Tribute Health Plans

Fax to: (866) 819-4774

Attn: Application Processing

Enrollment Form 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 #: _____

Tribute ADVANTAGE (HMO-POS D-SNP)

Tribute SELECT (HMO-POS I-SNP)