SUBSCRIBER APPLICATION CHANGE FORM

GEISINGER HEALTH PLAN®
M.C. 32-26
100 NORTH ACADEMY AVENUE
DANVILLE, PA 17822

☐ **Check if you are a member of Geisinger Health Plan Gold**

Effective Date of Change ___/___/___

SECTION I. SUBSCRIBER

GROUP NUMBER DIVISION NUMBER INSURANCE I.D. NUMBER

LEGAL NAME (LAST) (FIRST) (M.I.)

ADDRESS (NUMBER) (STREET) (APT. NO.)

CITY STATE ZIP CODE

COUNTY

SOCIAL SECURITY NUMBER

SECTION II.
CHANGES

Check which change(s) apply:

1. ❑ Add/Remove Dependent(s)
2. ❑ Address Change
3. ❑ Name Change

_____
(Previous last name)

4. ❑ New Home Telephone Number
(_____)_____
5. ❑ Changing Primary Care Physician

Reason for PCP Change: (check one)

a. ❑ Access dissatisfaction
b. ❑ Convenience
c. ❑ Error in PCP selection
d. ❑ Failure to establish relationship
e. ❑ Medical care dissatisfaction
f. ❑ PCP leaves the Health Plan
g. ❑ PCP moves
h. ❑ Provider service dissatisfaction

SECTION III.
DISENROLLMENT
Check which reason may apply

❑ **SUBSCRIBER** **OR** ❑ **DEPENDENT**

1. ❑ Deceased (DD)
(Date of Death)___/___/___
2. ❑ Dissatisfaction with Plan (DI)
3. ❑ Lay off (LO)
4. ❑ Leave of absence (LA)
5. ❑ Loss of dependent status (LS)
6. ❑ Moved out of service area (OA)
7. ❑ Non payment of premium
8. ❑ Personal preference (PP)
9. ❑ Reduction in work hours (RH)
10. ❑ Retired (RT)
11. ❑ Selected other insurance (SO)
❑ Open enrollment ___/___/___ (OE)
12. ❑ Termination of employment (TE)
13. ❑ Other:_____

SECTION IV. **COBRA / Mini-COBRA.** If changes noted in Section III are due to a Qualifying Event under COBRA or Mini-COBRA, as applicable, has the Subscriber or the Subscriber's eligible Dependent(s) elected continuation coverage under COBRA or Mini-COBRA? (Check One) 1. ☐ YES 2. ☐ NO 3. ☐ Determination is pending
4. ☐ Not Applicable. (Subscriber/Dependents is/are enrolled in Geisinger Health Plan Solutions (Non-Group) and COBRA/Mini-COBRA does not apply.)

SECTION V. SUBSCRIBER AND DEPENDENT CHANGES (PLEASE PRINT OR TYPE)

CHECK ONE		LEGAL NAME				BIRTHDATE			RELATION-SHIP TO SUBSCRIBER	CHECK REASON (NOTE DATE) DATE OF MAR-RIAGE	DATE OF DIVORCE	OTHER CHANGE OF STATUS	SOCIAL SECURITY NUMBER	MEDICAL RECORD NUMBER	PRIMARY CARE PHYSICIAN NAME/ LOCATION (TOWN)
ADD	RE-MOVE	LAST	FIRST	MAIDEN NAME	M.I.	MO.	DAY	YR.							

I HEREBY apply for amendment of my Subscriber Application. It is mutually agreed as follows: That these changes shall not become effective unless and until accepted by the Plan. That this application for change in coverage will become a part of my original application and if accepted will be subject to the terms of a Certificate or Agreement in effect with the Plan. 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 penalties.

SUBSCRIBER SIGNATURE DATE SIGNED GROUP BENEFITS ADMINISTRATOR / GROUP NAME (if applicable) DATE SIGNED