GEISINGER HEALTH PLAN
100 North Academy Avenue
Danville, PA 17822

Group Marketplace Subscriber Application

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

General Administrative Information (for completion by Employer)

Group Number:	Insurance ID Number:
Segment/Division:	Effective Date of Change: (MM/DD/YYYY)
Group Employee ID#:	Annual Salary

This Application is being submitted as a result of: **(Check One)**

- ☐ Group Initial Enrollment
- ☐ Group Open Enrollment Period
- ☐ Employee New Hire
- ☐ Change due to Qualifying Event (If you checked this box, please specify type of event)

  Specify type of event: _____

  Is the Subscriber or Subscriber's eligible Dependent(s) electing continuation coverage under COBRA and/or Mini-COBRA?

  (Check One) ☐ Yes ☐ No ☐ Not Applicable

☐ I declare that I have coverage under another group health plan or have other health insurance coverage and, therefore, decline enrollment for myself and any family dependents

Marketplace Plan Selection:	PCP Copay	Specialist Copay	Deductible
All-Access HMO ☐			
All-Access QHDHP ☐ POS			
All-Access PPO ☐			
All-Access PPO QHDHP ☐			
Choices PPO ☐			
PPO Extra ☐			
Premier HMO ☐			

Applicant (Employee) Information (Please Print Clearly)

Primary Care Physician (PCP) Name:	PCP Location (Town):	PCP Number:

Are you an existing patient of selected primary care physician? ☐ Yes ☐ No

Legal Name: (Last)	First Name:	M. Init:	Gender: (M or F)

Home Address:	City:	State:	Zip Code:	County:
Mailing Address: (if different than Home Address)	City:	State:	Zip Code:	County:

Home Phone Number: (###) ###-####	Cell Phone Number: (###) ###-####	Work Phone Number: (###) ###-####

Email Address:

(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)

Social Security Number: _____ - _____ - _____	Date of Birth: MM/DD/YYYY	Employment Status: ☐ Active ☐ Terminated
Job Description :	Date of Hire: MM/DD/YYYY	Tobacco Use in Past 6 Months*: ☐ Yes ☐ No

Employer Name, City, and Phone Number:

Working Hours: (per week)	Employment Type: (FT/PT/Other)	Geisinger Medical Record Number: (if any)

Dependent Information

Legal Name (List last name if different than applicant)			Social Security Number	Relationship	Date of Birth	Tobacco Use in Past 6 Months?*	Primary Care Physician (PCP) Name	PCP Number
First	MI	Last		☐ Husband ☐ Wife		☐ Yes ☐ No		
First	MI	Last		☐ Son ☐ Daughter ☐ Other**		☐ Yes ☐ No		
First	MI	Last		☐ Son ☐ Daughter ☐ Other**		☐ Yes ☐ No		
First	MI	Last		☐ Son ☐ Daughter ☐ Other**		☐ Yes ☐ No		
First	MI	Last		☐ Son ☐ Daughter ☐ Other**		☐ Yes ☐ No		

*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)

**In the space below, please list any disabled child over the age of 26 and/or describe instances where you selected 'Other' as your dependent relationship. NOTE: Documentation obligating the applicant or the applicant's spouse, if applicable, to provide health care coverage to Dependent(s) will be required. All Dependent(s) must meet eligibility criteria.

Dependent(s) Name	Gender	Disabled	Description of Legal Relationship
	☐ Female ☐ Male	☐ Yes ☐ No	
	☐ Female ☐ Male	☐ Yes ☐ No	
	☐ Female ☐ Male	☐ Yes ☐ No	
	☐ Female ☐ Male	☐ Yes ☐ No	

PLEASE NOTE: If any of your Dependent(s), for which you are applying, do not live at the address listed in the Applicant (Employee) Information section, please indicate name(s), current address(es) and reason(s) why your Dependent(s) do not live at such address, in the space provided below. If your Dependent(s) live with a custodial parent, please provide name of custodial parent.

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.

Declarations

I hereby apply to the Health Plan 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 the Health Plan 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. In the event it is determined that one (1) or more of my dependent(s) is/are ineligible for enrollment in the Health Plan pursuant to the Subscription 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 Subscription Certificate and/or Rider(s), if applicable, issued to me are subject to change by the Health Plan, in accordance with terms of the agreement with my employer, and upon thirty (30) days prior notice to my employer acting on my behalf. 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 Subscription Certificate and/or Rider(s). 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 Subscription Certificate and/or Rider(s), if applicable, issued by the Health Plan in consideration of this application. 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.

Signature of Applicant	Date Signed	Signature of Employer	Date Signed

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
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