



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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