



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 #: \_\_\_\_\_

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