Osage Nation Benefit Center
4 Main Street ▪ Peterborough, NH, 03458
Phone: 833.406.0969 ▪ Fax: 603.925.1357
Email: OsageNation@rtconsultingllc.com

Osage Nation Limited Health Benefit Plan - Newborns

Osage Member Enrollment Application – Calendar Year 2025

1. The Osage Nation Health Benefit Fund Act was revised in September 2020 with the passing of ONCA 20-79. In that law, 16 ONC §3-105, paragraph B requires that: "*Any member whether adult or minor, parent or legal guardian, must submit a completed application/enrollment from annually as stipulated in a plan document to access benefits between October 1st and December 15th for the following calendar year.*
2. Members must fill out a separate enrollment form for their newborn less than 1 year old, that is in the process of becoming a member and enroll in the plan on or before December 15, 2024 in order to receive the benefit for the 2025 calendar year.
3. As parent/guardian you must complete their application and submit it for them.
4. Once the Osage membership is complete, a copy of your **Osage Membership Card** must be sent to the Benefit Center for the enrollment application to be finalized.
5. **SUBMIT ONE ENROLLMENT APPLICATION FOR EACH NEWBORN OSAGE MEMBER ON OR BEFORE DECEMBER 15, 2024.**

☐ **Please check here if this enrollment is being requested by a NON-Osage Custodial Parent**

NON-Osage Custodial Parent's Name (Last, First): _____ ***(if applicable)***

OSAGE MEMBER INFORMATION

Name (Last, First, MI) *also list if you are a Sr.| Jr. | II | III | etc.	**Birthdate** (MM/DD/YYYY) / / **Gender** (M or F)	**Osage Membership Enrollment # (Required)** **(NOT YOUR CDIB#)**
Home Address **(Street / P.O. Box)** **(City)** **(State)** **(Zip)**		**Cellular Phone** ( ) -
Email address		

REQUIRED

***Osage Parent/Guardian Name (Last, First):** _____ **Membership #:**_____

NOTE: This individual will be responsible for the card and authorized to access member account information.

AUTHORIZATION

I am electing to participate in the 2025 Osage Nation Health Limited Benefit Plan. I certify that the information provided in this application is valid and true to the best of my knowledge. I understand my enrollment will end on December 31, 2025.

As an Osage Member and Limited Benefit Plan participant, I certify that the use of this card is my authorization that this is an eligible expense for which I have not been reimbursed and will not seek reimbursement for any other plan or source. Use of this card is authorized for eligible expenses only as set forth in the Cardholder Agreement.

I also agree to acquire and retain sufficient documentation of all claims and provide pertinent documentation to the Osage Nation Benefit Center 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 and future applications will not be processed until the debt has been paid in full.

Osage Parent/Legal Guardian/Custodian Signature (if applicable): _____ Date: _____