CONFEDERATED TRIBES OF GRAND RONDE
MEMBER SERVICES PROGRAM
STATEMENT OF CLAIM OR OTHER PERSON FORM

MEDICARE PREMIUM PAYMENT AUTHORIZATION AND RELEASE OF INFORMATION FORM

Social Security Recipient Name: _____

Social Security Number: _____

I understand that this statement is to be used for verification purposes through the Confederated Tribes of Grand Ronde Community of Oregon (the "Tribe") and the Social Security Administration.

Statement: I, _____, hereby certify that I have no objection to the Tribe paying for my Medicare Part B premium. I also authorize the Tribe to obtain any information regarding my Medicare Part B premiums through the Social Security Administration and authorize the Social Security Administration to release such information to the Tribe. I understand that I may revoke this authorization at any time by notifying the Tribe and the Social Security Administration in writing, but if I do, it will not have any effect on any action the Tribe or Social Security Administration took before receiving the revocation.

I know that anyone who makes, or causes to be made, a false statement or representation of the material fact in an application or for use in determining a right to payment under the Social Security Act commits a crime punishable under Federal Law and/or State Law. I affirm that all information given in this document is true.

APPROVAL SIGNATURE

_____ _____
Signature of Person Date

_____
Mailing Address/City and State/Zip

_____ _____
Telephone Number Message Telephone Number