

Employer group application

1. Group information					
Group name			Effective date		
Business description	SIC	EIN	Years in business		
Physical address		County			
City		State	Zip		
Financial address (if different from above)					
City		State	Zip		
Contact name		Contact title			
Contact email		Contact phone			
Eligibility requirements					
New hire criteria	Full time hours	Part time hours			
Employer contribution					
Employee composition					
Total company employees	Total eligible employees				
Employees waiving coverage	Enrolling employees				

2. Broker/consultant information	
Agency name	Agent name
Agent email	Agent phone

3. Group census information
<input type="checkbox"/> Submit your group census information in electronic format.

4. Employee condition disclosure

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? Provide the answer to the following questions as they pertain to all eligible employees and/or covered dependents (including COBRA, any state continuation programs and eligible retirees). Please check yes or no. For each item checked "Yes", please explain in section below.

1. Cancer Type (if known): _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Number of people
2. Heart disease/vascular disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Number of people
3. Organ transplant/bone marrow transplant (planned or past)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Number of people
4. Rheumatoid or psoriatic arthritis	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Number of people
5. Diabetes Type (if known): _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Number of people
6. Cystic fibrosis, emphysema, asthma or other lung disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Number of people
7. Disorder of the spine, back, joints, bones	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Number of people
8. Epilepsy/seizure disorder	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Number of people
9. Blood disorders including hemophilia	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Number of people
10. HIV/AIDS	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Number of people
11. Kidney or bladder disease; kidney dialysis	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Number of people
12. Liver disease or hepatitis Type (if known): _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Number of people
13. Multiple sclerosis, muscular dystrophy or cerebral palsy	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Number of people
14. High-end specialty drugs/infusion therapy	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Number of people
15. Psychological or other mental disorder	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Number of people
16. Stroke or paralysis	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Number of people
17. Gaucher's disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Number of people
18. Colitis or Crohn's disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Number of people
19. Any conditions not mentioned above or anticipated surgery	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Number of people
20. 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 <input type="checkbox"/>	No <input type="checkbox"/>	Number of people
21. Are any employees currently disabled or otherwise not actively at work?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Number of people
22. Are any eligible employees or dependents currently pregnant? 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.	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Number of people

5. If you answered "yes" to any conditions above, explain below. If more space is needed, attach a separate sheet and sign and date all attachments.

6. Required signatures and fraud statement

Employer name	Title
Employer signature	Date

My signature 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.