ENROLLMENT APPLICATION CHANGE FORM

Effective Date of Change ___/___/___

GEISINGER HEALTH PLAN
100 North Academy Avenue
Danville, PA 17822

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

☐ **Check if you are a member of Geisinger Gold**

SECTION I. SUBSCRIBER/POLICYHOLDER

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

1. ❑ Add/Remove Dependent(s)
2. ❑ Address Change
3. ❑ Name Change
   _____
   (Previous last name)
4. ❑ New Home Telephone Number
   (_____)_____
5. ❑ Changing Plan
   _____
   (Name of new plan)
6. ❑ 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

❑ **SUBSCRIBER/POLICYHOLDER** OR ❑ **DEPENDENT**

1. ❑ Deceased
   (Date of Death)___/___/___
2. ❑ Dissatisfaction with Plan
3. ❑ Lay off
4. ❑ Leave of absence
5. ❑ Loss of dependent status
6. ❑ Moved out of service area
7. ❑ Non payment of premium
8. ❑ Personal preference
9. ❑ Reduction in work hours
10. ❑ Retired
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/Policyholder or the Subscriber's/Policyholder's, eligible Dependent(s) elected continuation coverage under COBRA or Mini-COBRA? (Check One) 1. ☐ YES 2. ☐ NO 3. ☐ Determination is pending 4. ☐ Not Applicable. (COBRA/Mini-COBRA does not apply.)

SECTION V. SUBSCRIBER/POLICYHOLDER AND DEPENDENT CHANGES (PLEASE PRINT OR TYPE)

CHECK ONE			LEGAL NAME			BIRTHDATE			RELATIONSHIP TO SUBSCRIBER/POLICYHOLDER (Spouse, Domestic Partner†, Son, Daughter, Other†*)	CHECK REASON (NOTE DATE)			SOCIAL SECURITY NUMBER	Has Dependent used tobacco on average of four (4) or more times per week within past six (6) months?	GEISINGER MEDICAL RECORD NUMBER	PRIMARY CARE PHYSICIAN NAME/LOCATION (TOWN)
ADD	REMOVE	CHANGING PLAN	LAST	FIRST	M.I.	MO.	DAY	YR.		DATE OF MARRIAGE	DATE OF DIVORCE	OTHER CHANGE OF STATUS/LEGAL QUALIFYING EVENT				
														☐ Yes ☐ No		
														☐ Yes ☐ No		
														☐ Yes ☐ No		
														☐ Yes ☐ No		

†Documentation obligating the Subscriber/Policyholder or the Subcriber's/Policyholder's spouse, if applicable, to provide healthcare coverage to Dependent(s) will be required. All Dependents must meet eligibility criteria.

*Description of Legal Relationship:_____

I HEREBY apply for amendment of my Subscriber/Policyholder Application. I authorize Geisinger Health Plan or Geisinger Quality Options, Inc. (herinafter "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 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 Health Plan has verified my identity for this purpose in accordance with any applicable law or regulation. It is mutually agreed that (a) these changes shall not become effective unless and until accepted by Health Plan, and (b) this application for change in coverage will become a part of my original application and if accepted will be subject to the terms of the policy in effect with Health Plan. I understand that if I make any material misstatement in connection with the policy, Health Plan may cancel the policy or deny claims, provided such material misstatement is discovered by Health Plan within three (3) years of the policy Effective Date. In the event the insurer elects to void the policy, the Subscriber/Policyholder will forfeit any charges paid to the extent of any liability incurred by the insurer. 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/POLICYHOLDER SIGNATURE | DATE SIGNED | GROUP BENEFITS ADMINISTRATOR SIGNATURE (if applicable) | 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).

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