



# POARCH BAND OF CREEK INDIANS HEALTH INSURANCE PLAN ENROLLMENT FORM

(Please print)

TO BE COMPLETED ONLY BY TRIBAL MEMBERS (HEAD OF HOUSEHOLD)  
THAT DO NOT HAVE HEALTH INSURANCE

Name (Last)	(First)	(Middle)
Address (Street)	City	State (Zip Code)
Tribal Roll No: _____	Social Security No. _____ - _____ - _____	
Date of Birth : _____	Marital Status: _____	Sex: M _____ F _____
Telephone: (     ) _____ - _____	Email: _____	

### LIST ONLY TRIBAL MEMBERS IN HOUSEHOLD WITHOUT HEALTH INSURANCE COVERAGE

Last Name	First Name	MI	SS#	Relationship	Sex	DOB	Roll #

Please provide details of any pre-existing health conditions and prescribed medications. (Pre-existing conditions will not prohibit coverage)

\_\_\_\_\_  
\_\_\_\_\_

**Member Certification:** I declare that in the best of my knowledge and belief, all of the statements and answers given above are correct.

Member's Signature: X \_\_\_\_\_ Date: \_\_\_\_\_

<b>FOR INTERNAL USE ONLY (PLEASE LEAVE BLANK)</b>		
Group# _____	Division # _____	County # _____
PCI Authorized Signature _____		Date _____