



THE KLAMATH TRIBES MEMBER 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, 2016** FOR BENEFITS.

(Please Print Legibly or Type)

Date: _____

Name: _____ **Enrollment Number:** _____
First Middle Last

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, Alias Name

Address: _____ **Post Office Box:** _____

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.

Signature: _____ **Printed Name:** _____

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

FOR INTERNAL USE ONLY:

Enrollment Certified: _____ Date: _____
Adult: _____ Minor: _____
Status: <u>2016 Distribution</u>
MB eligible/entered db: _____ 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