



**Osage Nation Constituent Services**  
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 Phone (918) 287-5555  
 Fax (918) 287-5221  
[constituentservices@osagenation-nsn.gov](mailto:constituentservices@osagenation-nsn.gov)

**Limited Health Benefit Plan**

- Please check here if this enrollment is being Requested by a NON-Osage Custodial Parent:  
 Requester - PRINT YOUR NAME HERE: \_\_\_\_\_
- Please check here if you are turning age 18 and request to be removed from the following tribal member's account in order to be set up on your own account. Tribal Member Name \_\_\_\_\_ Membership Number \_\_\_\_\_

**Initial Enrollment Request for 2019 Tribal Member – Individual or Family**

1. If you are enrolled as a member of the Osage Nation and requesting to enroll in this benefit plan, please complete this form **Please print and use ink.**
2. **You must include a copy of your Tribal Membership Card in order to be eligible for the Limited Benefit Plan.**
3. Submit all the completed forms to Constituent Services either by Mail, FAX or Email: Contact information is shown in the upper right hand corner of this enrollment form to ensure you receive your Health Benefits Card.

**TRIBAL MEMBER INFORMATION**

Name (Last, First)	Birthdate (MM/DD/YYYY)	Tribal Membership Enrollment # <b>(REQUIRED-NOT CDIB)</b>
	Gender (M/F)	
Home Address (Street, City, State, Zip)		<input type="checkbox"/> Check here if Enrolling Child(ren) only (I am already enrolled see membership number above)
Email address		Daytime Phone

**Family Enrollees – proceed to the next section.**

**Individual Enrollees - proceed to the Authorization section.**

**Note: Persons Age 18 and Older on or before 12-31-2018 need to enroll as an Individual.**

**SPOUSE INFORMATION**

My spouse has enrolled using a separate form: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable	Tribal Membership Enrollment # <b>(REQUIRED-NOT CDIB)</b>
If yes, please provide spouse name and Tribal Membership Enrollment No:	

**MEMBER DEPENDENT INFORMATION (under age 18)**

**All benefits for dependent children under age 18 as of 12/31/2018 will be added to the debit card of the Osage Member parent/guardian designated below. Please provide all information requested for each dependent listed.**

Dependent benefits are to be applied to the debit card of - Name (Last, First):				Tribal Membership Enrollment # <b>(REQUIRED-NOT CDIB)</b>
Name (Last, First)	Relationship	Gender (M/F)	Birthdate (MM/DD/YYYY)	Tribal Membership Enrollment # <b>(REQUIRED-NOT CDIB)</b>
Name (Last, First)	Relationship	Gender (M/F)	Birthdate (MM/DD/YYYY)	Tribal Membership Enrollment # <b>(REQUIRED-NOT CDIB)</b>
Name (Last, First)	Relationship	Gender (M/F)	Birthdate (MM/DD/YYYY)	Tribal Membership Enrollment # <b>(REQUIRED-NOT CDIB)</b>
Name (Last, First)	Relationship	Gender (M/F)	Birthdate (MM/DD/YYYY)	Tribal Membership Enrollment # <b>(REQUIRED-NOT CDIB)</b>

**AUTHORIZATION**

I am electing to participate in the Osage Nation Health Limited Benefit Plan for the year of 2019. I certify that, except for any change in address noted above, the information provided in my initial enrollment for this plan is still valid and true to the best of my knowledge. I understand my enrollment in the Osage Nation Health Limited Benefit Plan for 2019 will end on December 31, 2019.

As an Osage Tribal Member and Health Limited Benefit Plan participant, I certify that any expense paid with the debit card has not been reimbursed by any other health plan and I will not seek reimbursement under any other plan covering health benefits. I also agree to acquire and retain sufficient documentation of all claims and provide pertinent documentation to WageWorks when it is requested. If I should purchase items using my debit card that are not eligible expenses, I authorize the Osage Nation to collect the improper payment from my Limited Health Benefit Plan money remaining in my account. If this option is unsuccessful, I understand that I will be denied access to the card's usage until the debt is paid by me.

Tribal Member Signature	Date
Tribal Member Spouse Signature	Date

**Please make sure all forms, i.e. "Consent and Release" are complete and you have included all the requested information. Incomplete forms will be returned and the processing of your benefit card will be delayed.**  
**Remember to enclose a copy of your Tribal Membership Card.**