GEISINGER HEALTH PLAN
100 North Academy Avenue
Danville, PA 17822

ACA Employer Group Application

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

General Group Information

Employer Group Name:	Doing Business As:	
Business Description:	EIN (Tax Id):	SIC Code:
Physical Address:	Financial Address:(leave blank if same as physical)	
City: State: Zip:	City: State: Zip:	
Physical Address County:	Current Health Carrier:	

Primary Contact Information

First Name:	M. Init:	Last Name:	Title:
Email Address:	Phone:	Fax:	

(The email address you provide on this application helps Geisinger Health Plan and/or Geisinger Quality Options, Inc. (the "Health Plan") to conduct business and provide good service. It is used to facilitate activities such as member satisfaction surveys. Please note that if you provide your e-mail address, it will be stored in a secure database and will not be sold to any entity outside of the Health Plan. You will be given an opportunity to opt-out of the e-mail communications)

Eligibility & Enrollment

Effective Date:	Open Enrollment Start Date:	Open Enrollment End Date:
New Hire Waiting Period (can't exceed 90 days from date of hire):	Part Time Hours to Qualify for Benefits if Less than 30: (Optional)	
Total Company Employees Working Over 30 Hours:	Number of Employees Waiving Coverage:	
Total Company Employees Working Less than 30 Hours:	Number of Employees on COBRA:	

Monthly Contribution

Group agrees, at a minimum, to contribute 50% of the cost of the employee only rate for the lowest benefit plan offered.

☐ By marking this check box, I confirm that I understand, and will comply with, the above requirement as part of the terms and conditions of purchasing employer group sponsored coverage through the Geisinger Health Plan/Geisinger Quality Options, Inc.

Producer of Record

General Agency Name:	General Agency Number:	General Agency Phone Number:
Agency Name:	Agency Number:	Agency Phone Number:
Producer Name:	Producer Number:	Producer Phone Number:

Employee and Dependent Roster

Instructions:
1. Please use the form below to submit your full roster of both employees and dependents. We also accept the information below in electronic format.

2. For "TYPE" please use the following codes:
[Employee=E, Spouse=S, Employee Child=C, Disabled Dependent over age 26=DD, Other Dependent=OD]

3. Tobacco use means use of tobacco on average four or more times per week within no longer than the past 6 months (excludes religious or ceremonial use of tobacco).

4. Please copy this page if additional space is required.

Employer Group Name:

First Name	M. I.	Last Name	Gender (M/F)	Date of Birth	Date of Hire	Tobacco Use Y/N	Postal Code	Type	County

Discrimination is against the law

Geisinger Health Plan and Geisinger Quality Options, Inc. (collectively referred to as the "Health Plan") comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. The Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity, or sexual orientation.

The Health Plan:

- 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 the Health Plan at 800-447-4000 or TTY: 711.

If you believe that the Health Plan 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 નિ:શુલ્ક 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 ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 800-447-4000 (TTY: 711)។

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

HPM 50 alb: Nondiscrimination dev. 9.12.16
Y0032_16242_2 File and Use 9/2/16

Summary of Benefits Coverage

Following the Affordable Care Act regulations, the Health Plan will be preparing the Summary of Benefits and Coverage and Uniform Glossary (SBC) and providing these documents for each finalized quote provided to a group. I understand that I may request an SBC at any time for any preliminary quote already received.

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.

Premium Payment

At any time during the benefit year, should the Group's enrollment be terminated with premium payments due ("past-due premiums") to either Geisinger Health Plan or Geisinger Quality Options, Inc., the Group may be required to pay any past-due premiums owed from the period not to exceed 12 months prior to the effective date of new coverage, in order to effectuate new coverage. Payment of past-due premiums may be required if the Group is applying for the same or different coverage either with Geisinger Health Plan and past-due premiums are owed to Geisinger Quality Options, Inc. or if the Group is applying for the same or different coverage with Geisinger Quality Options, Inc. and past-due premiums are owed to Geisinger Health Plan.

Please note: Prior coverage will not be reinstated. A new policy will be written.

Required Signatures

I understand that the 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 the Health Plan, individual group rates to vary based upon age factors and tobacco status.

The 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.

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 and dependents thereof.

I authorize the Health Plan to electronically transmit the information contained herein. If this application was taken over the phone or on the computer, I acknowledge that I, myself, have not actually signed this application but instead hereby authorize the Health Plan to print an electronic acknowledgement on the signature line of the application and I agree that such printing shall be treated as a valid signature for all purposes of this form. I acknowledge that the Health Plan has verified my identity for this purpose in accordance with any applicable law or regulation.

_____ Broker's Signature if Applicable

_____ Employer Representative's Signature

_____ Employer Representative's Name (print)

_____ Employer Representative's Title

_____ Date