GEISINGER HEALTH PLAN
100 North Academy Avenue
Danville, PA 17822

# EMPLOYEE SUBSCRIBER APPLICATION AND MEDICAL DISCLOSURE QUESTIONNAIRE

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

| FOR OFFICE USE ONLY | | | | |
|---|---|---|---|---|
| Group Number | Division Number | Cobra/Mini-Cobra/PHCS | Insurance ID Number | Effective Date |
| | | | | |

**Instructions: In order to avoid delays in the review process, please be sure that each section is fully completed. PRINT CLEARLY.**

## SECTION A. APPLICANT INFORMATION

| | | | | | | |
|---|---|---|---|---|---|---|
| LEGAL NAME OF PRIMARY APPLICANT FOR COVERAGE (LAST) | | | | (FIRST) | | (M.I.) |
| MAILING ADDRESS (Number) (Street) (Apt. Number) | | | CITY | STATE | ZIP CODE | COUNTY |
| PHYSICAL ADDRESS (if different than mailing address) | | | CITY | STATE | ZIP CODE | COUNTY |
| SOCIAL SECURITY NUMBER | DATE OF BIRTH | GENDER ☐ Male ☐ Female | HEIGHT Feet Inches | WEIGHT (lbs) | MARITAL STATUS ☐ MARRIED ☐ DIVORCED/SEPARATED ☐ SINGLE ☐ WIDOWED | |
| EMPLOYER (Name, City and Phone Number) | | HOME PHONE NUMBER | CELL PHONE NUMBER | | EMPLOYMENT STATUS ☐ ACTIVE ☐ COBRA ☐ MINI COBRA COBRA START DATE _____ COBRA END DATE _____ | |
| DATE OF EMPLOYMENT | WHEN COVERAGE BEGINS UNDER THIS POLICY, WILL YOU HAVE OTHER INSURANCE? If "YES", complete section E ☐ YES ☐ NO | | GEISINGER MEDICAL RECORD NUMBER | | | |

EMAIL ADDRESS:
(The email address you provide on this application helps Geisinger Health Plan and/or Geisinger Quality Options, Inc. (collectively the "Health Plan" to conduct business and provide good service. It is used to communicate with you to facilitate activities such as enrollment, customer identification, billing and member satisfaction surveys. The email address you provide 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 these communications whenever the Health Plan sends them).

PREFERRED CONTACT METHOD:
☐ EMAIL ☐ PHONE ☐ MAIL

## SECTION B. COVERED SPOUSE / DEPENDENT INFORMATION

Note: If there are more than 4 dependents to be covered, please complete a second application on behalf of those individuals and submit both applications together.

| LEGAL NAME | SOCIAL SECURITY NUMBER | RELATIONSHIP | DATE OF BIRTH | GENDER | HEIGHT (FEET / INCHES) | WEIGHT | When coverage begins under this policy, will you have other insurance? | GEISINGER MEDICAL RECORD NUMBER |
|---|---|---|---|---|---|---|---|---|
| SPOUSE (First) (M.I.) (Last) | | ☐ SPOUSE ☐ DOMESTIC PARTNER* | | ☐ FEMALE ☐ MALE | | (lbs) | ☐ YES ☐ NO If "YES", complete section E | |
| DEPENDENT #1 (First) (M.I.) (Last) | | ☐ SON ☐ DAUGHTER ☐ LegalCustodian/ Guardian* | | ☐ FEMALE ☐ MALE | | (lbs) | ☐ YES ☐ NO If "YES", complete section E | |
| DEPENDENT #2 (First) (M.I.) (Last) | | ☐ SON ☐ DAUGHTER ☐ LegalCustodian/ Guardian* | | ☐ FEMALE ☐ MALE | | (lbs) | ☐ YES ☐ NO If "YES", complete section E | |
| DEPENDENT #3 (First) (M.I.) (Last) | | ☐ SON ☐ DAUGHTER ☐ LegalCustodian/ Guardian* | | ☐ FEMALE ☐ MALE | | (lbs) | ☐ YES ☐ NO If "YES", complete section E | |
| DEPENDENT #4 (First) (M.I.) (Last) | | ☐ SON ☐ DAUGHTER ☐ LegalCustodian/ Guardian* | | ☐ FEMALE ☐ MALE | | (lbs) | ☐ YES ☐ NO If "YES", complete section E | |

*Note: A complete and notarized Declaration of Fact form must be attached to this application if relationship is "Domestic Partner"; and Legal documentation (court decree, guardianship papers, affidavit, etc.) must be attached to this application if relationship is "Legal Custodian/Guardian".

## SECTION C. MEDICAL INFORMATION

Instructions:
(a) Identify dependents in the same order as noted in Section B.
(b) Indicate "YES" or "NO" if any person listed on this application has ever received diagnosis or treatment by a licensed healthcare professional for any of the conditions listed below and **CIRCLE** the specified condition(s) that apply. **ALL QUESTIONS MUST BE CHECKED WITH A "YES" OR "NO" RESPONSE**.
(c) For each "YES", complete Section D on page 3.

Note: Please **DO NOT INCLUDE** any genetic information such as family medical history or any information related to genetic testing, genetic services, genetic services, genetic counseling, or genetic diseases for which you believe that you, your spouse, and/or dependents may be at risk.

| **Conditions**: (circle the specified condition(s) that apply) | Applicant | | Spouse | | Dependent #1 | | Dependent #2 | | Dependent #3 | | Dependent #4 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Name: | _____ | | _____ | | _____ | | _____ | | _____ | | _____ | |
| | YES | NO | YES | NO | YES | NO | YES | NO | YES | NO | YES | NO |
| 1. Aids, HIV, reactive, or any immune suppressed illness | | | | | | | | | | | | |
| 2. Alcoholism or drug abuse | | | | | | | | | | | | |
| 3. Emphysema, COPD, cystic fibrosis, asthma or allergies | | | | | | | | | | | | |
| 4. Aneurysm (aortic or cerebral), blood clot, TIA (mini-stroke) or stroke | | | | | | | | | | | | |
| 5. Arthritis (osteo, rheumatoid, other) joint replacement, joint pain, lupus, fibromyalgia, fractures or limb loss | | | | | | | | | | | | |
| 6. Neck or back pain, disorders of the spine, disc herniation or bulging disc | | | | | | | | | | | | |
| 7. Any blood disorder such as anemia or hemophilia | | | | | | | | | | | | |
| 8. Ulcerative colitis, Crohn's Disease, diverticulitis, stomach ulcers, acid reflux, GERD, hernia, gallbladder or rectal disorders | | | | | | | | | | | | |
| 9. Cancer, leukemia, tumor or cyst (list type, stage and location - give full details on next page) | | | | | | | | | | | | |
| 10. Convulsions, epilepsy or paralysis | | | | | | | | | | | | |
| 11. Diabetes - type I or II | | | | | | | | | | | | |
| 12. Hypothyroid, hyperthyroid, goiter, pituitary disorders, pancreas disorders, glandular disorders or disorders requiring growth hormones | | | | | | | | | | | | |
| 13. Eye conditions such as, cataracts, macular degeneration (excluding glasses & contacts) | | | | | | | | | | | | |
| 14. Migraines | | | | | | | | | | | | |
| 15. Heart surgery (angioplasty, stent or bypass), heart disease, implanted pace maker or defibrillator, irregular heartbeat, heart murmur, heart regurgitation, chest pain, congestive heart failure or mitral valve prolapse | | | | | | | | | | | | |
| 16. High blood pressure, and/or high cholesterol | | | | | | | | | | | | |
| 17. Kidney (failure or dialysis), kidney stones | | | | | | | | | | | | |
| 18. Hepatitis type (A, B, C, D) or autoimmune hepatitis or other liver disorder/disease | | | | | | | | | | | | |
| 19. Menstrual problems, endometriosis, polycystic ovaries | | | | | | | | | | | | |
| 20. Depression, anxiety, ADD, ADHD, psychotic disorder | | | | | | | | | | | | |
| 21. Is any female to be covered currently pregnant? Due date_____ (MM/DD/YY) If pregnant, please give details on the next page to include any complications | | | | | | | | | | | | |
| 22. Bladder, prostate, testicular, uterine or breast condition | | | | | | | | | | | | |
| 23. Skin disease (psoriasis, acne, other) | | | | | | | | | | | | |
| 24. Cigarette or tobacco use | | | | | | | | | | | | |
| 25. Any stem cell or organ transplant (planned, recommended, or already performed) | | | | | | | | | | | | |
| 26. Any hospitalizations in the last 5 years (give full details on next page) | | | | | | | | | | | | |
| 27. Any future surgeries discussed, planned or recommended (give full details on next page) | | | | | | | | | | | | |
| 28. Currently taking any prescription medicines? (give full details on next page to include name of the medication and condition for which medication is needed) | | | | | | | | | | | | |
| 29. Are there any other medical conditions not listed above? (give full details on next page) | | | | | | | | | | | | |

## SECTION D. MEDICAL DETAIL

| Person's Name | Question Number | Specific Medical Conditions/Diagnosis | Date of Diagnosis | Surgery Yes or No | Was treatment resolved or is ongoing treatment required? Please explain treatment and prognosis | Medication / Prescription Name* | Medication Dosage Amt/Freq, Oral Injections, Infusion, Inhaled | Are you currently taking this medication? Yes or No |
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*For questions regarding the coverage of specific prescription medication, please visit www.thehealthplan.com or call your authorized Health Plan Broker or sales rep.

## SECTION E. OTHER INSURANCE - When coverage begins under this policy, you have indicated that you and/or your dependent(s) will have other insurance. Please complete this section.

MEDICARE - Medicare Number _____ Part A Effective Date _____ Part B Effective Date _____

OTHER - Name of Insurance Carrier _____ Name of Policyholder _____ Insurance ID # _____

## SECTION F. ADDITIONAL INFORMATION

Use this section to provide additional information for persons listed on this application.

## SECTION G. 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.

## SECTION H. DECLARATIONS

I hereby apply 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 Health Plan or Geisinger Quality Options (collectively referred to as the "Health Plan"), as applicable, 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, and any susequent amendments to those documents (referred to hereafter as Certificate and/or Rider(s)). In the event it is determined that one (1) or more of my dependent(s) is/are ineligible for enrollment pursuant to the applicable Certificate, I authorize the Health Plan to process this application, omitting the names of such ineligible dependent(s). I further understand that rates for the Certificate and/or Rider(s), if applicable, issued to me are subject to change by the Health Plan in accordance with the terms and agreement with my employer, and upon thirty (30) days prior notice to my employer acting on my behalf, or as permitted by law. 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 Certificate and/or Rider(s).

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 the misrepresentation of any material fact by me on this application could constitute grounds for the cancellation of any Certificate and/or Rider(s), if applicable, issued by the Health Plan in consideration of this application. I also understand that this application for coverage may not be processed if I fail to complete any portion.

_____ _____

DATE SIGNED SIGNATURE OF APPLICANT

This Questionnaire must be completed and signed within 90 days of the group's effective date.

# 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).

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