Samaritan
Health Plans
Building healthier communities together

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TTY 1-800-735-2900

First Tier, Downstream, and Related Entity
CONFLICT OF INTEREST ATTESTATION

Please check those statements that apply in section I **or** II and then sign below.

I. Applies if You Are Free of Any Conflict of Interest

□ I, hereby, certify that I have reviewed Samaritan Health Plan's conflict of interest policy.

□ I, hereby, certify that I am free of any conflict of interest in administering or delivering Medicare benefits.

OR

II. Applies if You May Have a Conflict of Interest

□ I, hereby, certify that I have reviewed Samaritan Health Plan's conflict of interest policy.

□ I, hereby, certify that I have disclosed to management any potential conflicts of interest that I may have in administering or delivering Medicare benefits.

To the best of my knowledge and belief, the information contained in this response is true and accurate.

_____

Signature Date

_____

Print Name

_____

Title

_____

Employer/Name of Company