

Circle of Health – Mille Lacs Band of Ojibwe

Enrollment Form

2605 Chiminising Drive, Isle, MN 56342
Phone (3200 676-8214 or 1-800-491-6106
Fax 320-676-8235

Name: Last First Middle DOB:

Enrollment #: 410B- SSN: - -

Address: Street City State ZIP

Telephone: Home Work

Coverage Types:

Employer Insurance Employer Name Telephone
Medical
Dental
Address City State/ZIP

Medicare Part A Part B Part D

Policyholder Information It is your responsibility to report any changes regarding your insurance coverage, this includes employment as it relates to new employer eligibility or COBRA.

Name (Last First MI) Policy Name and Policy #

Street Address City State/ZIP

Telephone Number Social Security Number Date of Birth

COPIES OF THE FRONT AND BACK OF ALL INSURANCE CARDS MUST BE PROVIDED WITH THIS FORM, TO BE ELIGIBLE FOR THE ISSUANCE OF CIRCLE OF HEALTH PROGRAM CARDS. IF YOU NEED NEW CARDS CHECK HERE

List all individuals covered by your primary insurance policy

Table with 4 columns: Name, Relationship to Policyholder (self, spouse, child/other), Date of Birth, Mille Lacs Tribal Member Yes or No. Row 1 contains 'SELF'.

Signature Date

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

All the information provided on this enrollment form is CONFIDENTIAL and upheld by the rules and regulations of the Data Privacy Act of 1974.