GEISINGER HEALTH PLAN

100 North Academy Avenue Danville, PA 17822

GROUP SUBSCRIBER APPLICATION

GEISINGER QUALITY OPTIONS, INC.

100 North Academy Avenue Danville, PA 17822

		GENERAL	ADMINISTRA	IIVE INFO	JRIMA	ATION (fo	r completi	on by E	mploy	er)			
Group number	Insurance ID number:												
Division numb		Name of Sales Rep.:											
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	provide on this ap	customer identification,	er Health Plan and/or Geis billing and member satisfa										
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WE HONOR VETERAL		<u> </u>	DISABLED VETERAN						VA RECO	OGNIZE DI	SABILITY		
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	Yes □	No □ If "Yes	or Geisinger Quality Option s," please provide: Your M	edicare Nur	mber:	(Check o				
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If "Yes", please complete the following information: Name of Insurance Company: I.D. or Social Security										
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Check on	e: □ F Date of Co\	amily Plan	Self Only	Grou	up Number					
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MALE FEMALE NOT RECORDED ON BIRTH CERTIFICATE	FEMALE MALE FEMALE SHE/HER/HERS HE/HIM/HIS ECORDED X OR NON-BINARY THEY/THEM/THEIRS MY NAME RTH CHOOSE NOT TO DISCLOSE CHOOSE NOT TO DISCLOSE			☐ ENGLISH ☐ GUJARATI ☐ RUSSIA☐ SPANISH ☐ GERMAN ☐ CHINES☐ NEPALI ☐ VIETNAMESE ☐ ARABIC☐ YIDDISH, PENNSYLVANIA DUTCH OR OTHER			ESE OTHER:	
ETHNICITY	SEXUAL ORIEN		GENDER IDENTITY			RACE		
□ HISPANIC OR LATINO □ NOT HISPANIC OR LATINO □ CHOOSE NOT TO DISCLOSE □ STRAIGHT (NOT LESBIAN OR GAY) □ LESBIAN OR GAY □ LESBIAN OR GAY □ SISEXUAL □ SOMETHING ELSE □ CHOOSE NOT TO DISCLOSE		□ MALE □ FEMALE □ TRANSGENDER FEMALE (MALE-TO-FEMALE) □ TRANSGENDER MALE (FEMALE-TO-MALE) □ GENDERQUEER (NEITHER EXCLUSIVELY MALE NOR FEMALE) □ CHOOSE NOT TO DISCLOSE		AMERICAN INDIAN OR ALASKA NATIVE				
		IF DEPENDENT IS UND	· · · · · · · · · · · · · · · · · · ·			MAJOR CO		ZIII E WAD
VETERAN OR ACTIVE OF THE U.S. MILITARY YES NO CHOOSE NOT TO D IF YES, YEARS OF SE	?	MILITARY BRANCH AIR FORCE ARMY COAST GUARD	□ AIR NATIONAL GUARD □ AIR FORCE RESERVE □ NAVY □ ARMY NATIONAL GUARD □ ARMY RESERVE □ NAVY RESERVE			COLD WAR GULF WAR IRAQ WAR KOREAN WAR PEACE TIME VIETNAM WAR WWII WAR IN AFGHANISTAN		
WE HONOR VETERAL			DISABLED VETERAN			VA RECOG	NIZE DISA	BILITY
□ YES □ NO						YES NO		

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DEPENDENT 4		LEGAL NAME: (LAST,	FIRST M.I.):			BIRTH DATE: (MM/DD/YYYY.):			
CHECK ONE:			BSCRIBER/POLICY HOLDER	CIAL SECURITY NUMBER:	ER:				
☐ ADD ☐ REMOVE ☐ CHANGING PLAN		☐ SPOUSE ☐ DOM ☐ LEGAL CUSTODIAN/	IESTIC PARTNER† □ CHILD LEGAL GUARDIAN □ OTHER†*	GEI	SINGER MEDICAL RECORD NU	MBER:			
MARITAL STATUS	MARRIED - DATE	OF MARRIAGE	□ DIVORCED - DATE OF DIVORCE		OTHER CHANGE OF STATU	JS/LEGAL QI	JALIFYING F	EVENT DATE:	
		RE IF SAME AS PRIMAI							
			Street/Apartment/Suite #		City		State	Zip Country	
ARE YOU PREGNANT			HOW MANY BABIES ARE EXPECTED DURING T						
		BACCO ON AVERAGE years of age and older	OF FOUR OR MORE TIMES PER WEEK WITHIN	THE PAST	SIX (6) MONTHS?	□ NO			
PRIMARY CARE PHYSICIAN (PCP) INFORMATION	A PCP?	STABLISHED WITH	IF YES, PCP NAME:	-	PCP PHONE: (CTICE LOCATION ADDRESS):	
U.S. CITIZENSHIP HAVE YOU LIVED IN THE U.S. SINCE 1996?	ARE YOU U.S. C NATIONAL?		IF YOU ARE NOT A U.S. CITIZEN OR U.S. NATIONAL, DO YOU HAVE ELIGIBLE IMMIGRATION STATUS? ☐ YES ☐ NO			DOCUMEN	IT TYPE	DOCUMENT ID NUMBER	
□ YES □ NO		NO	IF YES, FILL IN YOUR DOCUMENT I					d improving a price for all	
			cost or eligibility. Consumer-reported race and						
AT BIRTH	SEX (LEGAL/AD	OMINISTRATIVE)	PRONOUNS	PREFERE	RED LANGUAGE				
□ MALE □ FEMALE □ NOT RECORDED ON BIRTH CERTIFICATE	☐ X OR NON-BI	□ FEMALE NARY Γ TO DISCLOSE	□ SHE/HER/HERS □ HE/HIM/HIS □ THEY/THEM/THEIRS □ MY NAME □ CHOOSE NOT TO DISCLOSE □ NOT LISTED:	□ SPANIS	SH GERMAN G	RUSSIAN CHINESE ARABIC LOTHER WE	□ OTHE	LANGUAGE HINDI ER: NIC LANGUAGES	
ETHNICITY	SEXUAL ORIEN	TATION	GENDER IDENTITY	l		RACE			
☐ HISPANIC OR LATINO ☐ NOT HISPANIC OR LATINO ☐ CHOOSE NOT TO DISCLOSE	□ LESBIAN OR □ BISEXUAL □ SOMETHING					□ AMERICAN INDIAN OR ALASKA NATIVE □ BLACK OR AFRICAN AMERICAN □ ASIAN □ WHITE □ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER □ TWO OR MORE RACES □ CHOOSE NOT TO DISCLOSE			
VETERAN STATUS (NOT APPLICABLE	IF DEPENDENT IS UN	DER THE AGE OF 17.)			MAJOR CO	ONFLICTS		
VETERAN OR ACTIVE DUTY MEMBER MILITARY BRANCH OF THE U.S. MILITARY? AIR FORCE YES NO CHOOSE NOT TO DISCLOSE COAST GUARD			□ AIR NATIONAL GUARD □ AIR FORCE RESERVE □ NAVY □ ARMY NATIONAL GUARD □ ARMY RESERVE □ NAVY RESERVE			□ COLD WAR □ GULF WAR □ IRAQ WAR □ KOREAN WAR □ PEACE TIME □ VIETNAM WAR □ WWII □ WAR IN AFGHANISTAN			
IF YES, YEARS OF SE	RVICE:	_							
WE HONOR VETERA	NS CEREMONY		DISABLED VETERAN				NIZE DISA	BILITY	
□ YES □ NO			□ YES □ NO			□ YES □	NO		
DEPENDENT 5		LEGAL NAME: (LAST,	· · · · · · · · · · · · · · · · · · ·			BIRTH D	ATE: (MM/D	D/YYYY):	
CHECK ONE: □ ADD □ REMOVE □ CHANGING PLAN			BSCRIBER/POLICY HOLDER IESTIC PARTNER† □ CHILD LEGAL GUARDIAN □ OTHER†*		CIAL SECURITY NUMBER:	MRED.			
MARITAL STATUS	MARRIED - DATE		DIVORCED - DATE OF DIVORCE		OTHER CHANGE OF STATU		IALIFYING F	EVENT DATE:	
		RE IF SAME AS PRIMAI				30, <u>22</u> 0, 12 q.	o, (2.11 1 1 1 1 0 1		
			Street/Apartment/Suite #		City		State	Zip Country	
ARE YOU PREGNANT			HOW MANY BABIES ARE EXPECTED DURING T						
		BACCO ON AVERAGE years of age and older	OF FOUR OR MORE TIMES PER WEEK WITHIN	THE PAST	SIX (6) MONTHS?	□ NO			
PRIMARY CARE PHYSICIAN (PCP) INFORMATION	A PCP?	STABLISHED WITH	IF YES, PCP NAME:	-	PCP PHONE: (CTICE LOCATION ADDRESS):	
U.S. CITIZENSHIP HAVE YOU LIVED IN THE U.S. SINCE 1996? YES NO	ARE YOU U.S. C NATIONAL?	ITIZEN OR U.S.	STATUS? YES NO	IF YOU ARE NOT A U.S. CITIZEN OR U.S. NATIONAL, DO YOU HAVE ELIGIBLE IMMIGRATION STATUS? YES NO IF YES, FILL IN YOUR DOCUMENT TYPE AND ID # TO THE RIGHT.			IT TYPE	DOCUMENT ID NUMBER	
The information below members. It does not	w may be used to impact plan opti	o identify possible app ons, health insurance	lication, enrollment and coverage barriers, and cost or eligibility. Consumer-reported race and	disparities ethnicity in	for the communities we serve formation is protected from dis	so we can sclosure or	work towar	d improving services for all ed access.	
SEX ASSIGNED AT BIRTH	SEX // FOA: /**	MINISTRATIVE'	PRONOLING	DDEEEE	DED LANGUAGE				
MALE FEMALE NOT RECORDED ON BIRTH CERTIFICATE	☐ MALE ☐ X OR NON-BI	FEMALE	☐ THEY/THEM/THEIRS ☐ MY NAME ☐ SPANISH ☐ GERMAN ☐ CHINESE						
ETHNICITY	SEXUAL ORIEN		GENDER IDENTITY			RACE			
□ HISPANIC OR LATINO □ NOT HISPANIC OR LATINO □ CHOOSE NOT TO DISCLOSE	□ HISPANIC OR LATINO □ LESBIAN OR GAY □ LESBIAN OR GAY □ TRANSGEI □ RISPANIC OR LATINO □ CHOOSE NOT TO □ CHOOSE NOT TO □ STRAIGHT (NOT LESBIAN OR GAY) □ TRANSGEI □ TRANSGEI □ GENDERQ □ CHOOSE N			LE FEMALE TRANSGENDER FEMALE (MALE-TO-FEMALE) INSGENDER MALE (FEMALE-TO-MALE) INDERQUEER (NEITHER EXCLUSIVELY MALE NOR FEMALE)			□ AMERICAN INDIAN OR ALASKA NATIVE □ BLACK OR AFRICAN AMERICAN □ ASIAN □ WHITE □ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER □ TWO OR MORE RACES □ CHOOSE NOT TO DISCLOSE		
,		IF DEPENDENT IS UN	·			MAJOR CO			
VETERAN OR ACTIVE OF THE U.S. MILITARY YES NO CHOOSE NOT TO D	(?	MILITARY BRANCH AIR FORCE ARMY	□ AIR NATIONAL GUARD □ AIR FORCE RESERVE □ NAVY □ ARMY NATIONAL GUARD □ ARMY RESERVE □ NAVY RESERVE			□ COLD WAR □ GULF WAR □ IRAQ WAR □ KOREAN WAR □ PEACE TIME □ VIETNAM WAR □ WWII □ WAR IN AFGHANISTAN			
IF YES, YEARS OF SE		□ COAST GUARD		KP5	MULTIPLE BRANCHES	U VVVVII		WAR IN AFGHANISTAN	
IF YES, YEARS OF SE	RVICE:	_ COAST GUARD	DISABLED VETERAN		□ MULTIPLE BRANCHES		NIZE DISA		

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SPOU	SE/DEPENDENT INF	ORMATION	
*In the space below, briefly describe the type of "Other" I NOTE: Documentation obligating the applicant or the applica All Dependents must meet eligibility criteria.			dent(s) will be required.
Dependent(s) Name	Gender	Description of Legal Relat	tionship
	☐ Female ☐ Male		· ·
	☐ Female ☐ Male		
	☐ Female ☐ Male		
	☐ Female ☐ Male		
PLEASE NOTE: If any of your Dependent(s), for which you are applying why your Dependent(s) do not live at such address, in the space provided the	ng, do not live at the address listed ided below. If your Dependent(s)	ad in Section B, please indicate name(s), current in live with a custodial parent, please provide name	address(es) and reason(s) e of custodial parent.
NOTICE OF	SPECIAL ENROLLM	IENT RIGHTS	
If you are declining enrollment for yourself or your dependents (includ yourself and your dependents in this plan if you or your dependents other coverage). However, you must request enrollment within 31 do other coverage).	lose eligibility for that other cove ays after you or your dependent	erage (or if the employer stops contributing towal is other coverage ends (or after the employer st	rds you or your dependents tops contributing toward the
In addition, if you have a new dependent as a result of marriage, birth must request enrollment within 31 days after the marriage, birth, ado	, adoption, or placement for adoption, or placement for adoption	ption, you may be able to enroll yourself and you	r dependents. However, you
To request special enrollment or obtain more information, contact our			
DECI	LINATION OF ENROL	LMENT	
☐ I declare that I have coverage under another group health plan or h	nave other health insurance cove	rage and, therefore decline enrollment for myself	and any family dependents
Signature of Applicant [Date Signed Sign	nature of Employer	Date Signed
	FRAUD STATEMEN		
Any person who knowingly and with intent to defraud any insurance false information or conceals for the purpose of misleading, informat such person to criminal and civil penalties.			
	DECLARATIONS		
I hereby apply to the Health Plan for the coverage now being offer to acceptance by the Health Plan, and that if a Subscription Certific Subscription Certificate and/or Rider(s), if applicable. In the event it pursuant to the Subscription Certificate, I authorize the Health Plan to for the Subscription Certificate and/or Rider(s), if applicable, issued to and upon thirty (30) days' prior notice to my employer acting on my beam required to contribute toward the rates for the coverage provided I authorize the Health Plan to electronically transmit the information contains and printing shall be treated as a valid signature for all purposes any applicable law or regulation. The information recorded above is true and correct to the best of my application could constitute grounds for the cancellation of any Subscription.	cate is issued, services will be is determined that one (1) or roprocess this application, omitting me are subject to change by the ehalf. I authorize my employer to under my Subscription Certifical ontained herein. If this application is the Health Plan to print an elect of this form. I acknowledge that knowledge and belief. I underst	available subject to the exclusions, limitations a more of my dependent(s) is/are ineligible for en- ing the names of such ineligible dependent(s). I full e Health Plan, in accordance with terms of the ago o make periodic deductions from my salary or was te and/or Rider(s). In was taken over the phone or on the computer, I tronic acknowledgement on the signature line of the Health Plan has verified my identity for this pand that the intentional misrepresentation of any	and other conditions of the rollment in the Health Plan urther understand that rates preement with my employer, ages of the amount, if any, I acknowledge that I, myself, the application and I agree purpose in accordance with
upon notice and in accordance with applicable law. I represent that I have read this document or it has been read to me,	including the sections titled, "No	ntice of Special Enrollment Rights," "Fraud State	ment" and "Declarations".

Date Signed

Signature of Employer

Date Signed

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Signature of Applicant

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, gencer 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 lingüistica. L'ame al 800-417-4000 (TTY:71f).

注意:如果您使用饕餮中文:您可以免費獲得話言提助服務・清致電 800-447-4000(TTY:7ff)。

CHÚ Ý. Nết, ban nói Tiếng Việt, có các dịch vụ hỗ trở ngôn ngữ miễn phi dành cho ban. Gọi số 800-447-4000 (TTY. 71%.

ВНИМАНИЕ: Если вы говорите на русскои языке, то вам доступны бесплатные услуги перезода. Звоните 800-447-4000 (телетайл: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen koster los sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 800-447-4000 (TTY: 7ff).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-447-4000 (TTY: 71) 번으로 전화해 주십시오.

AFTENZIONE: In caso a lingua parlata sia l'Italiano, sono disponibili servizi di assistenza linguistica gratutti. Chiamare il numero 800-447-4000 (TTY: 7ff).

ملموظة إذا كنت تتحث انكر الغة، فإن خدمك المساعم اللغرية تتوافر الكاباسجان. تسل برقم 800.447.4000 رقم هاتف السم والبكر 711

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés grafuitement. Appelez le 800-447-4000 (ATS : 71).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen ihnen kosterios sprachliche Hifsdienstleistungen zur Verfügung. Rufnummen: 800-447-4000 (TTY: 7ff).

સુચના: જો તમે ગુજરાતી બોલતા ફો, તો નિઃશુલ્ક ભાષા સફાચ સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 800-447-4000 (TTY: 71).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy jezykowej, Zadzwoń pod numer 800-447-4000 (TTY: 711),

ATANSYON: Silw gale Kreyòi Ayisyen, gen sèvis èd pou lang ki disconib gratis coulou. Rele 800 447-4000 (TTY: 71%).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយកាសខ្មែរ, សេវាជំនួយថ្ងែកកាស ដោយមិនអិកល្អល អឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ខ្ពស់ៗ 800.447.4000 (TTY: 7)(។

ATENÇÃO: Se tala português, encontram-se disponíveis serviços linguisticos, crátis, Lique para 800-447-4000 (TTY: 711).

HPM 50 alb: Nondiscrimination dev. 9.12.16 Y0032_16242_2 File and Use 9/2/16