GEISINGER INDEMNITY INSURANCE COMPANY
SUBSCRIBER APPLICATION

M.C. 30-29
100 N. Academy Ave.
Danville, PA 17822

SECTION A. GENERAL ADMINISTRATIVE INFORMATION (for completion by Employer)

1. Group number: _____ 3. Insurance ID number: _____

2. Class:_____ 4. Name of Sales Rep.: _____

5. Effective Date of Change: _____ (MM/DD/YY)

6. This Application is being submitted as a result of : (**Check one**)
   a. ❑ Group Initial Enrollment
   b. ❑ Group Open Enrollment Period
   c. ❑ Employee New Hire
   d. ❑ Change due to Qualifying Event (If you checked this box, please specify type of event and complete Question #7)
      (I) Specify type of event: _____

7. Is the applicant or any eligible dependent(s) of applicant **currently** covered under:
   (a) COBRA? YES ❑ NO ❑
   (b) Mini-COBRA? YES ❑ NO ❑

   If "YES", provide the following information for each person, as applicable:

Name of Covered Person:	End Date of Coverage: (MM/DD/YYYY)	Description of Qualifying Event:

8. Is the applicant or any eligible dependent(s) newly electing coverage under:
   (a) COBRA? YES ❑ NO ❑
   (b) Mini-COBRA? YES ❑ NO ❑

   If "YES", provide the following information for each person, as applicable:

Name of Person:	Start & End Date of Coverage: (MM/DD/YYYY)	Description of Qualifying Event:

SECTION B. APPLICANT INFORMATION (Please Print Clearly)

1. Primary Care Physician (PCP) Name:_____

2. PCP Location (Town): _____ 3. PCP Number:_____

4. Are you an existing patient of selected primary care physician? YES ❑ NO ❑

5. LEGAL NAME (LAST)	6. (MAIDEN NAME)	7. (FIRST)	8. (M.I.)	9. GENDER ❑ FEMALE ❑ MALE

10. ADDRESS (NUMBER) (STREET) (APT NO.)	11. CITY	12. STATE	13. ZIP CODE	14. COUNTY

15. HOME PHONE NUMBER	16. SOCIAL SECURITY NUMBER	17. DATE OF BIRTH MONTH / DAY / YEAR
	_____|_____|_____	

18. EMPLOYER (NAME, CITY, AND PHONE NUMBER)	19. DATE OF EMPLOYMENT	20. GEISINGER MED. REC. # (if any)

21. While covered under this policy, will you or any dependent(s) listed on this application also be covered by Medicare?
YES ❑ NO ❑

If you answered "YES" to this question, provide the following information for each person, as applicable:

Name of Person(s):	Medicare #:	Part A or Part B:	Effective Date:

SECTION B. APPLICANT INFORMATION (Continued)

22. Are you or any dependent(s) listed on this application currently receiving Disability/Workers' Compensation Benefits?
YES ❑ NO ❑

If you answered "YES" to this question, provide the following information for each person, as applicable:

Name of Person(s): Medicare #: Part A or Part B: Effective Date:

_____

_____

_____

_____

_____

23. While covered under this policy, will you or any dependent(s) listed on this application also be covered by other health insurance? YES ❑ NO ❑

If you answered "YES" to this question, provide the following information:

A. NAME OF INSURANCE COMPANY		B. SUBSCRIBER NAME
C. TYPE OF PLAN	D. EFFECTIVE DATE OF COVERAGE (MM/DD/YYYY)	E. INSURANCE I.D. NO. OR SOCIAL SECURITY NO.
F. GROUP NAME (EMPLOYER)		G. GROUP NUMBER ❑ FAMILY PLAN ❑ SELF ONLY

SECTION C. SPOUSE/DEPENDENT INFORMATION

LEGAL NAME	M.I.	LIST LAST NAME IF DIFFERENT FROM APPLICANT	SOCIAL SECURITY NO.	RELATIONSHIP	DATE OF BIRTH	GEISINGER MEDICAL RECORD # (IF ANY)	PRIMARY CARE PHYSICIAN NAME	PRIMARY CARE PHYSICIAN NUMBER	LOCATION (TOWN)
FIRST	M.I.	LAST MAIDEN NAME		☐ HUSBAND ☐ WIFE					
FIRST	M.I.	LAST		☐ SON ☐ DAUGHTER ☐ OTHER*					
FIRST	M.I.	LAST		☐ SON ☐ DAUGHTER ☐ OTHER*					
FIRST	M.I.	LAST		☐ SON ☐ DAUGHTER ☐ OTHER*					
FIRST	M.I.	LAST		☐ SON ☐ DAUGHTER ☐ OTHER*					

*In the space below, briefly describe the type of "Other" legal relationship between the Dependent(s) and yourself.

NOTE: Documentation obligating the applicant or the applicant's spouse, if applicable, to provide healthcare coverage to Dependent(s) will be required. All Dependents must meet eligibility criteria.

Dependent(s) Name	Gender	Description of Legal Relationship
	❑ Female ❑ Male	
	❑ Female ❑ Male	
	❑ Female ❑ Male	
	❑ Female ❑ Male	

PLEASE NOTE: If any of your Dependent(s), for which you are applying, do not live at the address listed in Section B, please indicate name(s), current address(es) and reason(s) why your Dependent(s) do not live at such address, in the space provided below. If your Dependent(s) live with a custodial parent, please provide name of custodial parent.

_____

_____

_____

_____

I understand that this application is subject to acceptance by my employer and that, if accepted, services will be available subject to the exclusions, limitations, and other conditions of my Employer's Health Benefit Plan. I authorize my employer to make periodic deductions from my salary or wages of the amount, if any, I am required to contribute toward the rates for the coverage provided. The information recorded above is true and correct to the best of my knowledge and belief.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim continuing any meterially 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 penalities.

_____ _____ _____ _____

Signature of Employer | Date | Signature of Applicant | Date Signed

Discrimination is Against the Law

Geisinger Indemnity Insurance Company complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, gender identity or sexual orientation. Geisinger Indemnity Insurance Company does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity, or sexual orientation.

Geisinger Indemnity Insurance Company:

- 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 Geisinger Indemnity Insurance Company at 800-447-4000 or TTY: 711.

If you believe that Geisinger Indemnity Insurance Company 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
Phone800–368–1019, 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).