

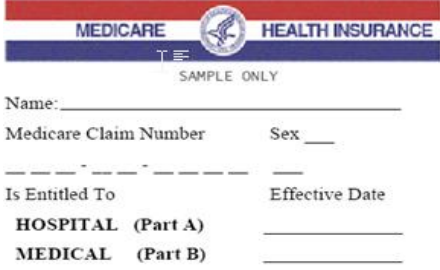
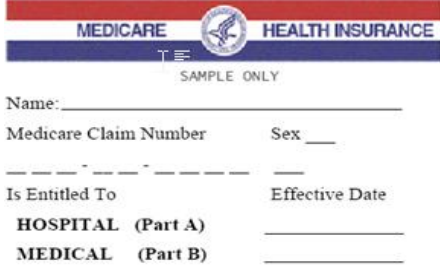


Osage Nation

1-877-722-6973

GROUP MEDICARE SUPPLEMENT ENROLLMENT FORM - PLAN F

Underwritten by United American Insurance Company

ELDER: COMPLETE ALL QUESTIONS BELOW IF YOU WANT TO ENROLL.				SPOUSE: IF YOU ARE NOT AN OSAGE ELDER, COMPLETE ALL QUESTIONS BELOW IF YOU WANT TO ENROLL. <input type="checkbox"/> **If you enrolled by phone, please check the box to the left and complete the name and address fields below.			
Elder Last Name	First Name	Middle Initial		Spouse Last Name	First Name	Middle Initial	
Address (no P.O. Box)	City	State	Zip	Address (no P.O. Box)	City	State	Zip
Mailing Address	City	State	Zip	Mailing Address	City	State	Zip
Phone #	Please complete using your Medicare Card:			Phone #	Please complete using your Medicare Card:		
Social Security #				Social Security #			
Tribal Membership Enrollment # (Required-Not CDIB)							
Date of Birth							
Gender <input type="checkbox"/> M <input type="checkbox"/> F							
Date of Birth	HOSPITAL (Part A) _____			Date of Birth	HOSPITAL (Part A) _____		
Gender <input type="checkbox"/> M <input type="checkbox"/> F	MEDICAL (Part B) _____			Gender <input type="checkbox"/> M <input type="checkbox"/> F	MEDICAL (Part B) _____		

I elect to participate in the Medicare Supplement: _____ **Elder (\$0.00)** _____ **Non-Osage Eligible Spouse (\$193.00)**

[Make check payable to United American and return with form]

Other Medical Insurance: Are you or anyone named above currently covered by any Medical Insurance program, other than Original Medicare or Indian Health Services? If yes, please provide this information.

Yes No

Elder Insurance Co. _____

Spouse Insurance Co. _____

Elder's Current Plan: (circle one) Medicare Supplement, Medicare Advantage, Employer Group Plan, or State Medicaid Program

Spouse's Current Plan: (circle one) Medicare Supplement, Medicare Advantage, Employer Group Plan, or State Medicaid Program

RELEASE OF INFORMATION AUTHORIZATION: My signature authorizes United American to release or obtain any information, medical or other, which may be necessary to properly administer this Plan. A copy of this release will carry the same authority as the original. This applies to my covered dependents and myself. I understand my information will remain strictly confidential.

***NOTE: IF YOU ARE SIGNING ON BEHALF OF A BENEFICIARY, PLEASE ATTACH A COPY OF POWER OF ATTORNEY.**

Elder Signature*	Date	Spouse Signature*	Date
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Please Call United American at 1-877-722-6973 with any Questions or Concerns

Return form to: Osage Nation, PO Box 42096, Oklahoma City, OK 73123-2096; Or Fax to: 806-473-3113; Or Email to: Osage@Healthsmart.com