Geisinger Quality Options, Inc.
M.C. 32-26
100 North Academy Avenue
Danville, PA 17822

GROUP SUBSCRIBER APPLICATION

GEISINGER CHOICE®
PPO with No Referral

SECTION A. 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

SECTION B. APPLICANT INFORMATION (Please Print Clearly)

1. LEGAL NAME (LAST)	2. (MAIDEN NAME)	3. (FIRST)	4. (M.I.)	5. GENDER ☐ FEMALE ☐ MALE

6. ADDRESS (NUMBER) (STREET) (APT. NO.)	7. CITY	8. STATE	9. ZIP CODE	10. COUNTY

11. HOME PHONE NUMBER	12. CELL PHONE NUMBER	13. WHAT IS THE BEST TIME TO REACH YOU? _____ ☐ AM ☐ PM

14. SOCIAL SECURITY NUMBER			15. DATE OF BIRTH			16. MARITAL STATUS
			MONTH	DAY	YEAR	☐ MARRIED ☐ SINGLE ☐ DIVORCED/SEPARATED ☐ WIDOWED

17. EMPLOYER (NAME, CITY, AND PHONE NUMBER)	18. DATE OF EMPLOYMENT	19. GEISINGER MEDICAL RECORD # (if any)

20. While enrolled in Geisinger Choice PPO with no Referral will you also be covered by Medicare? Yes ☐ No ☐
    If "Yes", please provide: Your Medicare Number: _____ (Check one) Part A ☐ Part B ☐
21. While enrolled in Geisinger Choice PPO with no Referral will any Dependent(s) listed on this form also be covered by Medicare?
    Yes ☐ No ☐ If "Yes", please provide the following information:

Dependent(s) Name	Medicare Number	Part A (check as applicable)	Part B (check as applicable)

22. While enrolled in this policy, 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: _____
    B. Subscriber Name: _____
    C. Check one: ☐ Family Plan ☐ Self Only
    D. Effective Date of Coverage: _____ (Month) _____ (Day) _____ (Year)
    E. I.D. or Social Security No.: _____
    F. Group Name (Employer): _____
    G. Group Number _____

White - Geisinger Quality Options, Inc. c/o Geisinger Choice PPO with no Referral

SECTION C. SPOUSE/DEPENDENT INFORMATION

LEGAL NAME			LIST LAST NAME IF DIFFERENT FROM APPLICANT	SOCIAL SECURITY NO.	RELATIONSHIP	DATE OF BIRTH			GEISINGER MEDICAL RECORD #
SPOUSE	(FIRST)	M.I	LAST MAIDEN NAME		☐ HUSBAND ☐ WIFE				
DEPENDENT #1	(FIRST)	M.I.	LAST		☐ SON ☐ DAUGHTER ☐ OTHER*				
DEPENDENT #2	(FIRST)	M.I.	LAST		☐ SON ☐ DAUGHTER ☐ OTHER*				
DEPENDENT #3	(FIRST)	M.I.	LAST		☐ SON ☐ DAUGHTER ☐ OTHER*				
DEPENDENT #4	(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 the above address, in the space provided below. If your Dependent(s) live with a custodial parent, please provide name of custodial parent.

SECTION D. DECLARATIONS

I hereby apply to Geisinger Quality Options, Inc. 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 Geisinger Quality Options, Inc., 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 Geisinger Choice PPO with no Referral pursuant to the Subscription Certificate, I authorize Geisinger Quality Options, Inc. 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 Geisinger Quality Options, Inc., 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 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 Geisinger Quality Options, Inc. in consideration of this application.

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 penalities.

Signature of Applicant _____ Date Signed _____ Signature of Employer _____ Date Signed _____

Yellow - Employer *Pink - Applicant*