GEISINGER HEALTH PLAN®

Employer Group Application

GEISINGER CHOICE®

Section A:

Employer Group Name:			**Effective Date:**		
Physical Address:			**Financial Address: (leave blank if same as physical)**		
City:	**State:**	**Zip:**	**City:**	**State:**	**Zip:**
Contact Person:	**Title:**		**Current Health Carrier:**		
Phone:	**Fax:**		**Required FT Hours (eligible employees):**	**Required PT Hours (eligible employees):**	
SIC Code:	**Business Description:**		**Total # Employees (FT/PT All Locations):**	**Total # of Eligible Employees:**	
EIN:	**New Hire Criteria:**		**# of Employees Waiving:**	**Employer Premium Contribution:**	

Section B: (Groups 2-24 - use template provided below; groups 25+ electronic spreadsheet is preferred)

Coverage Types: Employee = E; Employee/Spouse = E/S; Employee/Child = E/C; Employee/Children = E/R; Family = F

List all Employee Names:	Gender Male(M) Female(F)	Date of Birth	Date of Hire	Zip Code	Coverage Type	Check if Waving Coverage	Check if Employee Not Eligible

Page 2: Employer Group Name: _____

Section C: Employer groups with more than 50 total employees MUST complete Section C

Provide the answer to the following questions as they pertain to all eligible employees and/or covered dependents (including COBRA, any state continuation programs & eligible retirees). To your knowledge has any person, to be covered, been diagnosed or treated by a provider for any of the following conditions within the last five years? Please check yes or no, if yes please circle all that apply. For each item checked "YES", please explain in section below.

1. Cancer: Type (if known) _____	Yes _____	No _____	# of people: _____
2. Heart Disease or Vascular Disease	Yes _____	No _____	# of people: _____
3. Organ Transplant/Bone Marrow Transplant (planned or past)	Yes _____	No _____	# of people: _____
4. Rheumatoid or Psoriatic Arthritis	Yes _____	No _____	# of people: _____
5. Diabetes: Type (if known) _____	Yes _____	No _____	# of people: _____
6. Cystic Fibrosis, Emphysema, Asthma or other lung disease	Yes _____	No _____	# of people: _____
7. Disorder of the spine, back, joints, bones	Yes _____	No _____	# of people: _____
8. Epilepsy/seizure disorder	Yes _____	No _____	# of people: _____
9. Blood disorders including hemophilia	Yes _____	No _____	# of people: _____
10. HIV/AIDS	Yes _____	No _____	# of people: _____
11. Kidney or bladder disease, kidney dialysis	Yes _____	No _____	# of people: _____
12. Liver disease or hepatitis: Type (if known) _____	Yes _____	No _____	# of people: _____
13. Multiple Sclerosis, muscular dystrophy or cerebral palsy	Yes _____	No _____	# of people: _____
14. High end specialty drugs / infusion therapy	Yes _____	No _____	# of people: _____
15. Psychological or other mental disorder	Yes _____	No _____	# of people: _____
16. Stroke or paralysis	Yes _____	No _____	# of people: _____
17. Gaucher's Disease	Yes _____	No _____	# of people: _____
18. Colitis or Chron's Disease	Yes _____	No _____	# of people: _____
19. Any condition/disease not mentioned above or *anticipated surgery*	Yes _____	No _____	# of people: _____

Have any employees, dependents or Cobra individuals who are eligible for coverage incurred claims that have exceeded $10,000 (medical and/or pharmacy) during the past 12 months? _____ Yes _____ No. If yes, please explain below.

Are any employees currently disabled or otherwise not actively at work? _____ Yes _____No. If yes, please explain below.

Are any eligible employees or dependents currently pregnant? _____Yes _____ No. If yes, please explain below. List each person on a separate line, include age and due date. Also list, if it is a multiple birth pregnancy or if the birth is considered high risk.

***** Please explain any "YES" answers in this space. If more space is needed, attach a separate sheet. Please sign and date all attachments. *****

Description of condition	Is condition ongoing ? (Y or N)

My signature below verifies that the information contained on this application for group coverage is accurate and true to the best of my knowledge. I attest that the individuals listed above are active employees of the organization. I understand that Geisinger Health Plan has the right to perform annual renewal reviews of applicable tax form verifiers and/or payroll records in order to confirm employment of the individuals enrolled. I also understand that pending review of applications by Geisinger Health Plan underwriting, individual group rates to vary based upon age/gender factors and industry indexes. 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. Geisinger Health Plan will investigate information provided and take action against those involved with insurance fraud. The penalties include, but are not limited to, retroactive and/or immediate termination of group coverage, as well as criminal or civil action.

Section D: Required Signature(s)

Employer's Signature:_____ Broker Name (if applicable):_____

Employer's Name (print): _____ Broker Agency Name: _____

Title: _____ Date: _____