GEISINGER HEALTH PLAN
100 North Academy Avenue
Danville, PA 17822

GROUP SUBSCRIBER APPLICATION

GEISINGER QUALITY OPTIONS, INC.
100 North Academy Avenue
Danville, PA 17822

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
8. Plan selection: (check one) ☐ HMO ☐ PPO with Referral ☐ PPO without Referral

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	PREFERRED CONTACT METHOD: ☐ EMAIL ☐ PHONE ☐ MAIL

17. EMAIL ADDRESS:
(The email address you provide on this application helps Geisinger Health Plan and Geisinger Quality Options, Inc. (collectively tthe "Health Plan) to conduct business and provide you the best service possible. It is used to facilitate activities such as enrollment, customer identification and billing. The email address you provide is stored in a secure database and will not be sold to any entity outside of the Health Plan. It may be used for promotional or research purposes. You will be given an opportunity to opt-out of these communications whenever the Health Plan sends them).

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 or Geisinger Quality Options, Inc. (collectively the "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 the 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 the 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: _____ E. I.D. or Social Security No.: _____
B. Subscriber Name: _____ F. Group Name (Employer): _____
C. Check one: ☐ Family Plan ☐ Self Only G. Group Number _____
D. Effective Date of Coverage: _____ (Month) _____ (Day) _____ (Year)

SPOUSE/DEPENDENT INFORMATION

LEGAL NAME		LIST LAST NAME IF DIFFERENT FROM APPLICANT	SOCIAL SECURITY NO.	RELATIONSHIP	DATE OF BIRTH	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.

NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact our Customer Service Team at (1-800-447-4000).

DECLINATION OF ENROLLMENT

☐ I declare that I have coverage under another group health plan or have other health insurance coverage and, therefore decline enrollment for myself and any family dependents.

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

FRAUD STATEMENT

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.

DECLARATIONS

I hereby apply to the 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 the 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 the Health Plan pursuant to the Subscription Certificate, I authorize the 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 the 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 intentional 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 the Health Plan in consideration of this application, upon notice and in accordance with applicable law.

I represent that I have read this document or it has been read to me, including the sections titled, "Notice of Special Enrollment Rights," "Fraud Statement" and "Declarations".

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