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. ☐ **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 #	MEDICARE HEALTH INSURANCE SAMPLE ONLY Name: Medicare Claim Number Sex Is Entitled To Effective Date HOSPITAL (Part A) MEDICAL (Part B)			**Social Security #**	MEDICARE HEALTH INSURANCE SAMPLE ONLY Name: Medicare Claim Number Sex Is Entitled To Effective Date HOSPITAL (Part A) MEDICAL (Part B)		
Tribal Membership Enrollment # **(Required-Not CDIB)**							
Date of Birth				**Date of Birth**			
Gender ☐ **M** ☐ **F**				**Gender** ☐ **M** ☐ **F**			

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 Progran

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**

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