EMPLOYEE SUBSCRIBER APPLICATION AND MEDICAL DISCLOSURE QUESTIONNAIRE

GEISINGER HEALTH PLAN®

GEISINGER CHOICE®

FOR OFFICE USE ONLY				
Group Number	Division Number	Cobra/Mini-Cobra/PHCS	Insurance ID Number	Effective Date

Instructions: In order to avoid delays in the review process, please be sure that each section is fully completed. PRINT CLEARLY.

SECTION A. APPLICANT INFORMATION

LEGAL NAME OF PRIMARY APPLICANT FOR COVERAGE (LAST) (MAIDEN NAME)				(FIRST)	(M.I.)
MAILING ADDRESS (Number) (Street) (Apt. Number)			CITY	STATE / ZIP CODE	COUNTY
PHYSICAL ADDRESS (if different than mailing address)			CITY	STATE / ZIP CODE	COUNTY
SOCIAL SECURITY NUMBER	DATE OF BIRTH	GENDER ☐ Male ☐ Female	HEIGHT Feet Inches	WEIGHT (lbs)	MARITAL STATUS ☐ MARRIED ☐ DIVORCED/SEPARATED ☐ SINGLE ☐ WIDOWED
EMPLOYER (Name, City and Phone Number)		HOME PHONE NUMBER	CELL PHONE NUMBER		EMPLOYMENT STATUS ☐ ACTIVE ☐ COBRA ☐ MINI COBRA
DATE OF EMPLOYMENT	WHEN COVERAGE BEGINS UNDER THIS POLICY, WILL YOU HAVE OTHER INSURANCE? If "YES", complete section E ☐ YES ☐ NO		GEISINGER MEDICAL RECORD NUMBER		COBRA START DATE _____ COBRA END DATE _____

SECTION B. COVERED SPOUSE / DEPENDENT INFORMATION

Note: If there are more than 4 dependents to be covered, please complete a second application on behalf of those individuals and submit both applications together.

LEGAL NAME	SOCIAL SECURITY NUMBER	RELATIONSHIP	DATE OF BIRTH	GENDER	HEIGHT (FEET / INCHES)	WEIGHT	When coverage begins under this policy, will you have other insurance?	GEISINGER MEDICAL RECORD NUMBER
SPOUSE (First) (M.I.) (Last)		☐ SPOUSE ☐ DOMESTIC PARTNER*		☐ FEMALE ☐ MALE	FEET / INCHES	(lbs)	**If Other Medical Coverage Has Been Entered It Will Appear on the Following Page(s)**	
DEPENDENT #1 (First) (M.I.) (Last)		☐ SON ☐ DAUGHTER ☐ OTHER*		☐ FEMALE ☐ MALE	FEET / INCHES	(lbs)		
DEPENDENT #2 (First) (M.I.) (Last)		☐ SON ☐ DAUGHTER ☐ OTHER*		☐ FEMALE ☐ MALE	FEET / INCHES	(lbs)		
DEPENDENT #3 (First) (M.I.) (Last)		☐ SON ☐ DAUGHTER ☐ OTHER*		☐ FEMALE ☐ MALE	FEET / INCHES	(lbs)		
DEPENDENT #4 (First) (M.I.) (Last)		☐ SON ☐ DAUGHTER ☐ OTHER*		☐ FEMALE ☐ MALE	FEET / INCHES	(lbs)		

*Note: Legal documentation (court decree, guardianship papers, affidavit, etc.) must be attached to this application if relationship is "DOMESTIC PARTNER" or "OTHER".

Employee Name: ______________________________ SSN: ________________________________

LEGAL NAME	SOCIAL SECURITY NUMBER	RELATIONSHIP	DATE OF BIRTH	GENDER	HEIGHT	WEIGHT	When coverage begins under this policy, will you have other insurance?	GEISINGER MEDICAL RECORD NUMBER
		☐ SON ☐ DAUGHTER ☐ OTHER*		☐ M ☐ F	Feet / Inches		**If Other Medical Coverage Has Been Entered It Will Appear on the Following Page(s)**	
		☐ SON ☐ DAUGHTER ☐ OTHER*		☐ M ☐ F	Feet / Inches			
		☐ SON ☐ DAUGHTER ☐ OTHER*		☐ M ☐ F	Feet / Inches			
		☐ SON ☐ DAUGHTER ☐ OTHER*		☐ M ☐ F	Feet / Inches			
		☐ SON ☐ DAUGHTER ☐ OTHER*		☐ M ☐ F	Feet / Inches			
		☐ SON ☐ DAUGHTER ☐ OTHER*		☐ M ☐ F	Feet / Inches			
		☐ SON ☐ DAUGHTER ☐ OTHER*		☐ M ☐ F	Feet / Inches			
		☐ SON ☐ DAUGHTER ☐ OTHER*		☐ M ☐ F	Feet / Inches			
		☐ SON ☐ DAUGHTER ☐ OTHER*		☐ M ☐ F	Feet / Inches			
		☐ SON ☐ DAUGHTER ☐ OTHER*		☐ M ☐ F	Feet / Inches			
		☐ SON ☐ DAUGHTER ☐ OTHER*		☐ M ☐ F	Feet / Inches			
		☐ SON ☐ DAUGHTER ☐ OTHER*		☐ M ☐ F	Feet / Inches			
		☐ SON ☐ DAUGHTER ☐ OTHER*		☐ M ☐ F	Feet / Inches			
		☐ SON ☐ DAUGHTER ☐ OTHER*		☐ M ☐ F	Feet / Inches			
		☐ SON ☐ DAUGHTER ☐ OTHER*		☐ M ☐ F	Feet / Inches			

SECTION C. MEDICAL INFORMATION

Instructions:
(a) Identify dependents in the same order as noted in Section B.
(b) Indicate "YES" or "NO" if any person listed on this application has ever received diagnosis or treatment by a licensed healthcare professional for any of the conditions listed below and **CIRCLE** the specified condition(s) that apply. **ALL QUESTIONS MUST BE CHECKED WITH A "YES" OR "NO" RESPONSE**.
(c) For each "YES", complete Section D on page 3.

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

Conditions: (circle the specified condition(s) that apply)	All Members	
Name:		
	YES	NO
1. Aids, HIV, reactive, or any immune suppressed illness		
2. Alcoholism or drug abuse		
3. Emphysema, COPD, cystic fibrosis, asthma or allergies		
4. Aneurysm (aortic or cerebral), blood clot, TIA (mini-stroke) or stroke		
5. Arthritis (osteo, rheumatoid, other) joint replacement, joint pain, lupus, fibromyalgia, fractures or limb loss		
6. Neck or back pain, disorders of the spine, disc herniation or bulging disc		
7. Any blood disorder such as anemia or hemophilia		
8. Ulcerative colitis, Crohn's Disease, diverticulitis, stomach ulcers, acid reflux, GERD, hernia, gallbladder or rectal disorders		
9. Cancer, leukemia, tumor or cyst (list type, stage and location - give full details on next page)		
10. Convulsions, epilepsy or paralysis		
11. Diabetes - type I or II		
12. Hypothyroid, hyperthyroid, goiter, pituitary disorders, pancreas disorders, glandular disorders or disorders requiring growth hormones		
13. Eye conditions such as, cataracts, macular degeneration (excluding glasses & contacts)		
14. Migraines		
15. Heart surgery (angioplasty, stent or bypass), heart disease, implanted pace maker or defibrillator, irregular heartbeat, heart murmur, heart regurgitation, chest pain, congestive heart failure or mitral valve prolapse		
16. High blood pressure, and/or high cholesterol		
17. Kidney (failure or dialysis), kidney stones		
18. Hepatitis type (A, B, C, D) or autoimmune hepatitis or other liver disorder/disease		
19. Menstrual problems, endometriosis, polycystic ovaries		
20. Depression, anxiety, ADD, ADHD, psychotic disorder		
21. Is any female to be covered currently pregnant? Due date_____ (MM/DD/YY) If pregnant, please give details on the next page to include any complications		
22. Bladder, prostate, testicular, uterine or breast condition		
23. Skin disease (psoriasis, acne, other)		
24. Cigarette or tobacco use		
25. Any stem cell or organ transplant (planned, recommended, or already performed)		
26. Any hospitalizations in the last 5 years (give full details on next page)		
27. Any future surgeries discussed, planned or recommended (give full details on next page)		
28. Currently taking any prescription medicines? (give full details on next page to include name of the medication and condition for which medication is needed)		
29. Are there any other medical conditions not listed above? (give full details on next page)		

SECTION D. MEDICAL DETAIL

Person's Name	Question Number	Specific Medical Conditions/Diagnosis	Date of Diagnosis	Surgery Yes or No	Was treatment resolved or is ongoing treatment required? Please explain treatment and prognosis	Medication / Prescription Name*	Medication Dosage Amt/Freq, Oral Injections, Infusion, Inhaled	Are you currently taking this medication? Yes or No

If Medical Information Has Been Entered It Will Appear on the Following Page(s)

*For questions regarding the coverage of specific prescription medication, please visit www.thehealthplan.com or call your authorized GHP Broker or sales rep.

SECTION E. OTHER INSURANCE - When coverage begins under this policy, you have indicated that you and/or your dependent(s) will have other insurance. Please complete this section.

If Other Medical / Medicare Coverage Has Been Entered It Will Appear on the Previous Page(s)

SECTION F. ADDITIONAL INFORMATION

Use this section to provide additional information for persons listed on this application.

SECTION G. DECLARATIONS

I hereby apply 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 ("GHP") or Geisinger Quality Options ("GQO"), as applicable, 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, and any susequent amendments to those documents (referred to hereafter as Certificate and/or Rider(s)). In the event it is determined that one (1) or more of my dependent(s) is/are ineligible for enrollment pursuant to the applicable Certificate, I authorize GHP or GQO, as applicable, to process this application, omitting the names of such ineligible dependent(s). I further understand that rates for the Certificate and/or Rider(s), if applicable, issued to me are subject to change by GHP or GQO, as applicable, in accordance with the terms and agreement with my employer, and upon thirty (30) days prior notice to my employer acting on my behalf, or as permitted by law. 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 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 Certificate and/or Rider(s), if applicable, issued by GHP or GQO, as applicable, in consideration of this application. I also understand that this application for coverage may not be processed if I fail to complete any portion.

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.

_____ _____

DATE SIGNED SIGNATURE OF APPLICANT

This Questionnaire must be completed and signed within 90 days of the group's effective date.