

GEISINGER INDEMNITY INSURANCE COMPANY SUBSCRIBER APPLICATION

M.C. 30-29
100 N. Academy Ave.
Danville, PA 17822

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

1. Group number: _____ 3. Insurance ID number: _____
 2. Class: _____ 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 applicant or any eligible dependent(s) of applicant **currently** covered under:
 (a) COBRA? YES NO
 (b) Mini-COBRA? YES NO
 If "YES", provide the following information for each person, as applicable:
 Name of Covered Person: _____ End Date of Coverage: _____ Description of Qualifying Event: _____
 (MM/DD/YYYY)

 8. Is the applicant or any eligible dependent(s) newly electing coverage under:
 (a) COBRA? YES NO
 (b) Mini-COBRA? YES NO
 If "YES", provide the following information for each person, as applicable:
 Name of Person: _____ Start & End Date of Coverage: _____ Description of Qualifying Event: _____
 (MM/DD/YYYY)

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. SOCIAL SECURITY NUMBER _____ 17. DATE OF BIRTH
 MONTH | DAY | YEAR
 _____ | _____ | _____
 18. EMPLOYER (NAME, CITY, AND PHONE NUMBER) _____ 19. DATE OF EMPLOYMENT _____ 20. GEISINGER MED. REC. # (if any) _____
 21. While covered under this policy, will you or any dependent(s) listed on this application also be covered by Medicare?
 YES NO
 If you answered "YES" to this question, provide the following information for each person, as applicable:
 Name of Person(s): _____ Medicare #: _____ Part A or Part B: _____ Effective Date: _____

SECTION B. APPLICANT INFORMATION (Continued)

22. Are you or any dependent(s) listed on this application currently receiving Disability/Workers' Compensation Benefits?
 YES NO

If you answered "YES" to this question, provide the following information for each person, as applicable:
 Name of Person(s): Medicare #: Part A or Part B: Effective Date:

23. While covered under this policy, will you or any dependent(s) listed on this application also be covered by other health insurance?
 YES NO

If you answered "YES" to this question, provide the following information:

A. NAME OF INSURANCE COMPANY		B. SUBSCRIBER NAME	
C. TYPE OF PLAN	D. EFFECTIVE DATE OF COVERAGE (MM/DD/YYYY)	E. INSURANCE I.D. NO. OR SOCIAL SECURITY NO.	
F. GROUP NAME (EMPLOYER)		G. GROUP NUMBER <input type="checkbox"/> FAMILY PLAN <input type="checkbox"/> SELF ONLY	

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		<input type="checkbox"/> HUSBAND <input type="checkbox"/> WIFE					
FIRST	M.I. LAST		<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER <input type="checkbox"/> OTHER*					
FIRST	M.I. LAST		<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER <input type="checkbox"/> OTHER*					
FIRST	M.I. LAST		<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER <input type="checkbox"/> OTHER*					
FIRST	M.I. LAST		<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER <input type="checkbox"/> 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 healthcare coverage to Dependent(s) will be required. All Dependents must meet eligibility criteria.

Dependent(s) Name	Gender <input type="checkbox"/> Female <input type="checkbox"/> Male	Description of Legal Relationship
_____	<input type="checkbox"/> Female <input type="checkbox"/> Male	_____
_____	<input type="checkbox"/> Female <input type="checkbox"/> Male	_____
_____	<input type="checkbox"/> Female <input type="checkbox"/> 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.

I understand that this application is subject to acceptance by my employer and that, if accepted, services will be available subject to the exclusions, limitations, and other conditions of my Employer's Health Benefit Plan. 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. The information recorded above is true and correct to the best of my knowledge and belief.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim continuing 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.

 Signature of Employer Date Signature of Applicant Date Signed

Discrimination is Against the Law

Geisinger Indemnity Insurance Company complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, gender identity or sexual orientation. Geisinger Indemnity Insurance Company does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity, or sexual orientation.

Geisinger Indemnity Insurance Company:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, call Geisinger Indemnity Insurance Company at 800-447-4000 or TTY: 711.

If you believe that Geisinger Indemnity Insurance Company has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation, you can file a grievance with:

Civil Rights Grievance Coordinator
Geisinger Health Plan Appeals Department
100 North Academy Avenue, Danville, PA 17822-3220
Phone: 866-577-7733, TTY: 711
Fax: 570-271-7225
GHPCivilRights@thehealthplan.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Grievance Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW., Room 509F
HHH Building, Washington, DC 20201
Phone 800-368-1019, 800-537-7697 (TDD).
Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 800-447-4000 or TTY: 711.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-447-4000 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 800-447-4000（TTY：711）。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 800-447-4000 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 800-447-4000 (телетайп: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 800-447-4000 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-447-4000 (TTY: 711) 번으로 전화해 주십시오.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 800-447-4000 (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 800-447-4000 (رقم هاتف الصم والبكم: 711).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 800-447-4000 (ATS : 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 800-447-4000 (TTY: 711).

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિઃશુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 800-447-4000 (TTY: 711).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 800-447-4000 (TTY: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 800-447-4000 (TTY: 711).

ប្រយ័ត្ន: បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតលុយ គឺអាចមានសំរាប់អ្នក។ ចូរ ទូរស័ព្ទ 800-447-4000 (TTY: 711)។

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 800-447-4000 (TTY: 711).