



Fax to:  
**(866) 819-4774**

Attn:  
**Application Processing**

## Tribute Enrollment Form Submission Cover Sheet

Enrollee's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Circle One: **Facility** or **Community** Resident Facility Name: \_\_\_\_\_

For Oklahoma members, check box if private pay

Agent's Name: \_\_\_\_\_

Agent's Phone #: \_\_\_\_\_ Agent's E-mail: \_\_\_\_\_

Submission Date: \_\_\_\_\_

### Enrollment Form Checklist:

- |   |   |
|---|---|
| <input type="checkbox"/> Plan Selection Completed                                       | <input type="checkbox"/> "Important Questions" Answered                     |
| <input type="checkbox"/> Personal Info Entered (Ensure mailing address section is done) | <input type="checkbox"/> Primary Care Physician Selected (if applicable)    |
| <input type="checkbox"/> Payment Method (Circle one)                                    | <input type="checkbox"/> Election Period Selected                           |
| \$0 Premium   | <input type="checkbox"/> Applicant or POA Signature                         |
| Social Security/Railroad Deduction  | <input type="checkbox"/> Agent Section Completed w/ proposed effective date |
| Bank Draft (EFT)  | <input type="checkbox"/> Scope of Appointment Form (if required)            |
| Direct Bill   |   |

*For Plan use only*

Received by Plan on: \_\_\_\_\_

Member ID #: \_\_\_\_\_

6006-d-1 Internal Use Only

This fax sheet, and any attachment to it, may contain privileged and confidential information intended only for the use of the individuals or entities named above. If you are not the intended recipient, or the employee or agent responsible for delivering it to the intended recipient, you are hereby notified that reading it is strictly prohibited. If you have received this fax in error, please immediately contact Tribute at 1-877-583-4649.