2016

Circle of Health Benefit Enrollment Form

- *YOU MUST COMPLETE AND SUBMIT A NEW ENROLLMENT FORM EACH TIME YOU ELECT NEW HEALTH INSURANCE COVERAGE*
- *IF YOU DECLINE HEALTH INSURANCE COVERAGE, YOU AND YOUR FAMILY WILL NOT BE ELIGIBLE FOR CIRCLE OF HEALTH BENEFITS*
- *IF YOU ARE NOT SURE WHAT TYPE OF COVERAGE TO SELECT, PLEASE CALL CIRCLE OF HEALTH TO ASSIST WITH SELECTION OF A PLAN*
- *CIRCLE OF HEALTH IS A TRIBAL MEMBER PROGRAM, PREMIUMS WILL BE PAID OR REIMBURSED ONCE APPROVED BY CIRCLE OF HEALTH*
- *PLEASE CONTACT CIRCLE OF HEALTH FOR ANY QUESTIONS REGARDING THIS ENROLLMENT FORM: 1-800-491-6106*

PLEASE SUBMIT A COPY OF YOUR INSURANCE CARDS FOR ALL MEMBERS OF YOUR HOUSEHOLD. IF ADDING A NEW CHILD OR CHILDREN, PLEASE SUBMIT BIRTH CERTIFICATES FOR ALL CHILDREN.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for tribal benefits will be ineligible for Circle of Health benefits.

MILLE LACS BAND OF OJIBWE INDIANS

CIRCLE OF HEALTH BENEFIT ENROLLMENT FORM

ALL INFORMATION REQUESTED IS REQUIRED

Name: ____ Suffix: ______ SSN: _______-______-________
Last Name First Name Middle Name

DOB: ________________________________ Sex: _____ M _____ F Marital Status: ___________________________

Address: ____
Street

____
City State ZIP

Telephone: ____
Home Work Cell

Email Address: ____

Preferred Contact Method: *Home Phone* *Work Phone* *Cell Phone* *Mail* *Email* *SMS Text*
(Please Circle One)

Emergency Contact Name: ______________________________________ Relationship: _____________________
Last Name First Name

Emergency Contact Telephone: ____
Home Work Cell

Veteran: _____ Service Branch ______________ VA Card? ______ VA Disability? ______ Service Connected: _______
Yes/No Yes/No Yes/No

Tribe: ____ Enrollment #:___________________________________

Employer ____ Employed: Full Time? _____Part Time? _____

Policyholder Notice:

It is your responsibility to report any changes regarding your insurance coverage, this includes employment as it relates to new employer eligibility or COBRA. Failure to report changes to Circle of Health may result in a HOLD status on your account.

For questions regarding your tribal benefits, please call Circle of Health at 1-800-491-6106.

MILLE LACS BAND OF OJIBWE INDIANS

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ALL INFORMATION REQUESTED IS REQUIRED

Insurance Coverage: (Please check all that apply for your household)

___ Medicare ___ Part A ___ Part B ___ Part D ___ Medicaid ___ MNCare

___ Employer Insurance – Medical ___Employer Insurance – Dental

Documents Needed:

1. Health Insurance cards
2. Employee health and dental enrollment forms from your Human Resources department. Submit these documents with your insurance cards.

____

Policyholder Name (Last First MI) Policy Name and Policy #

____

Street Address (if different from enrollment form) City State/ZIP

____

Telephone Number Social Security # (if tribal member is not policy holder) DOB (if tribal member is not policy holder)

List all individuals covered by your primary insurance policy

Name	Relationship to Policyholder	Date of Birth	Social Security Number
	Policyholder		

Tribal Member and Descendant Verification:

Documents Needed:

1. Birth Certificates for all minor children
2. Tribal ID Card or Certificate of Enrollment

List all individuals who are tribal members or descendants

Name	Is child a 1st Line Descendant of a Mille Lacs Enrolled member (Yes or No)	Enrollment #	Name of Enrolled Parent

MILLE LACS BAND OF OJIBWE INDIANS

CIRCLE OF HEALTH BENEFIT ENROLLMENT FORM

ALL INFORMATION REQUESTED IS REQUIRED

PLEASE READ BEFORE SIGNING:

Data Privacy Act of 1974 Public Law 93-579
I understand that the information given by me and/or collected is necessary for the Circle of Health program. Furthermore, I have been informed that my records shall not be disclosed to any other agency or person without my signed consent.

Assignment of Benefits (AOB)
I understand the Circle of Health has a right of recovery and reimbursement from certain third parties for medical expenses paid on my behalf to the extent that such costs are covered. Further, I understand that Circle of Health may bring a claim or cause of action against the third party for recovery of each medical expenses.

Therefore, I agree as follows:

1. To assign to the Circle of Health any claim of cause of action against the third person to the extent of the medical expenses paid, or any portion thereof.
2. To furnish such information as may be requested concerning the circumstances giving rise to the injury or disease for which care and treatment is being given and concerning any action instituted or to be instituted by or against a third party.
3. To notify the Circle of Health of a settlement with, or an offer of settlement from a third person and
4. To cooperate in the prosecution of all claims and actions by Circle of Health against such third person.

I hereby authorize Circle of Health to furnish medical information related to payment of medical bills and other information to the Office of Solicitor General, insurance carriers, and other third party payers' concerning my medical care and treatment, and hereby assign all payments for medical services rendered to myself or my dependents. (This AOB authorization is in effect until revoked.)

I understand that Circle of Health benefits are for enrolled tribal members and eligible first generation tribal descendants. I understand that I must show proof of birth, guardianship or legal custody, if requested. I understand that any missing information will delay the eligibility process. I certify that the above information provided to be accurate and true to the best of my knowledge and authorize Circle of Health to verify the accuracy of this application. All the information provided on this enrollment form is CONFIDENTAL and upheld by the rules and regulations of the Data Privacy Act of 1974. The information will be shared within Circle of Health to determine eligibility for this program.

I certify that the above information provided to be accurate and true to the best of my knowledge and authorize Circle of Health to verify the accuracy of this application.

Print Name ____

Signature ____Date: ___________________

MILLE LACS BAND OF OJIBWE INDIANS

CIRCLE OF HEALTH BENEFIT ENROLLMENT FORM

ALL INFORMATION REQUESTED IS REQUIRED

AUTHORIZATION FOR USE AND DISCLOSURE OF INFORMATION

____

FIRST NAME **MI** **LAST NAME** **DATE OF BIRTH**

____

P.O. BOX OR STREET ADDRESS **CITY** **STATE, ZIP** **COUNTY** **TELEPHONE NUMBER**

BY SIGNING THIS FORM, I AUTHORIZE THE FOLLOWING: I authorize and consent Circle of Health to use my electronic and paper health records to track, communicate and share the following information. During the case management process, Circle of Health may identify other programs within the Mille Lacs Government that may be able to assist you and may make a referral. I understand that this general information may include:

To: ☐ Disclose ☐ Obtain from ☐ Exchange with

THE INFORMATION REQUESTED TO BE OBTAINED OR EXCHANGED:

- ☐ Insurance and Billing information
- ☐ Social service information
- ☐ Court/Legal information
- ☐ Verbal exchange
- ☐ Health Services information
- ☐ Housing information
- ☐ Tribal Enrollment information
- ☐ Other: __________________________________

REVOCATION AND CONSENT:
Upon fulfillment of the above stated purpose(s) this consent will automatically expire without express revocation, unless otherwise

specified as follows: ____________________________.
Valid for a maximum of one (1) year

I understand that I may revoke this consent to release information at any time by written notice, except when legal action prevents revocation (probation, court confinement, court ordered). However, any release made in good faith prior to receipt of revocation, shall be deemed valid. I also understand that information disclosed by this consent cannot be released to anyone else unless I give written permission.

ATTENTION: THIS IS A LEGAL DOCUMENT. PLEASE READ CAREFULLY. BY SIGNING, YOU AGREE THAT YOU UNDERSTAND AND ACCEPT THE TERMS ON THIS FORM. THIS AUTHORIZATION WILL EXPIRE ONE YEAR FROM THE DATE OF SIGNING UNLESS WRITTEN REQUEST FOR IMMEDIATE REVOCATION.

- **IF THE PATIENT IS 18 YEARS OF AGE OR OLDER, THE PATIENT MUST SIGN AND DATE THE FORM.**
- **IF THE PATIENT IS 18 YEARS OF AGE OR OLDER AND IS INCAPABLE OF SIGNING, A LEGALLY AUTHORIZED SUBSTITUTE MAY SIGN AND DATE THE FORM.**

PLEASE INDICATE YOUR LEGAL AUTHORITY AND INCLUDE DOCUMENTATION OF YOUR RELATIONSHIP.

______________________________ ______________________________

Signature **Signature of Parent/Guardian (if under 18)**

______________________________ ______________________________

Date **Relationship to member**

A copy, facsimile, or digitized image of this consent shall be considered as effective and valid as the original.