CHUKCHANSI TRIBAL HEALTH ENROLLMENT FORM

LAST NAME	FIRST NAME	MIDDLE INITIAL
SOCIAL SECURITY NUMBER	DATE OF BIRTH	PHONE NUMBER

○ MALE ○ FEMALE ○ MARRIED ○ SINGLE ○ DIVORCED ○ WIDOWED

STREET ADDRESS		
CITY	STATE	ZIP CODE
TRIBAL ENROLLMENT NUMBER	EMAIL ADDRESS	

MONTHLY PREMIUMS

○ ***INDIVIDUAL TRIBAL MEMBER ONLY-$150.00/MONTHLY*** ○ ***TRIBAL MEMBER + FAMILY-$300.00/MONTHLY***

DEPENDENT INFORMATION

NAME	BIRTHDATE	RELATIONSHIP	SOCIAL SECURITY NUMBER	M/F
NAME	BIRTHDATE	RELATIONSHIP	SOCIAL SECURITY NUMBER	M/F
NAME	BIRTHDATE	RELATIONSHIP	SOCIAL SECURITY NUMBER	M/F

Monthly premiums are to be paid in full by the 5th of each month. Coverage will be terminated for failure to pay monthly premiums in a timely manner

By initialing below, you acknowledge and agree to the following payment policy.

The member is responsible for paymet of monthly premiumsd to Chukchansi Insurance, Inc. Chukchansi Insurance, Inc. does not accept direct or indirect payments of premiums from any person or entity other than the Tribal Member, Members Family, or a Legal Guardian, or a Licensed Third Party Payor ______________

DECLARATION: UNDER PENALTIES OF PERJURY, I DECLARE THAT THE INFORMATION PRESENTED ON THIS FORM AND IN THE ACCOMPANYING DOCUMENTATION ARE, TO THE BEST OF MY KNOWLEDGE AND BELIEF, TRUE, CORRECT, AND COMPLETE

______________________________ ______________________________

TRIBAL MEMBER SIGNATURE *DATE*

Primary Applicant Name

Enter Payment Details

Payment Information

First Name of Person Responsible for Payment

MI

Last Name of Person Responsible for Payment

Address

City

State

Zip Code

Payment Options

☐ Credit Card ☐ Debit Card ☐ Visa ☐ Master Card ☐ Discover ☐ American Express

Cardholder's First Name as it Appears on Card

MI

Cardholder's Last Name as it Appears on Card

Card Number

Expiration Date (mm-yyyy)

\-

CSV

Date (mm-dd-yyyy)

\- -

Cardholder's Signature

☐ Electronic Payment ☐ Checking Account ☐ Savings Account

I authroize Chukchansi Insurance, Inc. and the designated financial institution to accept this transfer of the premium amount from my checking or saving account

Bank Name

Rounting Number

Account Number

Account Holders First Name

MI

Account Holders Last Name

Date (mm-dd-yyyy)

\- -

Account Holder's Signature

☐ Check ☐ Money Order

Write the name of the primary applicant on the check. Mail the payment to the address provided

Please note-Credit/Debit/ACH charges will show on your credt/debit or bank account as a charge to Administrative Solutions, Inc.

COORDINATION OF BENEFITS

Member ID	*Member Phone Number*
Member Name	*Member Date of Birth*

OTHER COVERAGE

Do you, your spouse or children have coverage **Other than Advantek?** ❑ Yes ❑ No

- If **No,** please skip all sections, sign, date and fax to **559-244-0458** or email to **eligibility@advantekbenefit.com**
- If **Yes,** please complete the following sections as applicable. **Important:** *Please provide a copy of the ID card*

Other Subscriber Name:		Other Subscriber Date of Birth:	
Medical Carrier	ID #	Group #	Effective Date
Dental Carrier	ID #	Group #	Effective Date
Vision Carrier	ID #	Group #	Effective Date

Important: Please complete for each covered dependent that has ***Other Coverage.*** Use a separate page if needed for additional dependents.		Medical	Dental	Vision
		Covered?	Covered?	Covered?
Spouse Name	Date of Birth	Yes No	Yes No	Yes No
Child #1 Name	Date of Birth	Yes No	Yes No	Yes No
Child #2 Name	Date of Birth	Yes No	Yes No	Yes No
Child #3 Name	Date of Birth	Yes No	Yes No	Yes No

CHILD COVERED UNDER MORE THAN ONE PLAN

Please complete this section if you are divorced, separated or not living with your child(ren)'s other parent

Please provide information on the Biological Parent of your child(ren). **Use a separate page if necessary.**

Name:____Date of Birth:__________________

Does this parent have other insurance for the child(ren)? ❑ Yes ❑ No

Is there a Court Order specifying legal requirements for benefit coverage for any of the covered children? ❑ Yes ❑ No

- If **No**, there is no action required;
- If **Yes**, please provide a copy of the Court Order which pertains to ***health insurance only***.

If there is no Court Order allocating responsibility for healthcare, who do the child(ren) primarily reside with?___________

MEDICARE INFORMATION

If this does not apply, skip this section

Does any member and/or dependent have Medicare? ❑ Yes ❑ No

- If No, skip to Member Signature section, sign, date and return.
- If Yes, complete the below information.

Name of Person with Medicare:			Medicare ID Number:	
Effective Date of Medicare Part A:			Effective Date of Medicare Part B:	
Medicare Due to Age?	❑ Yes ❑ No	Medicare Due to Disability?	❑ Yes ❑ No	1st Date of Disability:
Medicare Due to End Stage Renal Disease? (ESRD)	❑ Yes ❑ No	1st Date of Dialysis	Was ESRD started in a facility? ❑ Yes ❑ No	Was ESRD started as Home Dialysis? ❑ Yes ❑ No
Has a Transplant been performed? ❑ Yes ❑ No			If yes, please provide date of transplant:	

SUBSCRIBER SIGNATURE

I certify that the above information is correct and understand that I am obligated to provide this information to Advantek Benefit Administrators in accordance with the Certificate of Coverage. Failure to provide complete and accurate information may result in a delay in the payment of benefits.

Print Name	Signature	Date

If you need assistance completing this form, please contact Customer Service at 844-340-7953
Please Fax to 559-244-0458 or email to eligibility@advantekbenefit.com