☐ No	If, yes does your employer offer you medical insurance? ☐ Yes ☐ No	Do you have medical insurance through this employer? ☐ Yes ☐ No
Do you have any other Medical Insurance? ☐ Yes ☐ No If no, have you applied for Apple Health? ☐ Yes ☐ No		Date Applied:
Do you have Medicare? ☐ Yes ☐ No	If yes, Medicare ID:	
	Part D Carrier:	
	Part D ID#:	

Primary Medical Insurance Carrier:		
ID#	Group#	Effective Date:
Subscriber's name:	DOB	☐ Self ☐ Spouse ☐ Child ☐ Other
Secondary Medical Insurance Carrier:		
ID#	Group#	Effective Date:
Subscriber's name:	DOB	☐ Self ☐ Spouse ☐ Child ☐ Other
Primary Dental Insurance Carrier:		
ID#	Group#	Effective Date:
Subscriber's name:	DOB	☐ Self ☐ Spouse ☐ Child ☐ Other
Secondary Dental Insurance Carrier:		
ID#	Group#	Effective Date:
Subscriber's name:	DOB	☐ Self ☐ Spouse ☐ Child ☐ Other
Primary Vision Insurance Carrier:		
ID#	Group#	Effective Date:
Subscriber's name:	DOB	☐ Self ☐ Spouse ☐ Child ☐ Other
Secondary Vision Insurance Carrier:		
ID#:	Group#	Effective Date:
Subscriber's name:	DOB	☐ Self ☐ Spouse ☐ Child ☐ Other

The above information is true to the best of my knowledge.
I the undersigned, give the Suquamish Tribe Health Benefits department and Shasta Administrative services (and its agents) authorization to access my medical records or those of my covered dependents (if a minor child) in order to facilitate the processing of claims or to determine eligibility. I understand the benefits offered are subject to the Plan's coverage provisions and that services may require preauthorization by the Suquamish Tribe.

Member/Guardian signature ______________________ Date ______________________