Fax to: (866) 819-4774

Attn: Application Processing

Enrollment Form Submission Cover Sheet

Enrollee's Name:____Submission Date: ____________

Circle One: **Facility / Community** Resident Facility Name: ___________________________

☐ For I-SNP members, check box if private pay

☐ Community Reference Source: _________________________________

Agent Name: ____

Agent Phone #:_____________________ Agent E-mail: __________________________________

Enrollment Form Checklist:

☐ Plan Selection (Circle one)
Tribute Advantage / Tribute Select

☐ Personal Info Entered (Ensure mailing address section is done)

☐ Payment Method (Circle one)
Direct Bill
Social Security/Railroad Deduction

☐ "Important Questions" Answered

☐ Primary Care Physician Selected (if applicable)

☐ Election Period Selected

☐ Applicant or POA Signature

☐ Agent Section Completed w/ proposed effective date

☐ Scope of Appointment Form (if required)

For Plan use only

Received by Plan on: _______________________

Member ID #: _____________________

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