

DEPENDENT CERTIFICATION FORM



100 North Academy Avenue
Danville, PA 17822-3029

Date:

Dear Subscriber:

As a requirement for determination of eligibility, it is necessary for us to verify that your dependent, _____, is eligible for coverage under Geisinger Health Plan.

If your dependent is a full-time student, disabled or a dependent for whom you or your spouse have legal custody or legal guardianship, the Plan will regularly request verification that he or she remains eligible for coverage. Please complete the appropriate sections on the enclosed Dependent Certification Form and return it in the enclosed envelope within thirty one (31) days of the date of this letter.

Please use the following directions to complete the form:

1. **Legal Custody/Legal Guardianship** – The Subscriber must complete Sections I, II and III and attach a copy of the court document verifying legal custody or legal guardianship.
2. **Full-Time Student** – The subscriber must complete Sections I, II and IV.
3. **Disabled Dependent** – The subscriber must complete Sections I and II. It is necessary for the dependent's **Primary Care Physician** to complete Section V.

If your dependent is currently enrolled and we do not receive this form completed along with the applicable documentation within thirty one (31) days of the date of this letter, your dependent will be disenrolled. He or she may be eligible for Geisinger Health Plan coverage through a direct-pay non-group policy or through conversion. To obtain further information on coverage options, contact the Customer Service Team at the number listed on the back of your identification card. Your dependent may also be eligible for continued coverage under the Consolidated Omnibus Reconciliation Act (COBRA). You will need to contact your employer to determine if this is an option.

If this is an initial request to enroll your dependent, we will be unable to proceed with processing your child's enrollment without this completed form.

Your cooperation in this matter is imperative for coverage of your dependent.

Sincerely,

HMO Customer Service Team
Geisinger Health Plan



DEPENDENT CERTIFICATION FORM

(PLEASE PRINT OR TYPE)

SUBSCRIBER	SECTION I. GENERAL INFORMATION					
	LEGAL NAME (LAST)	(MAIDEN NAME)	(FIRST)	(M.I.)		
	ADDRESS (NUMBER)	(STREET)	(APT. NO.)	(CITY)	(STATE)	(ZIP)
	SOCIAL SECURITY NUMBER	DATE OF BIRTH		GROUP NUMBER		INSURANCE ID NUMBER

DEPENDENT	SECTION II.												
	LEGAL NAME		SOCIAL SECURITY NUMBER			RELATIONSHIP	DATE OF BIRTH			GEISINGER MEDICAL RECORD NUMBER (if any)	MARITAL STATUS	DATE OF MARRIAGE	
	FIRST	M.I.	LAST			<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER <input type="checkbox"/> STEP	MONTH	DAY	YEAR		<input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED		
			MAIDEN NAME										

WHILE ENROLLED IN GEISINGER HEALTH PLAN WILL DEPENDENT ALSO BE COVERED BY:												
<input type="checkbox"/> MEDICARE	YOUR MEDICARE NUMBER		PART A		PART B		SPOUSE'S MEDICARE NUMBER		PART A		PART B	
<input type="checkbox"/> OTHER HEALTH INSURANCE	NAME OF INSURANCE CO.				SUBSCRIBER NAME				<input type="checkbox"/> FAMILY PLAN <input type="checkbox"/> SELF ONLY			
	EFFECTIVE DATE OF COVERAGE				I.D. OR SOCIAL SECURITY NO.				GROUP NAME (EMPLOYER)		GROUP NUMBER	

Is dependent employed: YES NO IF YES, FULL-TIME PART-TIME SCHOOL VACATION ONLY

Member is chiefly (more than 50%) dependent on subscriber for support and maintenance YES NO

Do you claim this dependent as an income tax exemption? YES NO

PLEASE NOTE: IF THE ABOVE NAMED DEPENDENT LIVES WITH A CUSTODIAL PARENT, PLEASE PROVIDE THE NAME AND ADDRESS OF THE CUSTODIAL PARENT IN THE SPACE BELOW.

DEPENDENT	SECTION III. LEGAL CUSTODIANSHIP/LEGAL GUARDIANSHIP	
	The subscriber or the subscriber's spouse is:	
	<input type="checkbox"/> LEGAL CUSTODIAN of the dependent listed above. <input type="checkbox"/> LEGAL GUARDIAN of the dependent listed above.	
	*Please attach a copy of the court order document appointing the subscriber/subscriber's spouse as legal guardian/legal custodian.	

SECTION IV.	STUDENT DEPENDENT CERTIFICATION
Name of accredited school in which dependent is enrolled _____	
Address of accredited school _____	
Type of school * <input type="checkbox"/> UNIVERSITY <input type="checkbox"/> COLLEGE <input type="checkbox"/> HIGH SCHOOL <input type="checkbox"/> TRADE *Correspondence school is not accepted	
Student considered <input type="checkbox"/> FULL-TIME STUDENT <input type="checkbox"/> PART-TIME STUDENT	
Beginning date of school term ____ MO. ____ YR. Expected date of graduation ____ MO. ____ YR.	

SECTION V.	DISABLED DEPENDENT CERTIFICATION						
Is dependent incapable of self-sustaining employment by reason of disability resulting from a mental or physical disability which meets the criteria under Medicare definitions? <input type="checkbox"/> YES <input type="checkbox"/> NO							
Explanation of disabilities _____ _____ _____							
<div style="writing-mode: vertical-rl; transform: rotate(180deg); font-weight: bold; font-size: small;">PRIMARY CARE PHYSICIAN</div>	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 40%; border-bottom: 1px solid black; text-align: center;">Name of Primary Care Physician</td> <td style="width: 35%; border-bottom: 1px solid black; text-align: center;">Physician's Signature</td> <td style="width: 25%; border-bottom: 1px solid black; text-align: center;">Date</td> </tr> <tr> <td colspan="3" style="border-bottom: 1px solid black; text-align: center;">Address of Physician</td> </tr> </table>	Name of Primary Care Physician	Physician's Signature	Date	Address of Physician		
Name of Primary Care Physician	Physician's Signature	Date					
Address of Physician							

GEISINGER HEALTH PLAN OFFICE USE ONLY		
<input type="checkbox"/> APPROVED <input type="checkbox"/> DISAPPROVED		
Name	Signature	Effective Date

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, Agreement 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 penalties.

Signature of Applicant	Date Signed	Signature of Employer (if applicable)	Date Signed
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