Grand Traverse Band of
Ottawa and Chippewa Indians

Purchased/Referred Care Application

Employee

FOR OFFICE USE ONLY
EMPLOYEE COVERAGE

MEDICARE_____
FCP COFINITY_____
DELTA DENTAL_____
VSP_____

Section 1 Primary Tribal Member

Last Name X_____ First NameX _____Middle_X_____

Social Security Number _____ Date of Birth X_____ Tribal Enrollment # X_____

Physical Address: X_____ Mailing Address: X_____

City: X_____ State:X _____ Zip_X_____ Phone Number:_X_____ Sex: Male _____ Female _____

Section 2 Tribal Member's Information

Name of Tribal Members	Relationship	Date of Birth	Tribe/Enroll # (if applicable)	Sex	Social Security #	Address (if different from above)	Current Insurance
X							
X							
X							
X							
X							

PRC Member ID:_____ **Effective Date:** _____ **FY**_____ **HRN#**_____

Section 3 Insurance Information

Name of Tribal Members	Current Insurance Coverage	Insurance Numbers	Effective Dates	Medical	Dental	Vision	Prescription Drugs

I certify that all statements are true and complete to the best of my knowledge. I authorize any physician, medical facility, employer, having information as to employment, Medical coverage, or medical care, for my spouse, dependent children and myself to give such information to GTB Purchased/Referred Care or its administrators to determine Eligibility or coverage. GTB Purchased/Referred Care is a payer of last resort. I agree that the company may release such information to its representatives or re-insurers or as permitted by law.

***Signature of Tribal Member X_____ Date X_____