**GEISINGER HEALTH PLAN**
100 N. Academy Ave.
Danville, PA 17822

# Enrollment Application Change Form

**GEISINGER QUALITY OPTIONS, INC.**
100 N. Academy Ave.
Danville, PA 17822

**Effective date of change:** _____

## SUBSCRIBER / POLICYHOLDER

☐ Check if you are a member of Geisinger Gold

GROUP NUMBER | CLASS NUMBER | INSURANCE I.D. NUMBER

LEGAL NAME (LAST) | (FIRST) | (M.I.)

ADDRESS (NUMBER) | (STREET) | (APT. NO.)

CITY | STATE | ZIP CODE

COUNTY

SOCIAL SECURITY NUMBER

## ENROLLMENT CHANGES

☐ Add Dependent(s)
☐ Address Change
☐ Name Change
_____ (Previous last name)
☐ Primary Telephone Number
(_____)_____
☐ Changing Plan
_____ (Name of new plan)
☐ Changing Class: _____
☐ Other: _____

☐ Changing Primary Care Physician
**Reason for PCP Change:** (check one)
☐ Access dissatisfaction
☐ Convenience
☐ Error in PCP selection
☐ Failure to establish relationship
☐ Medical care dissatisfaction
☐ PCP leaves the Health Plan
☐ PCP moves
☐ Provider service dissatisfaction
☐ Disenrollment reason

* New PCP change information should be updated in Subscriber/Dependent Change section below

## DISENROLLMENT

☐ **SUBSCRIBER / POLICYHOLDER** ☐ **DEPENDENT**

☐ Deceased: (Date of Death) _____
☐ Leave of absence
☐ Non payment of premium
☐ Retired
☐ Termination of employment
☐ Dissatisfaction with Plan
☐ Loss of dependent status
☐ Personal preference
☐ Selected other insurance
☐ Open enrollment _____
☐ Lay off
☐ Moved out of service area
☐ Reduction in work hours
☐ Other: _____

COBRA / Mini-COBRA. If changes noted in DISENROLLMENT 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.)

## SUBSCRIBER/POLICYHOLDER AND DEPENDENT CHANGES (PLEASE PRINT OR TYPE)

Geisinger Health Plan may refer collectively to health care coverage sponsors Geisinger Health Plan, Geisinger Quality Options, Inc. and Geisinger Indemnity Insurance Company, unless otherwise noted. Geisinger Health Plan is part of Geisinger, an integrated health care delivery and coverage organization.

**CHANGES 1** (If not applicable, leave blank and continue to signatures page 3.)

| CHECK ONE | | | LEGAL NAME | BIRTH DATE | RELATIONSHIP TO SUBSCRIBER/ POLICYHOLDER | MARITAL STATUS | | | SOCIAL SECURITY NUMBER | Has adult dependent (applies to dependent over 21) used tobacco on average of four (4) or more times per week withing six (6) months? | GEISINGER MEDICAL RECORD NUMBER | PRIMARY CARE PHYSICIAN NAME/LOCATION (TOWN) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ADD | REMOVE | CHANGING PLAN | LAST FIRST M.I. | MO./DAY/YR. | (SPOUSE, DOMESTIC PARTNER†, SON, DAUGHTER, OTHER†*) | DATE OF MARRIAGE | DATE OF DIVORCE | OTHER CHANGE OF STATUS/LEGAL QUALIFYING EVENT | | | | |
| ☐ | ☐ | ☐ | | | | | | | | ☐ YES ☐ NO | | |

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.

| SEX ASSIGNED AT BIRTH | SEX (LEGAL/ADMINISTRATIVE) | PRONOUNS | PREFERRED LANGUAGE |
|---|---|---|---|
| ☐ MALE<br>☐ FEMALE<br>☐ NOT RECORDED ON BIRTH CERTIFICATE | ☐ MALE ☐ FEMALE<br>☐ X OR NON-BINARY<br>☐ CHOOSE NOT TO DISCLOSE | ☐ SHE/HER/HERS<br>☐ HE/HIM/HIS<br>☐ THEY/THEM/THEIRS<br>☐ MY NAME<br>☐ CHOOSE NOT TO DISCLOSE<br>☐ NOT LISTED: _____ | ☐ ENGLISH ☐ GUJARATI ☐ RUSSIAN ☐ HINDI<br>☐ SPANISH ☐ SIGN LANGUAGE ☐ CHINESE ☐ GERMAN<br>☐ NEPALI ☐ VIETNAMESE ☐ ARABIC<br>☐ YIDDISH, PENNSYLVANIA DUTCH OR OTHER WEST GERMANIC LANGUAGES<br>☐ OTHER: _____ |

| ETHNICITY | SEXUAL ORIENTATION | GENDER IDENTITY | RACE |
|---|---|---|---|
| ☐ HISPANIC OR LATINO<br>☐ NOT HISPANIC OR LATINO<br>☐ CHOOSE NOT TO DISCLOSE | ☐ STRAIGHT (NOT LESBIAN OR GAY)<br>☐ LESBIAN OR GAY<br>☐ BISEXUAL<br>☐ SOMETHING ELSE _____<br>☐ CHOOSE NOT TO DISCLOSE | ☐ MALE ☐ FEMALE<br>☐ TRANSGENDER MALE (FEMALE-TO-MALE)<br>☐ TRANSGENDER FEMALE (MALE-TO-FEMALE)<br>☐ GENDERQUEER (NEITHER EXCLUSIVELY MALE NOR FEMALE)<br>☐ CHOOSE NOT TO DISCLOSE | ☐ AMERICAN INDIAN OR ALASKA NATIVE<br>☐ ASIAN ☐ WHITE ☐ BLACK OR AFRICAN AMERICAN<br>☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER<br>☐ TWO OR MORE RACES<br>☐ CHOOSE NOT TO DISCLOSE |

| VETERAN STATUS | YEARS OF SERVICE | BRANCH OF SERVICE | MAJOR CONFLICTS |
|---|---|---|---|
| ☐ YES ☐ NO<br>☐ CHOOSE NOT TO DISCLOSE | | ☐ AIR FORCE ☐ AIR NATIONAL GUARD ☐ AIR FORCE RESERVE ☐ NAVY<br>☐ ARMY ☐ ARMY NATIONAL GUARD ☐ ARMY RESERVE ☐ NAVY RESERVE<br>☐ COAST GUARD ☐ COAST GUARD RESERVE ☐ MARINE CORPS ☐ MULTIPLE BRANCHES | ☐ COLD WAR ☐ GULF WAR ☐ IRAQ WAR ☐ KOREAN WAR<br>☐ PEACE TIME ☐ VIETNAM WAR ☐ WWII ☐ WAR IN AFGHANISTAN |

| WE HONOR VETERANS CEREMONY | DISABLED VETERAN | VA RECOGNIZE DISABILITY |
|---|---|---|
| ☐ YES ☐ NO | ☐ YES ☐ NO | ☐ YES ☐ NO |

**CHANGES 2** (If not applicable, leave blank and continue to signatures page 3.)

| CHECK ONE | | | LEGAL NAME | | | BIRTH DATE | RELATIONSHIP TO SUBSCRIBER/ POLICYHOLDER (SPOUSE, DOMESTIC PARTNER†, SON, DAUGHTER, OTHER†*) | MARITAL STATUS | | | SOCIAL SECURITY NUMBER | Has adult dependent (applies to dependent over 21) used tobacco on average of four (4) or more times per week withing 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 | | |

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**SEX ASSIGNED AT BIRTH**
- ☐ MALE
- ☐ FEMALE
- ☐ NOT RECORDED ON BIRTH CERTIFICATE

**SEX (LEGAL/ADMINISTRATIVE)**
- ☐ MALE ☐ FEMALE
- ☐ X OR NON-BINARY
- ☐ CHOOSE NOT TO DISCLOSE

**PRONOUNS**
- ☐ SHE/HER/HERS
- ☐ HE/HIM/HIS
- ☐ THEY/THEM/THEIRS
- ☐ MY NAME
- ☐ CHOOSE NOT TO DISCLOSE
- ☐ NOT LISTED: _____

**PREFERRED LANGUAGE**
- ☐ ENGLISH ☐ GUJARATI ☐ RUSSIAN ☐ HINDI
- ☐ SPANISH ☐ SIGN LANGUAGE ☐ CHINESE ☐ GERMAN
- ☐ NEPALI ☐ VIETNAMESE ☐ ARABIC
- ☐ YIDDISH, PENNSYLVANIA DUTCH OR OTHER WEST GERMANIC LANGUAGES
- ☐ OTHER: _____

**ETHNICITY**
- ☐ HISPANIC OR LATINO
- ☐ NOT HISPANIC OR LATINO
- ☐ CHOOSE NOT TO DISCLOSE

**SEXUAL ORIENTATION**
- ☐ STRAIGHT (NOT LESBIAN OR GAY)
- ☐ LESBIAN OR GAY
- ☐ BISEXUAL
- ☐ SOMETHING ELSE _____
- ☐ CHOOSE NOT TO DISCLOSE

**GENDER IDENTITY**
- ☐ MALE ☐ FEMALE
- ☐ TRANSGENDER MALE (FEMALE-TO-MALE)
- ☐ TRANSGENDER FEMALE (MALE-TO-FEMALE)
- ☐ GENDERQUEER (NEITHER EXCLUSIVELY MALE NOR FEMALE)
- ☐ CHOOSE NOT TO DISCLOSE

**RACE**
- ☐ AMERICAN INDIAN OR ALASKA NATIVE
- ☐ ASIAN ☐ WHITE ☐ BLACK OR AFRICAN AMERICAN
- ☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER
- ☐ TWO OR MORE RACES
- ☐ CHOOSE NOT TO DISCLOSE

**VETERAN STATUS**
- ☐ YES ☐ NO
- ☐ CHOOSE NOT TO DISCLOSE

**YEARS OF SERVICE**

**BRANCH OF SERVICE**
- ☐ AIR FORCE ☐ AIR NATIONAL GUARD ☐ AIR FORCE RESERVE ☐ NAVY
- ☐ ARMY ☐ ARMY NATIONAL GUARD ☐ ARMY RESERVE ☐ NAVY RESERVE
- ☐ COAST GUARD ☐ COAST GUARD RESERVE ☐ MARINE CORPS ☐ MULTIPLE BRANCHES

**MAJOR CONFLICTS**
- ☐ COLD WAR ☐ GULF WAR ☐ IRAQ WAR ☐ KOREAN WAR
- ☐ PEACE TIME ☐ VIETNAM WAR ☐ WWII ☐ WAR IN AFGHANISTAN

**WE HONOR VETERANS CEREMONY**
- ☐ YES ☐ NO

**DISABLED VETERAN**
- ☐ YES ☐ NO

**VA RECOGNIZE DISABILITY**
- ☐ YES ☐ NO

**CHANGES 3** (If not applicable, leave blank and continue to signatures page 3.)

| CHECK ONE | | | LEGAL NAME | | | BIRTH DATE | RELATIONSHIP TO SUBSCRIBER/ POLICYHOLDER (SPOUSE, DOMESTIC PARTNER†, SON, DAUGHTER, OTHER†*) | MARITAL STATUS | | | SOCIAL SECURITY NUMBER | Has adult dependent (applies to dependent over 21) used tobacco on average of four (4) or more times per week withing six (6) months? | GEISINGER MEDICAL RECORD NUMBER | PRIMARY CARE PHYSICIAN NAME/LOCATION (TOWN) |
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| ☐ | ☐ | ☐ | | | | | | | | | | ☐ YES ☐ NO | | |

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**PRONOUNS**
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**ETHNICITY**
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**SEXUAL ORIENTATION**
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**VETERAN STATUS**
- ☐ YES ☐ NO
- ☐ CHOOSE NOT TO DISCLOSE

**YEARS OF SERVICE**

**BRANCH OF SERVICE**
- ☐ AIR FORCE ☐ AIR NATIONAL GUARD ☐ AIR FORCE RESERVE ☐ NAVY
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**WE HONOR VETERANS CEREMONY**
- ☐ YES ☐ NO

**DISABLED VETERAN**
- ☐ YES ☐ NO

**VA RECOGNIZE DISABILITY**
- ☐ YES ☐ NO

**CHANGES 4** (If not applicable, leave blank and continue to signatures below.)

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| VETERAN STATUS | YEARS OF SERVICE | BRANCH OF SERVICE | MAJOR CONFLICTS |
|---|---|---|---|
| ☐ YES ☐ NO<br>☐ CHOOSE NOT TO DISCLOSE | | ☐ AIR FORCE ☐ AIR NATIONAL GUARD ☐ AIR FORCE RESERVE ☐ NAVY<br>☐ ARMY ☐ ARMY NATIONAL GUARD ☐ ARMY RESERVE ☐ NAVY RESERVE<br>☐ COAST GUARD ☐ COAST GUARD RESERVE ☐ MARINE CORPS ☐ MULTIPLE BRANCHES | ☐ COLD WAR ☐ GULF WAR ☐ IRAQ WAR ☐ KOREAN WAR<br>☐ PEACE TIME ☐ VIETNAM WAR ☐ WWII ☐ WAR IN AFGHANISTAN |

| WE HONOR VETERANS CEREMONY | DISABLED VETERAN | VA RECOGNIZE DISABILITY |
|---|---|---|
| ☐ YES ☐ NO | ☐ YES ☐ NO | ☐ YES ☐ NO |

†Documentation obligating the Subscriber/Policyholder or the Subscriber'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 acknowledgment 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 / GROUP NAME (if applicable) | DATE SIGNED |
|---|---|---|---|
| ADULT DEPENDENT SIGNATURE | DATE SIGNED | ADULT DEPENDENT SIGNATURE | DATE SIGNED |

# Discrimination is against the law

Geisinger Health Plan, Geisinger Quality Options, Inc., and Geisinger Indemnity Insurance Company (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
Y0032_16242_2 File and Use 9/2/16