

SUBSCRIBER APPLICATION CHANGE FORM

Effective Date
of Change ___/___/___

GEISINGER INDEMNITY INSURANCE COMPANY

M.C. 30-26
100 N. Academy Avenue
Danville, PA 17822

SECTION I. SUBSCRIBER

| | | |
|------------------------|-----------------|-----------------------|
| GROUP NUMBER | DIVISION NUMBER | INSURANCE I.D. NUMBER |
| LEGAL NAME (LAST) | (FIRST) | (M.I.) |
| ADDRESS (NUMBER) | (STREET) | (APT. NO.) |
| CITY | STATE | ZIP CODE |
| COUNTY | | |
| SOCIAL SECURITY NUMBER | | |

SECTION II. CHANGES

- Check which change(s) apply:
1. Add/Remove Dependent(s)
 2. Address Change
 3. Name Change
_____ (Previous last name)
 4. New Home Telephone Number
(_____) _____
 5. Changing Primary Care Physician
Reason for PCP Change: (check one)
 - a. Access dissatisfaction
 - b. Convenience
 - c. Error in PCP selection
 - d. Failure to establish relationship
 - e. Medical care dissatisfaction
 - f. PCP leaves the Health Plan
 - g. PCP moves
 - h. Provider service dissatisfaction

SECTION III. DISENROLLMENT

- Check which reason may apply
- SUBSCRIBER** OR **DEPENDENT**
1. Deceased
(Date of Death) ___/___/___
 2. Dissatisfaction with Plan
 3. Lay off
 4. Leave of absence
 5. Loss of dependent status
 6. Non payment of premium
 7. Moved out of service area
 8. Personal preference
 9. Reduction in work hours
 10. Retired (RT)
 11. Selected other insurance
 Open enrollment ___/___/___
 12. Termination of employment
 13. Other: _____

SECTION IV.

COBRA / Mini-COBRA. If changes noted in Section III are due to a Qualifying Event under COBRA or Mini-COBRA, as applicable, has the Subscriber or the Subscriber's eligible Dependent(s) elected continuation coverage under COBRA or Mini-COBRA? (Check One) 1. YES 2. NO 3. Determination is pending

SECTION V.

| SUBSCRIBER AND DEPENDENT CHANGES (PLEASE PRINT OR TYPE) | | | | | | | | | | CHECK REASON (NOTE DATE) | | | | | |
|---|---------|------------|-------|-------------|------|-----------|-----|-----|----------------------------|--------------------------|-----------------|------------------------|------------------------|-----------------------|--|
| CHECK ONE | | LEGAL NAME | | | | BIRTHDATE | | | RELATIONSHIP TO SUBSCRIBER | DATE OF MARRIAGE | DATE OF DIVORCE | OTHER CHANGE OF STATUS | SOCIAL SECURITY NUMBER | MEDICAL RECORD NUMBER | PRIMARY CARE PHYSICIAN NAME/ LOCATION (TOWN) |
| ADD | RE-MOVE | LAST | FIRST | MAIDEN NAME | M.I. | MO. | DAY | YR. | | | | | | | |
| | | | | | | | | | | | | | | | |
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I HEREBY apply for amendment of my subscriber application.

IT is mutually agreed as follows: That these changes shall not become effective unless and until accepted by my employer. That this application for change in coverage will become a part of my original application and if accepted will be subject to the terms of my Employer's Health Benefit Plan.

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.

SUBSCRIBER SIGNATURE

DATE SIGNED

GROUP BENEFITS ADMINISTRATOR / GROUP NAME

DATE SIGNED