GEISINGER GOLD®
MEDICARE SUPPLEMENT

Insured by Geisinger Indemnity Insurance Company
Danville, PA 17822

# Medicare Supplement Insurance Policy Application Form

## Instructions

1. Fill in all requested information on this form and sign in the 3 places indicated on pages 7 and 8.
2. Please refer to the "Geisinger Gold Medicare Supplement Outline of Benefit Coverage" for the monthly cost of all Medicare supplement plans offered by Geisinger Indemnity Insurance Company.
3. Print clearly, and use black or blue ink.
4. ✉ Mail the completed form(s) in the enclosed envelope. If your envelope is missing, please mail to:

   ATTN: Enrollment 32-29
   Geisinger Health Plan
   P.O. Box 900
   Danville, PA 17821-9989

**If you prefer to file online contact us at:**
**www.geisingergold.com**

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

## 1 Tell us about yourself

**Please supply the following information, found on your Medicare card.**

MEDICARE HEALTH INSURANCE

NAME _____
First / Middle Initial / Last

MEDICARE CLAIM # _____

HOSPITAL (PART A) EFFECTIVE DATE: ____ 01 _____
MM DD YYYY

MEDICAL (PART B) EFFECTIVE DATE: ____ 01 _____
MM DD YYYY

**Birthdate**

____ ____ _____
MM DD YYYY

**Gender**

☐ ☐
M F

**Phone**

_____ _____ _____
Area Code and Phone Number

**E-mail address**

_____
Be sure to write all necessary periods(.) and symbols (@).

Home Address (Street No., Apt. No., Suite No.): _____

City: _____ State: _____ Zip Code: _____ County: _____

## 2 Choose your plan and effective date

**Please indicate your plan choice below:**

☐ A ☐ B ☐ C ☐ F ☐ F-High Deductible ☐ M ☐ N

**You are eligible to enroll if the following are true:**

- you are enrolled in Medicare Parts A&B and
- you are not duplicating Medicare supplement coverage.

**Coverage Effective Date**

Your coverage will become effective on the first day of the month following receipt and approval of this application and first month's premium. You will receive an Enrollment Letter confirming your effective date.

If you would like your coverage to begin on a later date (the 1st day of a future month), please indicate below. However, the requested effective date cannot be greater than three (3) months from the signature date on this application.

Requested Effective Date

____ 01 _____
MM DD YYYY

## 3 PART I
## Answer these questions to determine if your acceptance is guaranteed

**3A.** Did you turn age 65 in the last 6 months?

☐ Y ☐ N **If YES,** skip to **Section 7**.

**3B.** Did you enroll in Medicare Part B within the last 6 months?

☐ Y ☐ N **If YES,** skip to **Section 7**.

**3C.** Will your plan effective date be within 6 months after turning age 65 and enrolling in Medicare Part B?

☐ Y ☐ N **If YES,** skip to **Section 7**.

- If you answered **YES to 3A, 3B, or 3C**, your acceptance is guaranteed, skip to **Section 7**.
- If you answered **NO to 3A, 3B, and 3C,** continue to **Section 3, Part II**. ↗

# 3 PART II

**For a Medicare Eligible enrolled in Medicare Part B for six (6) months or more, the Balanced Budget Act of 1997 and the Balanced Budget Refinement Act of 1999 provide set categories which guarantee health insurance coverage without preexisting condition waiting periods.**

In some situations, you have a guaranteed issue right to purchase Medicare supplement coverage. If you are not within your Open Enrollment Period[1], you may be able to obtain health insurance coverage without a preexisting condition limitation if you: (a) have Medicare Part A and Part B, (b) reside in our service area, (c) do not have group health coverage, (d) apply for this coverage within 63 days from the date your previous coverage was terminated, and (e) fall within one of the following categories:

1. Your employer group health benefit plan was: (a) coverage that supplemented (i.e., was in addition to) Medicare and was terminated by the employer, or (b) coverage that paid before Medicare and was terminated by you or the employer.
2. Your previous insurance company ended its Medicare Advantage coverage (a managed health care plan that replaces Medicare Part A and Part B benefits), Medicare SELECT coverage (a type of Medigap policy that may require you to use doctors and hospitals within its network to be eligible for full benefits), Medicare PACE[2] coverage, or you moved out of that Plan's service area.
3. You left Medicare Advantage/Medicare SELECT/Medicare PACE[2], or left other Medicare supplement coverage because your insurer is bankrupt, did not follow an important provision of your policy (i.e., which guarantees health insurance availability without preexisting condition waiting periods), or your policy was misrepresented to you when you purchased it.
4. You cancelled Geisinger Health Plan's coverage to join a Medicare Advantage/Medicare SELECT/Medicare PACE[2] plan. However, you now wish to terminate that coverage and return to Geisinger Health Plan's coverage. You must reapply within 12 months of the date you terminated your coverage, and you may apply for the plan in which you were originally enrolled or for a lower cost plan.
5. You cancelled Medicare supplement coverage to join a Medicare Advantage/Medicare SELECT/Medicare PACE[2] plan. However, within 12 months of joining, you chose to terminate coverage with the Medicare Advantage/Medicare SELECT/Medicare PACE[2] plan and return to your Medicare supplement coverage. You may apply for coverage only if the Medicare supplement coverage which you previously had with your prior insurer is no longer available.
6. You joined a Medicare Advantage/Medicare SELECT/Medicare PACE[2] plan when you were first notifed of your eligibility for Medicare. However, within 12 months of joining that plan, you decided to terminate that coverage and enroll in Geisinger Health Plan's coverage.
7. Your Medicare Advantage Plan has withdrawn from a service area. If you decide to leave the Medicare Advantage Plan prior to the termination date, you have 63 days from the date of your final notification letter to apply for coverage. If you decide to stay enrolled in a Medicare Advantage Plan until the contract terminates, you have 63 days from the date your coverage terminates under the Medicare Advantage Plan to apply for Geisinger Health Plan's coverage.

**NOTE:** You have 63 days from the date that your previous coverage terminated to apply for coverage. Eligible persons are permitted to apply for coverage. **3D.**

- If you feel you are qualified for any of the above categories, please (i) complete the spaces below, (ii) include a copy of your health insurance coverage termination notice with your application and (iii) go to Section 7.
- If the categories in this Section 3, Part II, do not apply to you, go to Section 4.

| Name | ID # | Category to which you belong (1-7 above)# |
|---|---|---|
| | | |

[1]Open Enrollment Period is the six-month time period after first enrolling in Medicare Part B, or reaching the age of sixty-five (65), in which an individual may enroll for Medicare supplement coverage.

[2]Medicare PACE refers to the federal Program for All-Inclusive Care of the Elderly and is not affiliated with the Pennsylvania PACE, Pharmaceutical Assistance Contract for the Elderly.

## 4 Within the last two (2) years, has a medical professional recommended or discussed as a treatment option, any of the following that has NOT been completed:

| YES | NO | |
|---|---|---|
| | | **A.** Hospital admittance as an inpatient or admittance to a nursing home |
| | | **B.** Organ transplant |
| | | **C.** Surgery |

If you answered **"YES"** to any question above, you are **NOT** eligible for this Medicare Supplemental Insurance Plan. **STOP HERE**
If you answered **"NO"** to all questions in this Section 4, please continue on to Section 5.

## 5 Have you ever been diagnosed, treated or had (as determined by a member of the medical profession) any of the following conditions or use of devices?

| YES | NO | A. HEART OR VASCULAR |
|---|---|---|
| | | Aneurysm |
| | | Arteriosclerosis or atherosclerosis |
| | | Artery or vein blockage within the last two (2) years |
| | | Atrial fibrillation |
| | | Cardiomyopathy |
| | | Carotid artery disease |
| | | Congestive Heart Failure (CHF) |
| | | Coronary Artery Disease (CAD) |
| | | Heart attack |
| | | Peripheral vascular disease or claudication |
| | | Stroke, TIA (Transient Ischemic Attack) or mini stroke |
| | | Valvular heart disease |
| | | Ventricular assist device/defibrillator/balloon pump |

| YES | NO | B. LUNG / RESPIRATORY |
|---|---|---|
| | | Bronchiectasis |
| | | Chronic Obstructive Pulmonary Disease (COPD) |
| | | Cystic fibrosis |
| | | Emphysema |
| | | Pulmonary fibrosis |
| | | Pulmonary hypertension |
| | | Sarcoidosis |
| | | Use of supplemental oxygen |

| YES | NO | C. CANCER OR TUMORS |
|---|---|---|
| | | Cancer (other than skin cancer) within last ten (10) years |
| | | Leukemia or lymphoma |
| | | Melanoma |

| YES | NO | D. KIDNEY |
|---|---|---|
| | | Chronic glomerulonephritis |
| | | Chronic Renal Failure or Insufficiency |
| | | Currently receiving dialysis |
| | | End stage renal (kidney) disease |
| | | Polycystic kidney disease |
| | | Renal artery stenosis |

| YES | NO | E. GASTROINTESTINAL |
|---|---|---|
| | | Barrett's esophagus |
| | | Chronic pancreatitis |
| | | Crohn's disease |
| | | Esophageal varices |
| | | Ulcerative colitis |

| YES | NO | F. MUSCULOSKELETAL |
|---|---|---|
| | | Ankylosing spondylitis |
| | | Joint replacement |
| | | Psoriatic arthritis |
| | | Rheumatoid arthritis |
| | | Sjogren's disease |
| | | Spinal stenosis |

| YES | NO | G. BLOOD DISORDERS |
|---|---|---|
| | | Aplastic anemia |
| | | Cooley's anemia |
| | | Hemolytic anemia |
| | | Hemophilia |
| | | Sickle cell anemia |

| YES | NO | H. NERVOUS SYSTEM |
|---|---|---|
| | | Alzheimer's disease or dementia |
| | | Amyotrophic Lateral Sclerosis (ALS) |
| | | CIDP (Chronic Inflammatory Demyelinanting Polyneuropathy) |
| | | Guillain-Barre syndrome |
| | | Multiple Sclerosis (MS) |
| | | Paralysis |
| | | Paraplegia, quadriplegia or hemiplegia |
| | | Parkinson's disease |
| | | Systemic Lupus Erythematosus (SLE) |

| YES | NO | I. OTHER |
|---|---|---|
| | | AIDS |
| | | Bipolar disorder |
| | | Bone marrow or organ transplant |
| | | Chronic hepatitis |
| | | Cirrhosis of the liver |
| | | Diabetic neuropathy |
| | | Enzyme replacement therapy |
| | | Gaucher's disease |
| | | Hypogammaglobulinemia |
| | | Insulin dependent diabetes with circulatory or kidney problems |
| | | Diabetic retinopathy |
| | | IVIG Therapy |
| | | Schizophrenia |
| | | Stem cell transplant |

If you answered **"YES"** to any question above, you are **NOT** eligible for this Medicare Supplemental Insurance Plan. **STOP HERE**
If you answered **"NO"** to all questions in this Section 5, please continue on to Section 6.

## 6 Please answers questions A through D below.

A. What is your height? _____ft _____ in
B. What is your weight ? _____ lbs
C. Have you smoked cigarettes or used any tobacco product at any time within the past twelve (12) months? ___ YES ___ NO
D. What prescription medications are you currently taking?

| Name of Drug | Dosage | Frequency of Dosage | Diagnosis | Prescribing Doctor Name | Is prescribing doctor a PCP or Specialist? | Is this drug administered by a medical professional? |
|---|---|---|---|---|---|---|
| | | | | | | ☐ Yes ☐ No |
| | | | | | | ☐ Yes ☐ No |
| | | | | | | ☐ Yes ☐ No |
| | | | | | | ☐ Yes ☐ No |
| | | | | | | ☐ Yes ☐ No |
| | | | | | | ☐ Yes ☐ No |
| | | | | | | ☐ Yes ☐ No |
| | | | | | | ☐ Yes ☐ No |
| | | | | | | ☐ Yes ☐ No |
| | | | | | | ☐ Yes ☐ No |
| | | | | | | ☐ Yes ☐ No |
| | | | | | | ☐ Yes ☐ No |

# 7 Tell us about your past and current coverage

**Please review the statements below, then answer all questions to the best of your knowledge.**

- You do not need more than one Medicare supplement insurance policy.
- If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
- You may be eligible for benefits under Medicaid and may not need a Medicare supplement insurance policy.
- If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement insurance policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement insurance policy or, if the Medicare supplement insurance policy is no longer available, a substantially equivalent policy will be reinstituted if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement insurance policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- If you are eligible for, and have enrolled in, a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement insurance policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement insurance policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement insurance policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement insurance policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

**For your protection, you are required to answer all the questions below (7A through 7O) and sign in the signature box on the next page.**

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare supplement insurance plans. Please include a copy of the notice from your prior insurer with your application. PLEASE ANSWER ALL QUESTIONS.

**7A.** Did you turn age 65 in the last 6 months?

☐ Y ☐ N

**7B.** Did you enroll in Medicare Part B within the last 6 months?

☐ Y ☐ N

**7C. If YES,** what is the effective date?

____ **0 1** _____
M M D D Y Y Y Y

**7D.** Are you covered for medical assistance through the state Medicaid program? (Medicaid is a state-run health care program that helps with medical costs for people with low or limited income. It is not the Federal Medicare Program.)

**Note to applicant:** If you are participating in a "Spend-down Program" and have not met your "Share of Cost," please answer **NO** to this question.

☐ Y ☐ N

**7E.** Will Medicaid pay your premiums for this Medicare supplement policy?

☐ Y ☐ N

**7F.** Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?

☐ Y ☐ N

## 7 Tell us about your past and current coverage - continued

**7G.** Have you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, a Medicare HMO or PPO)?

☐ Y ☐ N

**If YES,** fill in your start and end dates and continue to question 7H. If you are still covered under this plan, leave the end date blank.

**Start Date** ____ **0 1** _____
M M D D Y Y Y Y

**End Date** ____ **0 1** _____
M M D D Y Y Y Y

**7H.** If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement insurance policy?

☐ Y ☐ N

**7I.** Was this your first time in this type of Medicare plan?

☐ Y ☐ N

**7J.** Did you drop a Medicare supplement insurance policy to enroll in the Medicare plan?

☐ Y ☐ N

**7K.** Do you have another Medicare supplement insurance policy in force?

☐ Y ☐ N

**7L.(A)** If Yes, with what company and what plan do you have?

**Company Name:** _____

**Plan:** _____

**7L.(B) If YES**, do you intend to replace your current Medicare supplement insurance policy with this policy?

☐ Y ☐ N

**7M.** Have you had coverage under any other health insurance within the past 63 days (for example, an employer, union or individual plan)?

☐ Y ☐ N

**If YES,** please list with what company and what type of policy in the space provided below. Then continue to question **7N**.

**Company Name:**_____

**Policy Type**

☐ HMO/PPO ☐ Major Medical ☐ Employer Plan
☐ Union Plan ☐ Other_____

**7N.** What are your dates of coverage under the policy you listed in **7M**? Leave the end date blank if you are still covered under the other policy.

☐ Y ☐ N

**Start Date** ____ ____ _____
M M D D Y Y Y Y

**End Date** ____ ____ _____
M M D D Y Y Y Y

**7O.** Are you replacing this health insurance?

☐ Y ☐ N

***Your Signature - 1 (required)***

X _____

# 8 Authorization and Verification of Information

**Please read carefully, and sign and date in the signature box below.**

- My signature indicates I have read and understand the contents of this application form.
- I declare the answers on this application form are complete and true to the best of my knowledge and belief and are the basis for issuing coverage. I understand that this application form becomes a part of the insurance contract and that if the answers are incomplete, incorrect or untrue, Geisinger Indemnity Insurance Company may have the right to rescind my coverage, adjust my premium, or reduce my benefits.
- I understand the coverage under the plan I am applying for will not take effect until issued by Geisinger Indemnity Insurance Company.
- I acknowledge receipt of the "Guide to Health Insurance for People with Medicare" and "Geisinger Gold Medicare Supplement Outline of Benefit Coverage" as required.
- I alone am responsible for reading and accurately completing this application. I have left nothing out regarding my past or present health. I understand that I am not eligible for any benefits if any information requested on this application, even information about my Medicare coverage, is false, incomplete or omitted and that Geisinger Indemnity Insurance Company may void all coverage from the original effective date of the policy for intentional material misstatements or omissions.
- 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.

**Authorization for the Release of Medical Information**

I authorize any health care provider, licensed physician, medical practitioner, hospital, pharmacy, clinic or other medical facility, health care clearinghouse, pharmacy benefit manager, insurance company, or other organization, institution, or person to give Geisinger Indemnity Insurance Company and its insurance company affiliates ("Company") any data or records about me or my mental or physical health. I understand the purpose of this disclosure and use of my information is to allow Company to determine my eligibility for coverage and rate. I understand this authorization is voluntary and I may refuse to sign the authorization. My refusal may, however, affect my eligibility to enroll in Geisinger Indemnity Insurance Company or to receive benefits, if permitted by law. I understand the information I authorize Company to obtain and use may be re-disclosed to a third party only as permitted under applicable law, and once re-disclosed, the information may no longer be protected by Federal privacy laws. I understand I may end this authorization if I notify Company, in writing, prior to the issuance of coverage. After coverage is issued, this authorization is not revocable. This authorization is valid for 24 months from the date of my signature.

**I have read all information and have answered all questions to the best of my ability.**

**Your Signature - 2** (required)

X _____

**Today's Date** (required)

____ ____ _____

M M D D Y Y Y Y

**Note:** If you are signing as the legal representative for the applicant, please enclose a copy of the appropriate legal documentation.

## Authorization for the Release of Medical Information to Determine Eligibility of Claims and for Analytic Studies

I authorize any health care provider, licensed physician, medical practitioner, hospital, pharmacy, clinic or other medical facility, health care clearinghouse, pharmacy benefit manager, insurance company, or other organization, institution, or person to give Geisinger Indemnity Insurance Company and its insurance company affiliates ("Company") any data or records about me or my mental or physical health. I understand the purpose of this disclosure and use of my information is to allow Company to determine the eligibility of and/or amount payable for my claims and for analytic studies. I understand I may end this authorization if I notify Company, in writing, except to the extent that Company has already acted on my authorization. If not revoked, this authorization is valid for the term of the coverage.

**Your Signature - 3**

X _____

**Today's Date** (required)

____ ____ _____

M M D D Y Y Y Y

**Note:** If you are signing as the legal representative for the applicant, please enclose a copy of the appropriate legal documentation.

# 9 Billing Information Sections 9A, 9B and 9C must be completed.

**Please refer to the "Geisinger Gold Medicare Supplement Outline of Benefit Coverage" for the monthly cost of the plan you have selected and submit the appropriate rate.**

## 9A. INITIAL PREMIUM PAYMENT OPTIONS. (Initial payment will be processed immediately upon Application approval.)

**Please choose one of the following:**

☐ EFT (Electronic Funds Transfer)

☐ Credit Card

☐ Check or Money Order (payable to Geisinger Indemnity Insurance Company and submit payment with this Application.)

- A CHECK AUTHORIZES ELECTRONIC DEBIT - Your payment by personal check may be processed as an electronic ACH debit. By mailing us a check for payment, you are authorizing us to use certain information from your check to initiate a one-time ACH debit in the amount of your check from the account on which you have written the check. To avoid possible costs due to a rejected ACH debit, please make sure that the check is covered by funds already in your account before you mail us the check. Your check will not be returned to you and the original is destroyed.

## 9B. SUBSEQUENT PREMIUM PAYMENT OPTIONS. (A monthly premium bill will be mailed regardless of payment selection.)

**Please choose one of the following:**

| Payment Options: | Place **X** at Selection | Charge my Account on the **First (1st)** calendar day of each month: | Charge my Account on the **Sixth (6th)** calendar day of each month: |
|---|---|---|---|
| EFT (Electronic Funds Transfer) | | | |
| Credit Card | | | |
| Bill Me | | | |

- EFT and Credit Card payments will be charged on with the 1st or the 6th calendar day of each month as you have selected above. However, if your regularly scheduled payment day falls on a Saturday, Sunday or holiday, charges will be applied on the following business day.

## 9C. PAYMENT AUTHORIZATION.

I authorize Geisinger Indemnity Insurance Company ("Company") to draw premium payment from the accounts and/or credit card as noted in 9A and 9B above. I represent that my account(s) at the institution named in this Application has sufficient funds to pay all premiums due. I understand that Company shall initiate electronic debit to pay premiums for authorized policies, and the entries are my transaction receipt. I understand that corrections to the entries may involve an account adjustment, and that my direct electronic payment of the policy premium will be debited on or after the premium due date.

_____ _____

Applicant's Signature Date

**Important Policyholder Information and Terms**

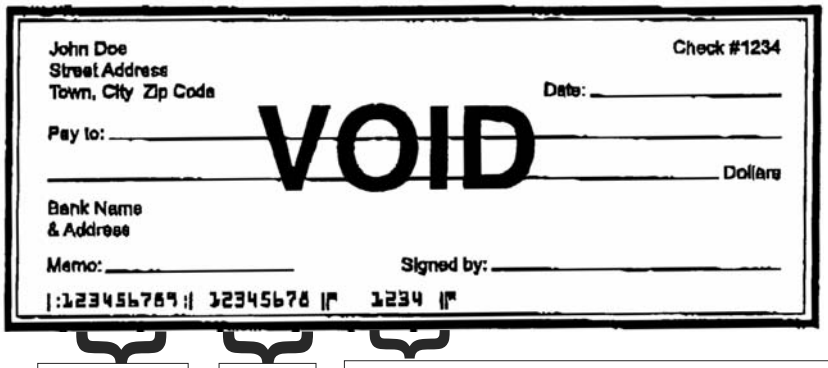
- **Your initial premium payment must be submitted with your Application**. However, payment does not guarantee coverage. Your policy will be effective only if your Application has been approved by Geisinger Indemnity Insurance Company ("Company"), medical underwriting has been completed and approved (if applicable), and premium has been received and accepted.
- Your premium amount is not final until the medical underwriting process (if applicable) has been completed. Coverage may be declined or final premium may be adjusted (higher or lower) based on information provided to Company or election of a different benefit level.
- If coverage is declined or cancelled by either Company or the applicant, Section(s) 9, 10 and 11 of this Application will be redacted and/or destroyed.
- Do not cancel other coverage presently in force until written notification is received from Company indicating that your enrollment has been approved and you have received your Enrollment Letter providing the effective date of coverage.
- There is no payment to Company until Company receives full and final credit for the payment, and Company reserves the right to refuse/terminate electronic payment services at any time.

# 10 EFT Information (Electronic Funds Transfer)

**If you elected to make premium payment(s) by EFT, complete this Section; otherwise, skip to Section 11.**

- Name on Account: _____
- Address on Account: _____
  (Street) (Apt # / Suite #)

  _____
  (City) (State) (Zip Code)
- Bank Name: _____
- Account Type: ☐ Checking Account ☐ Savings Account
- Bank Routing Number (9-digit #):__ __ __ __ __ __ __ __ __
- Bank Account Number: _____




Bank Routing Number

Bank Account Number

Check Number
Please **do not include** the check number (it may be before or after the account number) as it may delay processing.

# 11 Credit Card Information

**If you elected to make premium payment(s) by Credit Card, complete this Section; otherwise, skip to Section 12.**

- Credit Card Type: ☐ VISA ☐ MasterCard ☐ Discover
- Cardholder's Name: _____
  (exactly as it appears on the card)
- Cardholder's Address: _____
  (as it appears on the statement) (Street) (Apt # / Suite #)

  _____
  (City) (State) (Zip Code)
- Account number: __ __ __ __ - __ __ __ __ - __ __ __ __ - __ __ __ __
- Card Expiration Date: __ __ / __ __ __ __
  M M Y Y Y Y

# 12 Application Form Checklist

**Did you remember to...**

√ Complete this application form in black or blue INK?
√ Fill in all requested information in all sections?
√ Sign in all 3 signature boxes?
√ Include termination notice from previous insurance coverage (if applicable)?
√ Enclose your first month's insurance payment? Please refer to the "Geisinger Gold Medicare Supplement Outline of Benefit Coverage" for the monthly cost of the plan you have selected.

Make check or money order payable to:
**Geisinger Indemnity Insurance Company**

Once your application is processed, you'll be notified of your acceptance, rate and insurance start date. *Thank you!*

# 13 FOR AGENT ONLY

Please list any other health insurance policies or coverages you have sold to the applicant which are still in force, and any other health insurance policies or coverages you have sold to the applicant in the past five years which are no longer in force. Please submit with the application, as required:

| Date | Name of Policy | Name and Address of Insurance Company |
|---|---|---|
| From: Mo./Yr. _____ | _____ | Name: _____ |
| To: Mo./Yr. _____ | _____ | Address: _____ |
| | _____ | City/State: _____ |

(Attach additional sheets if necessary)

I have read and understand the application. I additionally certify that I have given the "Guide to Health Insurance for People with Medicare," and an outline of coverage and a disclosure statement for the policy applied for, and that the applicant has both Parts A and B of Medicare. The applied for policy will not duplicate any health insurance coverage. I have requested and received documentation that indicates that the applied for policy will not duplicate any coverage.

SIGNED AT

_____ _____ _____
Agent's Signature | Date of Signature | (City and State)

_____
Print Agent's Name | Agent No.

_____
Street Address | Telephone No.

_____
City | State | ZIP

_____
E-mail Address

Premium Amount $ _____ _____

**BROKER HOTLINE TOLL-FREE NUMBER**
Monday - Friday: 8:00 a.m. to 5:00 p.m.
866-488-6653