GEISINGER HEALTH PLAN
GEISINGER COLLEGE OF HEALTH SCIENCES STUDENT HEALTH PLAN

100 North Academy Avenue
Danville, PA 17822

Enrollment Application for Individual & Family Health Care Coverage

Use this application to select health care coverage for you and your family	• Affordable private health insurance plans that offer comprehensive coverage to help you stay well • You may qualify for a free or low-cost program
Who can use this application?	• Use this application to apply for anyone in your family • If someone is helping you fill out this application, you may need to complete Appendix A
Apply faster online	• Apply faster online at www.GeisingerMarketplace.com
What you need to apply	• Blue or black ink pen • Social Security numbers • Policy numbers for any current health insurance
What happens next?	• Send your completed, signed application to the address on page 10. We'll follow-up with you within 7-10 days. If you don't hear from us, call 800-918-5154.
Get help with this application	• **Online:** www.GeisingerMarketplace.com • **Phone:** Call to speak with a Health Plan advisor at 800-918-5154 • **En Español:** Llame a nuestro centro de ayuda gratis al 800-918-5154

Step 1 Tell us about yourself (primary applicant).

Please DO NOT include any genetic information such as family medical history or any information related to genetic testing, genetic services, genetic counseling, or genetic diseases for which you believe you may be at risk.

1. Name: Prefix, First Name, Middle Initial, Last name, & Suffix

2. Residential address (Leave blank if you don't have one.) | 3. Apartment or suite number

4. City | 5. State | 6. Zip code | 7. County

8. Mailing address (if different from residential address) | 9. Apartment or suite number

10 City | 11. State | 12. Zip code | 13. County

14. Phone number (preferred) | 15. Mobile number | 16. Work number

17. Date of birth (mm/dd/yyyy)

18. Sex assigned at birth: ☐ Male ☐ Female ☐ Not recorded on birth certficate ☐ Choose not to disclose

19. Social security number (SSN)

20. Are you pregnant? ☐ Yes ☐ No
a. If yes, how many babies are expected during this pregnancy? _____

21. Have you used tobacco on average of four or more times per week within the past six (6) months? ☐ Yes ☐ No
(applies to persons 21 years of age and older)

22. Primary Care Physician (PCP) Information:
a. Are you an established patient with a PCP: ☐ Yes ☐ No
If yes, please complete the following:
b. PCP Name (first/last): _____ c. PCP Phone Number: (_____) - _____ - _____
d. PCP Practice Location (Mailing address): _____
Street City State Zip

23. Email address:
_____
(The email address you provide on this application helps 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.)

24. Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

25. Are you a U.S. citizen or U.S. National? ☐ Yes ☐ No

26. If you aren't a U.S. citizen or U.S. national, do you have eligible immigration status? ☐ Yes ☐ No
If Yes, fill in your document type and ID number below.
a. Immigration document type: _____ b. Document ID Number: _____
c. Have you lived in the U.S. since 1996? ☐ Yes ☐ No
d. Are you, or your spouse or parent a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

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SEX (LEGAL/ADMINISTRATIVE)
☐ MALE ☐ FEMALE ☐ X OR NON-BINARY
☐ CHOOSE NOT TO DISCLOSE

ETHNICITY
☐ HISPANIC OR LATINO
☐ NOT HISPANIC OR LATINO
☐ CHOOSE NOT TO DISCLOSE

PRONOUNS
☐ SHE/HER/HERS
☐ HE/HIM/HIS
☐ THEY/THEM/THEIRS
☐ MY NAME
☐ CHOOSE NOT TO DISCLOSE
☐ NOT LISTED: _____

PREFERRED LANGUAGE
☐ ENGLISH ☐ GUJARATI ☐ RUSSIAN ☐ GERMAN
☐ SPANISH ☐ SIGN LANGUAGE ☐ CHINESE ☐ HINDI
☐ NEPALI ☐ VIETNAMESE ☐ ARABIC
☐ YIDDISH, PENNSYLVANIA DUTCH OR OTHER WEST GERMANIC LANGUAGES
☐ OTHER: _____

SEXUAL ORIENTATION
☐ STRAIGHT (NOT LESBIAN OR GAY)
☐ LESBIAN OR GAY
☐ BISEXUAL
☐ SOMETHING ELSE _____
☐ CHOOSE NOT TO DISCLOSE

GENDER IDENTITY
☐ MALE ☐ FEMALE
☐ TRANSGENDER MALE (FEMALE-TO-MALE)
☐ TRANSGENDER FEMALE (MALE-TO-FEMALE)
☐ GENDERQUEER (NEITHER EXCLUSIVELY MALE NOR FEMALE)
☐ CHOOSE NOT TO DISCLOSE

RACE
☐ AMERICAN INDIAN OR ALASKA NATIVE ☐ ASIAN
☐ WHITE ☐ BLACK OR AFRICAN AMERICAN
☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER
☐ TWO OR MORE RACES
☐ CHOOSE NOT TO DISCLOSE

VETERAN STATUS
☐ YES ☐ NO
☐ CHOOSE NOT TO DISCLOSE

YEARS OF SERVICE

BRANCH OF SERVICE
☐ AIR FORCE ☐ AIR NATIONAL GUARD ☐ AIR FORCE RESERVE ☐ NAVY
☐ ARMY ☐ ARMY NATIONAL GUARD ☐ ARMY RESERVE ☐ NAVY RESERVE
☐ COAST GUARD ☐ COAST GUARD RESERVE ☐ MARINE CORPS ☐ MULTIPLE BRANCHES

MAJOR CONFLICTS
☐ COLD WAR ☐ GULF WAR ☐ IRAQ WAR ☐ KOREAN WAR
☐ PEACE TIME ☐ WWII ☐ VIETNAM WAR
☐ WAR IN AFGHANISTAN

WE HONOR VETERANS CEREMONY
☐ YES ☐ NO

DISABLED VETERAN
☐ YES ☐ NO

VA RECOGNIZE DISABILITY
☐ YES ☐ NO

STEP 2 Tell us about the primary applicant's family.

The following person(s) in your family may be eligible for coverage:

• Yourself	• Your spouse under an existing marriage legally recognized under the laws of the Commonwealth of Pennsylvania
• Your domestic partner who needs health coverage (A completed and notarized Declaration of Fact form is required to be submitted)	• Your children or your spouse's children (married or unmarried) who have not yet attained age 26 (Dependents of the Domestic Partner are not eligible)
• Your disabled children or your spouse's disabled children age 26 or older (A completed Dependent Certification form is required to be submitted)	• Please DO NOT include any genetic information such as family medical history or any information related to genetic testing, genetic services, genetic counseling, or genetic diseases for which you believe your dependents may be at risk.

Complete Step 2 for each person in your family applying for coverage under this policy. Start with your spouse or domestic partner and then add other adults and children. If you have more than 5 people in your family, you'll need to make a copy of the pages and attach them. We'll keep all the information you provide private and secure as required by law. We'll use personal information only to check if you're eligible for health coverage.

Complete Step 2 for your spouse or domestic partner, and eligible children.

DEPENDENT 1 | **LEGAL NAME:** (LAST, FIRST M.I.): | **BIRTH DATE:** (MM/DD/YYYY.):

CHECK ONE: ☐ ADD ☐ REMOVE ☐ CHANGING PLAN

RELATIONSHIP TO SUBSCRIBER/POLICY HOLDER ☐ SPOUSE ☐ DOMESTIC PARTNER† ☐ CHILD ☐ LEGAL CUSTODIAN/LEGAL GUARDIAN ☐ OTHER†* _____

SOCIAL SECURITY NUMBER:

GEISINGER MEDICAL RECORD NUMBER:

MARITAL STATUS ☐ MARRIED - DATE OF MARRIAGE _____ ☐ DIVORCED - DATE OF DIVORCE _____ OTHER CHANGE OF STATUS/LEGAL QUALIFYING EVENT DATE: _____

RESIDENTIAL ADDRESS: (☐ CHECK HERE IF SAME AS PRIMARY APPLICANT)

Street/Apartment/Suite # | City | State | Zip | Country

ARE YOU PREGNANT? ☐ YES ☐ NO A. IF YES, HOW MANY BABIES ARE EXPECTED DURING THIS PREGNANCY? _____

TOBACCO USE: HAVE YOU USED TOBACCO ON AVERAGE OF FOUR OR MORE TIMES PER WEEK WITHIN THE PAST SIX (6) MONTHS? ☐ YES ☐ NO
(applies to persons 21 years of age and older)

PRIMARY CARE PHYSICIAN (PCP) INFORMATION

ARE YOU AN ESTABLISHED WITH A PCP? ☐ YES ☐ NO

IF YES, PCP NAME: _____

PCP PHONE: (_____) - _____- _____

PCP PRACTICE LOCATION (MAILING ADDRESS): _____

U.S. CITIZENSHIP

HAVE YOU LIVED IN THE U.S. SINCE 1996? ☐ YES ☐ NO

ARE YOU U.S. CITIZEN OR U.S. NATIONAL? ☐ YES ☐ NO

IF YOU ARE NOT A U.S. CITIZEN OR U.S. NATIONAL, DO YOU HAVE ELIGIBLE IMMIGRATION STATUS? ☐ YES ☐ NO
IF YES, FILL IN YOUR DOCUMENT TYPE AND ID # TO THE RIGHT.

DOCUMENT TYPE _____

DOCUMENT ID NUMBER _____

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SEX ASSIGNED AT BIRTH
☐ MALE ☐ FEMALE ☐ NOT RECORDED ON BIRTH CERTIFICATE

SEX (LEGAL/ADMINISTRATIVE)
☐ MALE ☐ FEMALE ☐ X OR NON-BINARY ☐ CHOOSE NOT TO DISCLOSE

PRONOUNS
☐ SHE/HER/HERS ☐ HE/HIM/HIS ☐ THEY/THEM/THEIRS ☐ MY NAME ☐ CHOOSE NOT TO DISCLOSE ☐ NOT LISTED: _____

PREFERRED LANGUAGE
☐ ENGLISH ☐ GUJARATI ☐ RUSSIAN ☐ SIGN LANGUAGE ☐ HINDI ☐ SPANISH ☐ GERMAN ☐ CHINESE ☐ OTHER: _____ ☐ NEPALI ☐ VIETNAMESE ☐ ARABIC ☐ YIDDISH, PENNSYLVANIA DUTCH OR OTHER WEST GERMANIC LANGUAGES

ETHNICITY
☐ HISPANIC OR LATINO ☐ NOT HISPANIC OR LATINO ☐ CHOOSE NOT TO DISCLOSE

SEXUAL ORIENTATION
☐ STRAIGHT (NOT LESBIAN OR GAY) ☐ LESBIAN OR GAY ☐ BISEXUAL ☐ SOMETHING ELSE _____ ☐ CHOOSE NOT TO DISCLOSE

GENDER IDENTITY
☐ MALE ☐ FEMALE ☐ TRANSGENDER FEMALE (MALE-TO-FEMALE) ☐ TRANSGENDER MALE (FEMALE-TO-MALE) ☐ GENDERQUEER (NEITHER EXCLUSIVELY MALE NOR FEMALE) ☐ CHOOSE NOT TO DISCLOSE

RACE
☐ AMERICAN INDIAN OR ALASKA NATIVE ☐ BLACK OR AFRICAN AMERICAN ☐ ASIAN ☐ WHITE ☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER ☐ TWO OR MORE RACES ☐ CHOOSE NOT TO DISCLOSE

VETERAN STATUS (NOT APPLICABLE IF DEPENDENT IS UNDER THE AGE OF 17.)

VETERAN OR ACTIVE DUTY MEMBER OF THE U.S. MILITARY? ☐ YES ☐ NO ☐ CHOOSE NOT TO DISCLOSE

IF YES, YEARS OF SERVICE: _____

MILITARY BRANCH:
☐ AIR FORCE ☐ AIR NATIONAL GUARD ☐ AIR FORCE RESERVE ☐ NAVY
☐ ARMY ☐ ARMY NATIONAL GUARD ☐ ARMY RESERVE ☐ NAVY RESERVE
☐ COAST GUARD ☐ COAST GUARD RESERVE ☐ MARINE CORPS ☐ MULTIPLE BRANCHES

MAJOR CONFLICTS
☐ COLD WAR ☐ GULF WAR ☐ IRAQ WAR ☐ KOREAN WAR ☐ PEACE TIME ☐ VIETNAM WAR ☐ WWII ☐ WAR IN AFGHANISTAN

WE HONOR VETERANS CEREMONY
☐ YES ☐ NO

DISABLED VETERAN
☐ YES ☐ NO

VA RECOGNIZE DISABILITY
☐ YES ☐ NO

DEPENDENT 2

LEGAL NAME: (LAST, FIRST M.I.):

BIRTH DATE: (MM/DD/YYYY.):

CHECK ONE:
☐ ADD ☐ REMOVE
☐ CHANGING PLAN

RELATIONSHIP TO SUBSCRIBER/POLICY HOLDER
☐ SPOUSE ☐ DOMESTIC PARTNER† ☐ CHILD
☐ LEGAL CUSTODIAN/LEGAL GUARDIAN ☐ OTHER†* _____

SOCIAL SECURITY NUMBER:

GEISINGER MEDICAL RECORD NUMBER:

MARITAL STATUS ☐ MARRIED - DATE OF MARRIAGE _____ ☐ DIVORCED - DATE OF DIVORCE _____ OTHER CHANGE OF STATUS/LEGAL QUALIFYING EVENT DATE: _____

RESIDENTIAL ADDRESS: (☐ CHECK HERE IF SAME AS PRIMARY APPLICANT)

Street/Apartment/Suite # City State Zip Country

ARE YOU PREGNANT? ☐ YES ☐ NO **A.** I YES, HOW MANY BABIES ARE EXPECTED DURING THIS PREGNANCY? _____

TOBACCO USE: HAVE YOU USED TOBACCO ON AVERAGE OF FOUR OR MORE TIMES PER WEEK WITHIN THE PAST SIX (6) MONTHS? ☐ YES ☐ NO
(applies to persons 21 years of age and older)

PRIMARY CARE PHYSICIAN (PCP) INFORMATION
ARE YOU AN ESTABLISHED WITH A PCP?
☐ YES ☐ NO
IF YES, PCP NAME: _____
PCP PHONE: (_____) - _____ - _____
PCP PRACTICE LOCATION (MAILING ADDRESS): _____

U.S. CITIZENSHIP
HAVE YOU LIVED IN THE U.S. SINCE 1996?
☐ YES ☐ NO
ARE YOU U.S. CITIZEN OR U.S. NATIONAL?
☐ YES ☐ NO
IF YOU ARE NOT A U.S. CITIZEN OR U.S. NATIONAL, DO YOU HAVE ELIGIBLE IMMIGRATION STATUS? ☐ YES ☐ NO
IF YES, FILL IN YOUR DOCUMENT TYPE AND ID # TO THE RIGHT.
DOCUMENT TYPE _____
DOCUMENT ID NUMBER _____

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SEX ASSIGNED AT BIRTH
☐ MALE ☐ FEMALE
☐ NOT RECORDED ON BIRTH CERTIFICATE

SEX (LEGAL/ADMINISTRATIVE)
☐ MALE ☐ FEMALE
☐ X OR NON-BINARY
☐ CHOOSE NOT TO DISCLOSE

PRONOUNS
☐ SHE/HER/HERS ☐ HE/HIM/HIS
☐ THEY/THEM/THEIRS ☐ MY NAME
☐ CHOOSE NOT TO DISCLOSE
☐ NOT LISTED: _____

PREFERRED LANGUAGE
☐ ENGLISH ☐ GUJARATI ☐ RUSSIAN ☐ SIGN LANGUAGE ☐ HINDI
☐ SPANISH ☐ GERMAN ☐ CHINESE ☐ OTHER: _____
☐ NEPALI ☐ VIETNAMESE ☐ ARABIC
☐ YIDDISH, PENNSYLVANIA DUTCH OR OTHER WEST GERMANIC LANGUAGES

ETHNICITY
☐ HISPANIC OR LATINO
☐ NOT HISPANIC OR LATINO
☐ CHOOSE NOT TO DISCLOSE

SEXUAL ORIENTATION
☐ STRAIGHT (NOT LESBIAN OR GAY)
☐ LESBIAN OR GAY
☐ BISEXUAL
☐ SOMETHING ELSE _____
☐ CHOOSE NOT TO DISCLOSE

GENDER IDENTITY
☐ MALE ☐ FEMALE ☐ TRANSGENDER FEMALE (MALE-TO-FEMALE)
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☐ GENDERQUEER (NEITHER EXCLUSIVELY MALE NOR FEMALE)
☐ CHOOSE NOT TO DISCLOSE

RACE
☐ AMERICAN INDIAN OR ALASKA NATIVE
☐ BLACK OR AFRICAN AMERICAN
☐ ASIAN ☐ WHITE
☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER
☐ TWO OR MORE RACES
☐ CHOOSE NOT TO DISCLOSE

VETERAN STATUS (NOT APPLICABLE IF DEPENDENT IS UNDER THE AGE OF 17.)

VETERAN OR ACTIVE DUTY MEMBER OF THE U.S. MILITARY?
☐ YES ☐ NO
☐ CHOOSE NOT TO DISCLOSE
IF YES, YEARS OF SERVICE: _____

MILITARY BRANCH:
☐ AIR FORCE ☐ AIR NATIONAL GUARD ☐ AIR FORCE RESERVE ☐ NAVY
☐ ARMY ☐ ARMY NATIONAL GUARD ☐ ARMY RESERVE ☐ NAVY RESERVE
☐ COAST GUARD ☐ COAST GUARD RESERVE ☐ MARINE CORPS ☐ MULTIPLE BRANCHES

MAJOR CONFLICTS
☐ COLD WAR ☐ GULF WAR
☐ IRAQ WAR ☐ KOREAN WAR
☐ PEACE TIME ☐ VIETNAM WAR
☐ WWII ☐ WAR IN AFGHANISTAN

WE HONOR VETERANS CEREMONY
☐ YES ☐ NO

DISABLED VETERAN
☐ YES ☐ NO

VA RECOGNIZE DISABILITY
☐ YES ☐ NO

DEPENDENT 3

LEGAL NAME: (LAST, FIRST M.I.):

BIRTH DATE: (MM/DD/YYYY):

CHECK ONE:
☐ ADD ☐ REMOVE
☐ CHANGING PLAN

RELATIONSHIP TO SUBSCRIBER/POLICY HOLDER
☐ SPOUSE ☐ DOMESTIC PARTNER† ☐ CHILD
☐ LEGAL CUSTODIAN/LEGAL GUARDIAN ☐ OTHER†* _____

SOCIAL SECURITY NUMBER:

GEISINGER MEDICAL RECORD NUMBER:

MARITAL STATUS ☐ MARRIED - DATE OF MARRIAGE _____ ☐ DIVORCED - DATE OF DIVORCE _____ OTHER CHANGE OF STATUS/LEGAL QUALIFYING EVENT DATE: _____

RESIDENTIAL ADDRESS: (☐ CHECK HERE IF SAME AS PRIMARY APPLICANT)

Street/Apartment/Suite # City State Zip Country

ARE YOU PREGNANT? ☐ YES ☐ NO **A.** I YES, HOW MANY BABIES ARE EXPECTED DURING THIS PREGNANCY? _____

TOBACCO USE: HAVE YOU USED TOBACCO ON AVERAGE OF FOUR OR MORE TIMES PER WEEK WITHIN THE PAST SIX (6) MONTHS? ☐ YES ☐ NO
(applies to persons 21 years of age and older)

PRIMARY CARE PHYSICIAN (PCP) INFORMATION
ARE YOU AN ESTABLISHED WITH A PCP?
☐ YES ☐ NO
IF YES, PCP NAME: _____
PCP PHONE: (_____) - _____ - _____
PCP PRACTICE LOCATION (MAILING ADDRESS): _____

U.S. CITIZENSHIP
HAVE YOU LIVED IN THE U.S. SINCE 1996?
☐ YES ☐ NO
ARE YOU U.S. CITIZEN OR U.S. NATIONAL?
☐ YES ☐ NO
IF YOU ARE NOT A U.S. CITIZEN OR U.S. NATIONAL, DO YOU HAVE ELIGIBLE IMMIGRATION STATUS? ☐ YES ☐ NO
IF YES, FILL IN YOUR DOCUMENT TYPE AND ID # TO THE RIGHT.
DOCUMENT TYPE _____
DOCUMENT ID NUMBER _____

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☐ CHOOSE NOT TO DISCLOSE

PRONOUNS
☐ SHE/HER/HERS ☐ HE/HIM/HIS
☐ THEY/THEM/THEIRS ☐ MY NAME
☐ CHOOSE NOT TO DISCLOSE
☐ NOT LISTED: _____

PREFERRED LANGUAGE
☐ ENGLISH ☐ GUJARATI ☐ RUSSIAN ☐ SIGN LANGUAGE ☐ HINDI
☐ SPANISH ☐ GERMAN ☐ CHINESE ☐ OTHER: _____
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☐ YIDDISH, PENNSYLVANIA DUTCH OR OTHER WEST GERMANIC LANGUAGES

ETHNICITY
☐ HISPANIC OR LATINO
☐ NOT HISPANIC OR LATINO
☐ CHOOSE NOT TO DISCLOSE

SEXUAL ORIENTATION
☐ STRAIGHT (NOT LESBIAN OR GAY)
☐ LESBIAN OR GAY
☐ BISEXUAL
☐ SOMETHING ELSE _____
☐ CHOOSE NOT TO DISCLOSE

GENDER IDENTITY
☐ MALE ☐ FEMALE ☐ TRANSGENDER FEMALE (MALE-TO-FEMALE)
☐ TRANSGENDER MALE (FEMALE-TO-MALE)
☐ GENDERQUEER (NEITHER EXCLUSIVELY MALE NOR FEMALE)
☐ CHOOSE NOT TO DISCLOSE

RACE
☐ AMERICAN INDIAN OR ALASKA NATIVE
☐ BLACK OR AFRICAN AMERICAN
☐ ASIAN ☐ WHITE
☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER
☐ TWO OR MORE RACES
☐ CHOOSE NOT TO DISCLOSE

VETERAN STATUS (NOT APPLICABLE IF DEPENDENT IS UNDER THE AGE OF 17.)

VETERAN OR ACTIVE DUTY MEMBER OF THE U.S. MILITARY?
☐ YES ☐ NO
☐ CHOOSE NOT TO DISCLOSE
IF YES, YEARS OF SERVICE: _____

MILITARY BRANCH:
☐ AIR FORCE ☐ AIR NATIONAL GUARD ☐ AIR FORCE RESERVE ☐ NAVY
☐ ARMY ☐ ARMY NATIONAL GUARD ☐ ARMY RESERVE ☐ NAVY RESERVE
☐ COAST GUARD ☐ COAST GUARD RESERVE ☐ MARINE CORPS ☐ MULTIPLE BRANCHES

MAJOR CONFLICTS
☐ COLD WAR ☐ GULF WAR
☐ IRAQ WAR ☐ KOREAN WAR
☐ PEACE TIME ☐ VIETNAM WAR
☐ WWII ☐ WAR IN AFGHANISTAN

WE HONOR VETERANS CEREMONY
☐ YES ☐ NO

DISABLED VETERAN
☐ YES ☐ NO

VA RECOGNIZE DISABILITY
☐ YES ☐ NO

DEPENDENT 4

LEGAL NAME: (LAST, FIRST M.I.):

BIRTH DATE: (MM/DD/YYYY.):

CHECK ONE:
☐ ADD ☐ REMOVE
☐ CHANGING PLAN

RELATIONSHIP TO SUBSCRIBER/POLICY HOLDER
☐ SPOUSE ☐ DOMESTIC PARTNER† ☐ CHILD
☐ LEGAL CUSTODIAN/LEGAL GUARDIAN ☐ OTHER†* _____

SOCIAL SECURITY NUMBER:

GEISINGER MEDICAL RECORD NUMBER:

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RESIDENTIAL ADDRESS: (☐ CHECK HERE IF SAME AS PRIMARY APPLICANT)

Street/Apartment/Suite # City State Zip Country

ARE YOU PREGNANT? ☐ YES ☐ NO A. IF YES, HOW MANY BABIES ARE EXPECTED DURING THIS PREGNANCY? _____

TOBACCO USE: HAVE YOU USED TOBACCO ON AVERAGE OF FOUR OR MORE TIMES PER WEEK WITHIN THE PAST SIX (6) MONTHS? ☐ YES ☐ NO
(applies to persons 21 years of age and older)

PRIMARY CARE PHYSICIAN (PCP) INFORMATION

ARE YOU AN ESTABLISHED WITH A PCP?
☐ YES ☐ NO

IF YES, PCP NAME: _____

PCP PHONE: (_____) - _____ - _____

PCP PRACTICE LOCATION (MAILING ADDRESS): _____

U.S. CITIZENSHIP
HAVE YOU LIVED IN THE U.S. SINCE 1996?
☐ YES ☐ NO

ARE YOU U.S. CITIZEN OR U.S. NATIONAL?
☐ YES ☐ NO

IF YOU ARE NOT A U.S. CITIZEN OR U.S. NATIONAL, DO YOU HAVE ELIGIBLE IMMIGRATION STATUS? ☐ YES ☐ NO
IF YES, FILL IN YOUR DOCUMENT TYPE AND ID # TO THE RIGHT.

DOCUMENT TYPE _____

DOCUMENT ID NUMBER _____

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☐ SHE/HER/HERS ☐ HE/HIM/HIS
☐ THEY/THEM/THEIRS ☐ MY NAME
☐ CHOOSE NOT TO DISCLOSE
☐ NOT LISTED: _____

PREFERRED LANGUAGE
☐ ENGLISH ☐ GUJARATI ☐ RUSSIAN ☐ SIGN LANGUAGE ☐ HINDI
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☐ YIDDISH, PENNSYLVANIA DUTCH OR OTHER WEST GERMANIC LANGUAGES

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☐ HISPANIC OR LATINO
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☐ STRAIGHT (NOT LESBIAN OR GAY)
☐ LESBIAN OR GAY
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GENDER IDENTITY
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☐ TRANSGENDER MALE (FEMALE-TO-MALE)
☐ GENDERQUEER (NEITHER EXCLUSIVELY MALE NOR FEMALE)
☐ CHOOSE NOT TO DISCLOSE

RACE
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☐ BLACK OR AFRICAN AMERICAN
☐ ASIAN ☐ WHITE
☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER
☐ TWO OR MORE RACES
☐ CHOOSE NOT TO DISCLOSE

VETERAN STATUS (NOT APPLICABLE IF DEPENDENT IS UNDER THE AGE OF 17.)

VETERAN OR ACTIVE DUTY MEMBER OF THE U.S. MILITARY?
☐ YES ☐ NO
☐ CHOOSE NOT TO DISCLOSE
IF YES, YEARS OF SERVICE: _____

MILITARY BRANCH:
☐ AIR FORCE ☐ AIR NATIONAL GUARD ☐ AIR FORCE RESERVE ☐ NAVY
☐ ARMY ☐ ARMY NATIONAL GUARD ☐ ARMY RESERVE ☐ NAVY RESERVE
☐ COAST GUARD ☐ COAST GUARD RESERVE ☐ MARINE CORPS ☐ MULTIPLE BRANCHES

MAJOR CONFLICTS
☐ COLD WAR ☐ GULF WAR
☐ IRAQ WAR ☐ KOREAN WAR
☐ PEACE TIME ☐ VIETNAM WAR
☐ WWII ☐ WAR IN AFGHANISTAN

WE HONOR VETERANS CEREMONY
☐ YES ☐ NO

DISABLED VETERAN
☐ YES ☐ NO

VA RECOGNIZE DISABILITY
☐ YES ☐ NO

DEPENDENT 5

LEGAL NAME: (LAST, FIRST M.I.):

BIRTH DATE: (MM/DD/YYYY.):

CHECK ONE:
☐ ADD ☐ REMOVE
☐ CHANGING PLAN

RELATIONSHIP TO SUBSCRIBER/POLICY HOLDER
☐ SPOUSE ☐ DOMESTIC PARTNER† ☐ CHILD
☐ LEGAL CUSTODIAN/LEGAL GUARDIAN ☐ OTHER†* _____

SOCIAL SECURITY NUMBER:

GEISINGER MEDICAL RECORD NUMBER:

MARITAL STATUS ☐ MARRIED - DATE OF MARRIAGE _____ ☐ DIVORCED - DATE OF DIVORCE _____ OTHER CHANGE OF STATUS/LEGAL QUALIFYING EVENT DATE: _____

RESIDENTIAL ADDRESS: (☐ CHECK HERE IF SAME AS PRIMARY APPLICANT)

Street/Apartment/Suite # City State Zip Country

ARE YOU PREGNANT? ☐ YES ☐ NO A. IF YES, HOW MANY BABIES ARE EXPECTED DURING THIS PREGNANCY? _____

TOBACCO USE: HAVE YOU USED TOBACCO ON AVERAGE OF FOUR OR MORE TIMES PER WEEK WITHIN THE PAST SIX (6) MONTHS? ☐ YES ☐ NO
(applies to persons 21 years of age and older)

PRIMARY CARE PHYSICIAN (PCP) INFORMATION

ARE YOU AN ESTABLISHED WITH A PCP?
☐ YES ☐ NO

IF YES, PCP NAME: _____

PCP PHONE: (_____) - _____ - _____

PCP PRACTICE LOCATION (MAILING ADDRESS): _____

U.S. CITIZENSHIP
HAVE YOU LIVED IN THE U.S. SINCE 1996?
☐ YES ☐ NO

ARE YOU U.S. CITIZEN OR U.S. NATIONAL?
☐ YES ☐ NO

IF YOU ARE NOT A U.S. CITIZEN OR U.S. NATIONAL, DO YOU HAVE ELIGIBLE IMMIGRATION STATUS? ☐ YES ☐ NO
IF YES, FILL IN YOUR DOCUMENT TYPE AND ID # TO THE RIGHT.

DOCUMENT TYPE _____

DOCUMENT ID NUMBER _____

The information below may be used to identify possible application, enrollment and coverage barriers, and disparities for the communities we serve so we can work toward improving services for all members. It does not impact plan options, health insurance cost or eligibility. Consumer-reported race and ethnicity information is protected from disclosure or unauthorized access.

SEX ASSIGNED AT BIRTH
☐ MALE ☐ FEMALE
☐ NOT RECORDED ON BIRTH CERTIFICATE

SEX (LEGAL/ADMINISTRATIVE)
☐ MALE ☐ FEMALE
☐ X OR NON-BINARY
☐ CHOOSE NOT TO DISCLOSE

PRONOUNS
☐ SHE/HER/HERS ☐ HE/HIM/HIS
☐ THEY/THEM/THEIRS ☐ MY NAME
☐ CHOOSE NOT TO DISCLOSE
☐ NOT LISTED: _____

PREFERRED LANGUAGE
☐ ENGLISH ☐ GUJARATI ☐ RUSSIAN ☐ SIGN LANGUAGE ☐ HINDI
☐ SPANISH ☐ SIGN LANGUAGE ☐ CHINESE ☐ OTHER: _____
☐ NEPALI ☐ VIETNAMESE ☐ ARABIC ☐ GERMAN
☐ YIDDISH, PENNSYLVANIA DUTCH OR OTHER WEST GERMANIC LANGUAGES

ETHNICITY
☐ HISPANIC OR LATINO
☐ NOT HISPANIC OR LATINO
☐ CHOOSE NOT TO DISCLOSE

SEXUAL ORIENTATION
☐ STRAIGHT (NOT LESBIAN OR GAY)
☐ LESBIAN OR GAY
☐ BISEXUAL
☐ SOMETHING ELSE _____
☐ CHOOSE NOT TO DISCLOSE

GENDER IDENTITY
☐ MALE ☐ FEMALE ☐ TRANSGENDER FEMALE (MALE-TO-FEMALE)
☐ TRANSGENDER MALE (FEMALE-TO-MALE)
☐ GENDERQUEER (NEITHER EXCLUSIVELY MALE NOR FEMALE)
☐ CHOOSE NOT TO DISCLOSE

RACE
☐ AMERICAN INDIAN OR ALASKA NATIVE
☐ BLACK OR AFRICAN AMERICAN
☐ ASIAN ☐ WHITE
☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER
☐ TWO OR MORE RACES
☐ CHOOSE NOT TO DISCLOSE

VETERAN STATUS (NOT APPLICABLE IF DEPENDENT IS UNDER THE AGE OF 17.)

VETERAN OR ACTIVE DUTY MEMBER OF THE U.S. MILITARY?
☐ YES ☐ NO
☐ CHOOSE NOT TO DISCLOSE
IF YES, YEARS OF SERVICE: _____

MILITARY BRANCH:
☐ AIR FORCE ☐ AIR NATIONAL GUARD ☐ AIR FORCE RESERVE ☐ NAVY
☐ ARMY ☐ ARMY NATIONAL GUARD ☐ ARMY RESERVE ☐ NAVY RESERVE
☐ COAST GUARD ☐ COAST GUARD RESERVE ☐ MARINE CORPS ☐ MULTIPLE BRANCHES

MAJOR CONFLICTS
☐ COLD WAR ☐ GULF WAR
☐ IRAQ WAR ☐ KOREAN WAR
☐ PEACE TIME ☐ VIETNAM WAR
☐ WWII ☐ WAR IN AFGHANISTAN

WE HONOR VETERANS CEREMONY
☐ YES ☐ NO

DISABLED VETERAN
☐ YES ☐ NO

VA RECOGNIZE DISABILITY
☐ YES ☐ NO

Step 3 Insurance plan options

Please review the plan options listed below and check the box of the specific plan you've selected. The plan option selected will apply to the applicant and his/her approved eligible dependents.

Requested effective date (mm/yyyy): _____

INSURANCE PLAN OPTIONS

Geisinger Premier HMO.
The Premier HMO network is made up of the highest performing providers.
(Choose one)

- ☐ **Premier HMO 10/20/500**
- ☐ **Premier HMO 30/60/6000**

Geisinger Marketplace All-Access Value. To be eligible for the "Value" plan, applicants and dependents must be less than 30 years of age prior to their plan effective date or possess a certification that he/she is exempt from the requirements to maintain minimum essential coverage.

Geisinger Marketplace Premier HMO. The Premier HMO network is made up of the highest performing providers and generally has a lower cost than our other network options.

Geisinger Marketplace Extra HMO gives members access to the Health Plan's entire network of participating providers and also offers "ProvenHealth Navigator" medical practice sites where the member can receive primary care services for a lower primary care physician office visit copayment.

Geisinger Marketplace All-Access QHDHP PPO has lower premiums and higher deductibles than a traditional insurance plan. You will pay more of the cost for healthcare services up front until you meet your deductible, at which point your plan pays for most of the covered services. This plan may be paired with a health savings account (HSA), a type of savings account that lets you set aside money on a pre-tax basis to pay for qualified medical expenses; this will help you pay for those upfront costs until you meet the deductible. In order to contribute funds into a health savings account, you must be enrolled in a QHDHP plan.

For Agent/Broker use only:
Is this an ICHRA policy? ☐Yes ☐No If yes, should autopay be setup? ☐Yes ☐No

STEP 4 Your family's health coverage

Answer these questions for each person in your family applying for coverage under this policy.

1. **Is anyone enrolled in health coverage, including outpatient prescription drug coverage, now from the following?**

☐ **YES.** ☐ **NO.**

If yes, check the type of coverage and write the person(s)' name(s) next to the coverage they have.

☐ Medicaid _____

☐ CHIP _____

☐ Medicare Part A

☐ Medicare Part B

☐ Medicare Part D

☐ TRICARE (Don't check if you have direct care or Line of Duty)

_____

☐ VA health care programs _____

☐ Peace Corps _____

☐ Employer insurance

Name of health insurance:

_____

Policy number:

_____

Is this COBRA coverage? ☐ Yes ☐ No

Is this a retiree health plan? ☐ Yes ☐ No

☐ Other

Name of health insurance: _____

Policy number: _____

Is this a limited-benefit plan (like a school accident policy)?

☐ Yes ☐ No

2. **Is anyone listed on this application offered health coverage from a job?** Check YES even if the coverage is from someone else's job, such as a parent or spouse.

☐ **YES.** Is this a state employee benefit plan? ☐ Yes ☐ No

☐ **NO.**

Step 5 Read & sign this application

READ THESE NOTICES CAREFULLY BEFORE SIGNING THIS APPLICATION.

I understand, agree, and represent that:

This application is for individual coverage with Geisinger Health Plan or Geisinger Quality Options, Inc. (collectively referred to as the "Health Plan"). This is NOT an application for group coverage.

This application is subject to acceptance by the Health Plan and I agree to immediately notify the Health Plan of any change(s) to the information contained within this application following submission of the application. Furthermore, I understand that the application process may include follow-up telephone calls by the Health Plan and/or requests for additional documentation to the Applicant for the purpose of verifying information contained within this application, and that my obligation to provide truthful and accurate information to the Health Plan extends to any such follow-up communications.

If a policy is issued, benefits (including state and federal mandates) will be available subject to the exclusions, limitations, and other conditions of the policy and any subsequent amendments to those documents, if applicable.

Rates for the policy issued to Applicant will only be changed at time of renewal by the Health Plan, after approval from all applicable regulatory authorities and upon thirty (30) days prior notice to Applicant or as permitted by law; provided, however, in the event Applicant has made a material misstatement in the application that would have resulted in the issuance of a different premium, the Health Plan may retroactively revise the premium to reflect the appropriate premium for the actual level of risk subject to the three (3) year time limit on the defense noted below. The Health Plan will notify Applicant, in writing, if anyone listed on this application is rejected for coverage.

If this application is accepted by the Health Plan, payment of the first month's premium is required to effectuate enrollment. The first month's premium is due no earlier than the coverage effective date and no later than thirty-one (31) calendar days from the coverage effective date. The grace period for premium payment is thirty-one (31) days or three (3) months depending upon your receipt of an advance premium tax credit. If the premium is not paid, coverage terminates on the last day of the grace period or, if you are in receipt of an advance premium tax credit, to the last day of the first month of the 3-month grace period, as applicable.

In the event your enrollment is terminated and you owe premiums ("past-due premiums) to either Geisinger Health Plan or Geisinger Quality Options, Inc., in order to effectuate new coverage, the Health Plan may require you to pay any past-due premiums owed for a period not to exceed twelve (12) months prior to the requested effective date of new coverage and a new binder payment. Payment of past-due premiums may be required if you are applying for coverage either with Geisinger Health Plan and you owe past-due premiums to Geisinger Quality Options, Inc., or if you are applying for coverage with Geisinger Quality Options, Inc., and you owe past-due premiums to Geisinger Health Plan. For example, if you owe past-due premiums for prior coverage with Geisinger Health Plan, you may be required to pay those premiums, and the new binder payment, before you may enroll in new coverage with either Geisinger Health Plan or Geisinger Quality Options, Inc. If you owe past-due premiums for prior coverage with Geisinger Quality Options, Inc., you may be required to pay those premiums, and the new binder payment, before you may enroll in new coverage with either Geisinger Quality Options, Inc. or Geisinger Health Plan. **Please note**: If you pay only the binder payment for new coverage, the payment will be applied to past-due premiums owed to either health plan entity, and you will not be enrolled in the new coverage.

I have read this document, or it has been read to me. I understand that I should retain a duplicate copy of this application for my own records. A photographic copy of this acknowledgement shall be as valid as the original.

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.

The information recorded above is true and correct to the best of my knowledge and belief. I understand that if I make any material misstatement during the application process, the Health Plan may cancel the policy or deny claims, provided such material misstatement is discovered by GHP within three (3) years of the policy effective date. I also understand that if I make any fraudulent representation or

intentional misrepresentation of a material fact during the application process, the Health Plan may render the policy void from inception. In the event the Health Plan elects to void this policy, the Policyholder/Subscriber will forfeit any charges paid to the extent of any liability incurred by the Health Plan.

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.

By signing below, I acknowledge that I have read and understand this document and I am signing of my own free will.

Date	Signature of Applicant
Date	Health Plan Representative

STEP 6 Mail completed application.

Mail your signed application to:

Geisinger Health Plan
2266 Wilkes-Barre Township Marketplace
Wilkes-Barre Township, PA 18702

APPENDIX A

Assistance with completing this application

You can choose an authorized representative.

You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative." If you ever need to change your authorized representative for purposes of this application, contact customer service at 800-447-4000. If you're a legally appointed representative for someone on this application, submit proof with the application.

1. Name of authorized representative (Prefix, First Name, Middle Initial, Last Name, Suffix)

2. Address		3. Apartment or suite number
4. City	5. State	6. ZIP code

7. Phone Number

( ) –

8. Email address: _____

9. What is the best time to call?

☐ Morning ☐ Afternoon ☐ Evening ☐ Anytime between 8 A.M. and 8 P.M.

By signing, you allow this person to sign your application, get official information about this application, and act for you on all future matters with this agency related to this application only.

10. Your signature	11. Date (mm/dd/yyyy)

For certified application counselors, navigators, agents, and brokers only.

Complete this section if you're a certified application counselor, navigator, agent, or broker filling out this application for somebody else.

1. Application start date (mm/dd/yyyy)

2. First name, Middle name, Last name, & Suffix

3. Organization name	4. ID number (if applicable)

HEALTH PLAN PREMIUM AUTHORIZATION FORM

Applicant: _____
Last Name First Name Middle Initial

Address: _____
Street City State Zip

Phone Number (Daytime): (____) _____

Official Use Only AR 32-51

Policyholder's ID Number _____

PART 1. INITIAL PREMIUM PAYMENT OPTIONS (Initial Payment will be processed immediately upon Application approval.)

Please choose one of the following:

☐ EFT (Electronic funds transfer) - Complete part 2 below
☐ Credit card - Complete part 3 below

PART 2. EFT (ELECTRONIC FUNDS TRANSFER) INFORMATION

Complete this section if applicable.

Name on account*: _____

Address on account: _____
Street City State Zip

Bank Name: _____

☐ Checking account ☐ Savings account

Bank routing number (ABA) (9-digit #): __ __ __ __ __ __ __ __ __

Bank account number (DDA): _____

(Bank routing and account numbers are located on the bottom of your check)

Additional Terms of Agreement: My account(s) at the institution named has sufficient funds to pay all premiums due. The Health Plan shall initiate electronic debit to pay premiums for authorized policies, and the entries are my transaction receipt. There is no payment to the Health Plan until full and final credit for the payment is received. I understand that corrections to the entries may involve an account adjustment, and that my direct electronic payment of the premium will be debited immediately following the receipt of the Application. I understand that with my Application signature and signature below, if applicable, I am accepting the terms of this agreement.
NOTE: The Health Plan reserves the right to refuse/terminate electronic payment services at any time. This agreement remains in full force and effect until the Health Plan or the policyholder terminates it. **Joint accounts require the signature of ALL account authorized persons even if not enrolling**.*

PART 3. CREDIT CARD INFORMATION

Complete this section if applicable.

Credit Card Type: ☐ VISA ☐ MasterCard ☐ Discover

Cardholder's name (exactly as it appears on the card): _____

Cardholder's address (as it appears on the statement): _____
Street City State Zip

Account number: Card Expiration Date

__ __ __ __ - __ __ __ __ - __ __ __ __ - __ __ __ __ ____ / ____

PART 4.

This section must be completed by the appropriate person(s).

Applicant's signature: _____ Date: _____

Payer's signature (if different from Applicant): _____ Date: _____

By signing this agreement, I accept the terms of this payment authorization form.

*Authorized signature of joint account holder: _____ Date: _____

By signing this agreement, I accept the terms of this payment authorization form.

Important policyholder information and terms

☐ **Your initial premium payment must be submitted with your Application.** Your 1st month's premium payment will be processed immediately. Once enrolled, policyholders will be invoiced monthly and may make payments by visiting www.thehealthplan.com

☐ Do not cancel other coverage presently in force until written notification is received from The Health Plan indicating that your enrollment has been approved and you and your covered dependents have received your member ID card(s) providing the effective date of coverage.

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