THE KLAMATH TRIBES MEMBERS BENEFITS DEPARTMENT
PO BOX 436
CHILOQUIN, OREGON 97624

MEMBER BENEFITS FORM

Complete one form for each enrolled member of the family and attach a copy of your social security card. Each member age 18 and older must fill out and sign his/her own form. MUST BE RETURNED BY **APRIL 15, 2013** FOR BENEFITS.

(Please Print Legibly or Type) **Date**: _____

Name: _____Enrollment Number: _____
Last First Middle

Social Security Number: _____-_____-_____ Date of Birth: _____
Copy of Social Security card must be provided with application for eligibility. Attach copy to this application

Other Name(s): _____
Maiden, Nickname, Previous Married Name

Mailing Address: _____City:_____

State: _____Zip: _____-_____ County: _____

Physical Address: _____City: _____

State: _____Zip: _____-_____ County: _____

Phone Numbers: Home: (_____) _____-_____ Cell: (_____) _____-_____

Msg: (_____) _____-_____ Email:_____

I do hereby certify that I am the above named person and that all of the information is true and accurate, and I am an enrolled member of The Klamath Tribes. I understand there may be times when I will be requesting tribal, state, and federal assistance that will require an income verification of my annual per capita revenues and I release the Klamath Tribes to provide this information as requested.

Printed Name: _____Signature: _____

Parent, Guardian Name:_____Signature: _____
If member is a minor child-name & signature of parent/guardian is required.

FOR INTERNAL USE ONLY:

Enrollment Certified: _____Date: _____
Adult: _____Minor: _____
Status: ___2013 Distribution_____
Finance copied: _____ Initial and Date: _____
Newsletter copied: _____ Initial and Date: _____

Mail this form back to: The Klamath Tribes, Member Benefits or Enrollment, PO Box 436, Chiloquin, OR 97624