



# The Chickasaw Nation Services at Large (SAL) Health Spending Account (HSA)

Please Print

Patient name: \_\_\_\_\_ Gender:  M  F  
Last First MI Marital Status:  S  M  D  W

Date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ City of birth: \_\_\_\_\_ State of birth: \_\_\_\_ SSN: \_\_\_\_-\_\_\_\_-\_\_\_\_

Current mailing address: \_\_\_\_\_  
Street/PO Box/RR City State Zip code

City of residence unless same as mailing address: \_\_\_\_\_

(\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_  
Home phone Work phone Emergency contact phone

Email address: \_\_\_\_\_

Tribal citizenship: \_\_\_\_\_ Degree of blood: \_\_\_\_\_

Other tribes: \_\_\_\_\_ Total degree of blood: \_\_\_\_\_

Employer's name (or employment status): \_\_\_\_\_

Chickasaw citizen?  Yes  No

**Attach a copy of your Chickasaw Nation citizenship card and CDIB to this application.  
Incomplete applications will delay setting up your account and processing your claim.**

**Eligibility Requirements:**

- Chickasaw citizen with a Chickasaw Nation citizenship card **and** CDIB.
- Aged 65 or over.
- Reside **outside** the Chickasaw Nation boundary.
- Not currently receiving services from the Chickasaw Nation Division of Health in Oklahoma.

**Program Guidelines:**

- Maximum of \$100 per month reimbursed to citizen.
- Reimbursement by direct deposit into banking account (**complete direct deposit authorization form on next page**).
- Claim will be submitted within 30 days of expense.
- 90-day pre-enrollment period.

**Reimbursable Services:** Please check below the medical expense(s) you anticipate using for your HSA benefit. You may check more than one.

- Monthly premiums for Medicare Part B-Out-patient Care and/or Medicare Part D-Prescription drug coverage.
- Premiums, co-pays and deductibles for medical, dental, vision or supplemental insurance.
- Prescription expenses – **over-the-counter medications are excluded.**
- Qualified medical expenses.
- Other: \_\_\_\_\_

**Mail completed application to:**  
**The Chickasaw Nation**  
**Tribal Health Program**  
**1215 West Willow**  
**Duncan, OK 73533**  
**For information: (580) 470-2115 Ext. 61301**

Under penalty of law I attest that all statements are true and that I hereby understand and agree to eligibility requirements, reimbursable services and program guidelines.

Patient's signature: \_\_\_\_\_ Date: \_\_\_\_\_  
or legal guardian (include copy of letters of guardianship)

