Geisinger Gold Rx Federal Employees Plan (HMO)

Geisinger HEALTH PLAN

Enrollment Request

■ Who can use this form?

People with Medicare who want to join a Medicare Advantage Plan and are approved to enroll in Geisinger Gold Rx Federal Employees Plan (HMO)

Important: Before completing the Geisinger Gold Rx Federal Employees Plan (HMO) Enrollment Application, be sure you meet all OPM eligibility criteria and complete all required OPM-specific enrollment instructions.

■ To join Geisinger Gold Rx Federal Employees Plan (HMO), you must:

- Be a United States citizen or be lawfully present in the U.S.
- Live in the plan's service area
- Have both:
  - Medicare Part A (Hospital Insurance)
  - Medicare Part B (Medical Insurance)

■ When do I use this form?

You can join a plan:

- During your plan's Open Enrollment Period (OEP). For 2027 coverage, the OEP is Nov. 9 through Dec. 14, 2026 (coverage effective Jan. 1 – Dec. 31, 2027).
- Within 3 months of first getting Medicare.
- You may be able to enroll outside the OEP if you meet certain eligibility requirements. Refer to OPM for more information.

Visit **opm.gov/healthcare-insurance** to learn more about when you can sign up for a plan.

Reminder:

If you want to join a plan during Open Enrollment (Nov. 9 – Dec. 14), the plan must receive your completed form by Dec. 14.

■ What do I need to complete this form?

- Your Medicare number (the number on your red, white, and blue Medicare card)
- Your permanent address and phone number

Note: You must complete all items in Section 1. The items in Section 2 are optional — you can't be denied coverage because you don't fill them out.

■ What happens next?

Send your completed and signed form to:

Geisinger Gold
ATTN: Enrollment 32-20
100 N. Academy Ave.
Danville, PA 17822-3227
Fax: 570-271-5970

Once they process your request to join, they'll contact you.

■ How do I get help with this form?

Call Geisinger Gold Rx Federal Employees Plan (HMO) at 800-554-4907 (TTY: 711). Representatives are available Monday through Friday, 8 a.m. to 5 p.m., excluding holidays.

En español: Llame a Geisinger Gold al 800-483-2598 / 711 o a Medicare gratis al 800-633-4227 y oprima el 2 para asistencia en español y un representante estará disponible para asistirle.

■ Individuals experiencing homelessness

If you want to join a plan but have no permanent residence, a Post Office Box, an address of a shelter or clinic, or the address where you receive mail (e.g., Social Security checks) may be considered your permanent residence address.

Geisinger Health Plan, Geisinger Indemnity Insurance Company, and Geisinger Quality Options, Inc. are part of Geisinger, an integrated health care delivery and coverage organization. Risant Health is the parent organization of Geisinger.

This is a summary of the features of the Geisinger Health Plan health plan, including Geisinger Health Plan Geisinger Gold Federal Advantage. Before making a final decision, please read the Plan's Federal brochure (RI 73-XXX). All benefits are subject to the definitions, limitations, and exclusions set forth in the Federal brochure and the Geisinger Health Plan Geisinger Gold Federal Advantage, Evidence of Coverage.

Section 1 – You must complete all

Select the plan you want to join:

Geisinger Gold Rx Federal Employees Plan (HMO)

First name:	**Last name:**	**Middle initial (optional):**
Birth date (MM/DD/YYYY): (/ /)	Sex: ☐ Male ☐ Female	Phone number: _____ - _____ - _____

Email address:

Permanent residence street address (Don't enter a P.O. Box. Note: For individuals experiencing homelessness, a P.O. Box may be considered your permanent residence address):

City: County: State: Zip code:

Mailing address street address, if different from your permanent address (P.O. Box allowed):

City: County: State: Zip code:

Your Medicare information:

Medicare number: _____ - _____ - _____

Answer these important questions:

Some individuals may have other medical or drug coverage, including other private insurance, TRICARE, federal employee health benefits coverage, VA benefits or state pharmaceutical assistance programs.

Will you have other medical coverage in addition to Geisinger Gold? ☐ Yes ☐ No

If "yes," please list your other coverage and your identification (ID) number(s) for this coverage:

Name of other coverage:	**ID # for this coverage:**	**Group # for this coverage:**

Will you have other prescription drug coverage in addition to Geisinger Gold? ☐ Yes ☐ No

If "yes," please list your other coverage and your identification (ID) number(s) for this coverage:

Name of other coverage:	**ID # for this coverage:**	**Group # for this coverage:**

HMO plans: List your primary care physician (PCP), clinic or health center:

PCP name:	**PCP office location:**

Connecting your care for a smoother start

Want the transition to your Geisinger Health Plan coverage to be as easy and stress-free as possible? With your permission, we can securely connect with your previous health plan to gather your health information. This helps your new doctors, pharmacists and care team understand your health history right away — so you don't have to start from scratch.

Why this matters for you

When your new providers can see your medications, conditions and past care, it:

- Reduces the need to repeat tests or paperwork
- Supports safer, more coordinated care from day one
- Saves you time and helps avoid delays in treatment

This information sharing is called interoperability. Sharing your healthcare information safely between trusted healthcare organizations better supports your care.

Your permission

Do you give Geisinger Health Plan permission to obtain your health records from your current or previous health plan? ☐ Yes ☐ No

If "yes," list your current or previous health plan provider:

Your information

First name:	**Last name:**
Address:	
City: **State:** **Zip code:**	
Date of birth:	**Member ID:**

We can securely connect with your previous health plan(s) to gather up to five years of your health information. The information retrieved will depend on data availability from your previous health plan. If there are additional health plans that you would like to retrieve your health records from, you may do so on our member portal or by calling our Customer Care team at 800-498-9731. TTY users, call 711. Our hours of operation are 8 a.m. to 8 p.m., daily, Oct. 1 through March 31. All other times of year, we're open 8 a.m. to 8 p.m., Monday through Friday, and Saturdays, 8 a.m. to 2 p.m.

Important: Read and sign below

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Geisinger Gold.
- By joining this Medicare Advantage Plan, I acknowledge that Geisinger Gold will share my information with Medicare, who may use it to track my enrollment, to make payments and for other purposes allowed by federal law that authorize the collection of this information (see Privacy Act Statement below).
- Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- I understand that I can be enrolled in only one MA plan at a time — and that enrollment in this plan will automatically end my enrollment in another MA plan (exceptions apply for MA PFFS, MA MSA plans).
- I understand that when my Geisinger Gold coverage begins, I must get all of my medical and prescription drug benefits from Geisinger Gold. Benefits and services provided by Geisinger Gold and contained in my Geisinger Gold "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Geisinger Gold will pay for benefits or services that are not covered.
- The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.
- I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (as described above), this signature certifies that:
  1. This person is authorized under state law to complete this enrollment, and
  2. Documentation of this authority is available upon request by Medicare.

Signature	**Today's date:**

If you're the authorized representative, sign above and fill out these fields:

Name:	**Address:**

Phone number:	**Relationship to enrollee:**
_____ - _____ - _____	

Paying your plan premiums

Your employer can tell you whether you owe a premium, how much to pay, and your options for payment based on your employer's policies. Geisinger Health Plan will not mail billing statements to you.

PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) Plans, improve care, and for the payment of Medicare benefits. Sections 1851 of the Social Security Act and 42 CFR §§ 422.50 and 422.60 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

Section 2 – All fields on this page are optional.

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Let us know if you want us to send you information in a language other than English.

Language:

☐ English
☐ Spanish
☐ Nepali
☐ Chinese
☐ Other: _____
☐ Arabic
☐ Russian
☐ Hindi
☐ Gujarati

Select one if you want us to send you information in an accessible format:

☐ Braille ☐ Large print ☐ Audio CD ☐ Data CD

Call Geisinger Gold Rx Federal Employees Plan (HMO) at 800-498-9731 (TTY users should call 711) if you need information in an accessible format other than what's listed above. Our office hours are Monday through Friday, 8 a.m. – 5 p.m., excluding holidays.

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.

Do you require interpreter services for a spoken language or sign language? ☐ Yes ☐ No

Office Use Only
Application: ☐ Left with applicant ☐ Mail ☐ Office ☐ Meeting
Effective Date of Coverage: _____ ICEP/IEP: _____ AEP: _____ SEP (type): _____
Agent/Producer Signature
Agent/Producer Printed Name
Agent/Producer ID Number
Agency Name
National Producer Number