Lac Courte Oreilles Community Health Center
9940 N County Hwy K
Hayward, WI 54843
Phone: 715-638-5100
Fax: 715-634-2740

Tribal Health Insurance Premium Reimbursement Application

Client Information

Last Name	First Name	Middle Name	Birthdate

County of Residence	Tribal Enrollment Number

Mailing address (box/street name)	City	State	Zip Code

Physical address (fire number/road)	City	State	Zip Code

Primary phone number	Work phone number	Alternate phone number

Insurance Carrier	Insurance Premium Cost (Weekly)	Employer

I certify that the information given is true and correct:

Signature _____ Date _____

AUTHORIZATION FOR RELEASE OF HEALTH INSURANCE DEDUCTION INFORMATION

I, _____ (Participant Name), hereby authorize the Lac Courte Oreilles Tribal Government to release health insurance deduction information to the Lac Courte Oreilles Community Health Center (LCO-CHC) for the purpose of determining my eligibility for the Tribal Member Health Insurance Premium Reimbursement Program.

I understand that this information will be used solely for determining eligibility and program compliance related to the Tribal Member Health Insurance Premium Reimbursement Program and will be maintained in accordance with applicable privacy and confidentiality requirements.

I understand that I may revoke this authorization at any time by providing written notice to LCO-CHC, except to the extent that action has already been taken in reliance upon this authorization.

Signature _____ Date _____

For Office Use Only

Proof of Information	Verified
Tribal Identification	
Residency	
Signed W-9	
Cost of Premiums (Quarterly)	
Payment Approved:	Yes No