M.C. 32-29
100 NORTH ACADEMY AVENUE
DANVILLE, PA 17822

administered by
Geisinger Quality Options, Inc.

ENROLLMENT APPLICATION CHANGE FORM

Effective Date of Change ___/___/___

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

SECTION I. SUBSCRIBER/POLICYHOLDER

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

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

____
(Previous last name)

4. ☐ New Home Telephone Number
(____) ____________
5. ☐ Changing Plan

____
(Name of new plan)

6. ☐ 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

☐ **SUBSCRIBER/POLICYHOLDER** OR ☐ **DEPENDENT**

1. ☐ Deceased
   (Date of Death)___/___/___
2. ☐ Dissatisfaction with Plan
3. ☐ Lay off
4. ☐ Leave of absence
5. ☐ Loss of dependent status
6. ☐ Moved out of service area
7. ☐ Non payment of premium
8. ☐ Personal preference
9. ☐ Reduction in work hours
10. ☐ Retired
11. ☐ Selected other insurance
    ☐ Open enrollment ___/___/___
12. ☐ Termination of employment
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/Policyholder or the Subscriber's/Policyholder'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. (COBRA/Mini-COBRA does not apply.)

SECTION V. SUBSCRIBER/POLICYHOLDER AND DEPENDENT CHANGES (Please Print or Type)

CHECK ONE			LEGAL NAME				BIRTHDATE			RELATIONSHIP TO SUBSCRIBER/POLICYHOLDER	CHECK REASON (NOTE DATE)			SOCIAL SECURITY NUMBER	Has Dependent used tobacco on average of four (4) or more times per week within past six (6) months?	GEISINGER MEDICAL RECORD NUMBER	PRIMARY CARE PHYSICIAN NAME/LOCATION (TOWN)
ADD	REMOVE	CHANGING PLAN	LAST	FIRST	MAIDEN NAME	M.I.	MO.	DAY	YR.	(Spouse, Domestic Partner†, Son, Daughter, Other*)	DATE OF MARRIAGE	DATE OF DIVORCE	OTHER CHANGE OF STATUS/LEGAL QUALIFYING EVENT				
															☐ Yes ☐ No		
															☐ Yes ☐ No		
															☐ Yes ☐ No		
															☐ Yes ☐ No		

†Documentation obligating the Subscriber/Policyholder or the Subcriber's/Policyholder's spouse, if applicable, to provide healthcare coverage to Dependent(s) will be required. All Dependents must meet eligibility criteria.

*Description of Legal Relationship:____________________________

I HEREBY apply for amendment of my Subscriber/Policyholder Application. It is mutually agreed that (a) these changes shall not become effective unless and until accepted by the insurer, and (b) this application for change in coverage will become a part of my original application and if accepted will be subject to the terms of the policy in effect with the insurer. I understand that if I make any material misstatement in connection with the policy, the insurer may cancel the policy or deny claims, provided such material misstatement is discovered by the insurer within three (3) years of the policy Effective Date. In the event the insurer elects to void the policy, the Subscriber/Policyholder will forfeit any charges paid to the extent of any liability incurred by the insurer. 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/POLICYHOLDER SIGNATURE
________ DATE SIGNED
____________________ GROUP BENEFITS ADMINISTRATOR / GROUP NAME (if applicable)
________ DATE SIGNED

#M-150-001-F Rev. 1/14js

White - Insurer *Pink - Subscriber/Policyholder* *Yellow - Employer/Primary Care Site (if applicable)*