GEISINGER HEALTH PLAN®

GROUP SUBSCRIBER APPLICATION

M.C. 32-26
100 North Academy Avenue
Danville, PA 17822

SECTION A. GENERAL ADMINISTRATIVE INFORMATION (for completion by Employer)

1. Group number: _____ 3. Insurance ID number: _____
2. Division number: _____ 4. Name of Sales Rep.: _____
5. Effective Date of Change: _____ (MM/DD/YY)
6. This Application is being submitted as a result of: **(Check one)**
   a. ☐ Group Initial Enrollment
   b. ☐ Group Open Enrollment Period
   c. ☐ Employee New Hire
   d. ☐ Change due to Qualifying Event (If you checked this box, please specify type of event and complete Question #7)
      (i) Specify type of event:_____
7. Is the Subscriber or Subscriber's eligible Dependent(s) electing continuation coverage under COBRA and/or Mini-COBRA?
   (Check one) ☐ Yes ☐ No ☐ Not Applicable

SECTION B. APPLICANT INFORMATION (Please Print Clearly)

1. Primary Care Physician (PCP) Name _____
2. PCP Location (Town) _____ 3. PCP Number _____
4. Are you an existing patient of selected primary care physician? ☐ Yes ☐ No

5. LEGAL NAME (LAST)	6. (MAIDEN NAME)	7. (FIRST)	8. (M.I.)	9. GENDER ☐ FEMALE ☐ MALE

10. ADDRESS (NUMBER) (STREET) (APT. NO.)	11. CITY	12. STATE	13. ZIP CODE	14. COUNTY

15. HOME PHONE NUMBER	16. CELL PHONE NUMBER	17. WHAT IS THE BEST TIME TO REACH YOU? _____ ☐ AM ☐ PM

18. SOCIAL SECURITY NUMBER			19. DATE OF BIRTH			20. MARITAL STATUS
			MONTH	DAY	YEAR	☐ MARRIED ☐ SINGLE ☐ DIVORCED/SEPARATED ☐ WIDOWED

21. EMPLOYER (NAME, CITY, AND PHONE NUMBER)	22. DATE OF EMPLOYMENT	23. GEISINGER MEDICAL RECORD # (if any)

24. While enrolled in Geisinger Health Plan will you also be covered by Medicare? Yes ☐ No ☐
    If "Yes", please provide: Your Medicare Number: _____ (Check one) Part A ☐ Part B ☐
25. While enrolled in Geisinger Health Plan will any Dependent(s) listed on this form also be covered by Medicare?
    (Check one) Yes ☐ No ☐ If "Yes", please provide the following information:

Dependent(s) Name	Medicare Number	Part A (check as applicable)	Part B (check as applicable)

26. While enrolled in Geisinger Health Plan will you or any Dependent(s) listed on this form also be covered by other health insurance?
    Yes ☐ No ☐
    If "Yes", please complete the following information:
    A. Name of Insurance Company: _____
    B. Subscriber Name: _____
    C. Check one: ☐ Family Plan ☐ Self Only
    D. Effective Date of Coverage: _____ (Month) _____ (Day) _____ (Year)
    E. I.D. or Social Security No.: _____
    F. Group Name (Employer): _____
    G. Group Number _____

White - Geisinger Health Plan

SECTION C. SPOUSE/DEPENDENT INFORMATION

LEGAL NAME		LIST LAST NAME IF DIFFERENT FROM APPLICANT	SOCIAL SECURITY NO.	RELATIONSHIP	DATE OF BIRTH	GEISINGER MEDICAL RECORD # (IF ANY)	PRIMARY CARE PHYSICIAN NAME	PRIMARY CARE PHYSICIAN NUMBER	LOCATION (TOWN)
FIRST	M.I	LAST MAIDEN NAME		☐ HUSBAND ☐ WIFE					
FIRST	M.I.	LAST		☐ SON ☐ DAUGHTER ☐ OTHER*					
FIRST	M.I.	LAST		☐ SON ☐ DAUGHTER ☐ OTHER*					
FIRST	M.I.	LAST		☐ SON ☐ DAUGHTER ☐ OTHER*					
FIRST	M.I.	LAST		☐ SON ☐ DAUGHTER ☐ OTHER*					

*****In the space below, briefly describe the type of "Other" legal relationship between the Dependent(s) and yourself.

NOTE: Documentation obligating the applicant or the applicant's spouse, if applicable, to provide health care coverage to Dependent(s) will be required. All Dependents must meet eligibility criteria.

Dependent(s) Name	Gender	Description of Legal Relationship
	☐ Female ☐ Male	
	☐ Female ☐ Male	
	☐ Female ☐ Male	
	☐ Female ☐ Male	

PLEASE NOTE: If any of your Dependent(s), for which you are applying, do not live at the address listed in Section B, please indicate name(s), current address(es) and reason(s) why your Dependent(s) do not live at such address, in the space provided below. If your Dependent(s) live with a custodial parent, please provide name of custodial parent.

_____

_____

_____

_____

SECTION D. DECLARATIONS

I hereby apply to Geisinger Health Plan for the coverage now being offered for myself and the dependent(s), if any, as shown above. I understand that this application is subject to acceptance by Geisinger Health Plan, and that if a Subscription Certificate is issued, services will be available subject to the exclusions, limitations and other conditions of the Subscription Certificate and/or Rider(s), if applicable. In the event it is determined that one (1) or more of my dependent(s) is/are ineligible for enrollment in Geisinger Health Plan pursuant to the Subscription Certificate, I authorize Geisinger Health Plan to process this application, omitting the names of such ineligible dependent(s). I further understand that rates for the Subscription Certificate and/or Rider(s), if applicable, issued to me are subject to change by Geisinger Health Plan, in accordance with terms of the agreement with my employer, and upon thirty (30) days' prior notice to my employer acting on my behalf. I authorize my employer to make periodic deductions from my salary or wages of the amount, if any, I am required to contribute toward the rates for the coverage provided under my Subscription Certificate and/or Rider(s).

The information recorded above is true and correct to the best of my knowledge and belief. I understand that the misrepresentation of any material fact by me on this application could constitute grounds for the cancellation of any Subscription Certificate and/or Rider(s), if applicable, issued by Geisinger Health Plan in consideration of this application.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalities.

_____ _____ _____ _____

Signature of Applicant | Date Signed | Signature of Employer | Date Signed

Yellow - Employer *Pink - Applicant*