GROUP SUBSCRIBER APPLICATION

M.C. 30-29
100 North Academy Avenue
Danville, PA 17822

GROUP NUMBER	DIVISION NUMBER	INSURANCE ID NUMBER	EFFECTIVE DATE	SALES REP

GENERAL INFORMATION (Please Print or Type)

APPLICANT

Primary Care Physician (PCP) Name ____________________ PCP Location (Town)__________________ PCP Number ___________________

Are you an existing patient of selected primary care physician? ☐ Yes ☐ No

LEGAL NAME (LAST) (MAIDEN NAME)	(FIRST)	(M.I.)	☐ FEMALE ☐ MALE

ADDRESS (NUMBER) (STREET) (APT. NO.)	CITY	STATE	ZIP CODE	COUNTY	PHONE NUMBER

SOCIAL SECURITY NUMBER			DATE OF BIRTH			MARITAL STATUS
			MONTH	DAY	YEAR	☐ MARRIED ☐ SINGLE ☐ DIVORCED/SEPARATED ☐ WIDOWED

EMPLOYER (NAME, CITY, AND PHONE NUMBER)	DATE OF EMPLOYMENT	MEDICAL RECORD NUMBER (if any)

WHILE ENROLLED IN GEISINGER HEALTH PLAN, WILL YOU OR YOUR SPOUSE, IF LISTED ON THIS FORM, ALSO BE COVERED BY:

☐ MEDICARE	YOUR MEDICARE NUMBER	PART A	PART B	SPOUSE'S MEDICARE NUMBER	PART A	PART B

☐ OTHER HEALTH INSURANCE	NAME OF INSURANCE CO.	SUBSCRIBER NAME	☐ FAMILY PLAN ☐ SELF ONLY
	EFFECTIVE DATE OF COVERAGE / I.D. OR SOCIAL SECURITY NO.	GROUP NAME (EMPLOYER)	GROUP NUMBER

DEPENDENT

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

I hereby apply to Geisinger Health Plan for the coverage now being offered for myself and the dependent(s), if any, as shown above. I understand that this application is subject to acceptance by Geisinger Health Plan, and that if a Subscription Certificate is issued, services will be available subject to the exclusions, limitations and other conditions of the Subscription Certificate and/or Rider(s), if applicable. In the event it is determined that one (1) or more of my dependent(s) is/are ineligible for enrollment in Geisinger Health Plan pursuant to the Subscription Certificate, I authorize Geisinger Health Plan to process this application, omitting the names of such ineligible dependent(s). I further understand that rates for the Subscription Certificate and/or Rider(s), if applicable, issued to me are subject to change by Geisinger Health Plan, in accordance with terms of the agreement with my employer, and upon thirty (30) days' prior notice to my employer acting on my behalf. 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 under my Subscription Certificate and/or Rider(s).

The information recorded above is true and correct to the best of my knowledge and belief. I understand that the misrepresentation of any material fact by me on this application could constitute grounds for the cancellation of any Subscription Certificate and/or Rider(s), if applicable, issued by Geisinger Health Plan in consideration of this application.

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 penalities.

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Signature of Applicant Date Signed Signature of Employer Date Signed

PLEASE NOTE: If any of your dependent(s) do not live at the above address, please indicate name(s), current address(es) and reason(s) why your dependent(s) do not live at the above address. If your dependent(s) live with a custodial parent, please provide name of custodial parent.

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