

GROUP SUBSCRIBER APPLICATION

GROUP NUMBER	DIVISION NUMBER	INSURANCE ID NUMBER	EFFECTIVE DATE	SALES REP
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GENERAL INFORMATION (Please Print or Type)

APPLICANT

LEGAL NAME (LAST)		(MAIDEN NAME)		(FIRST)			(M.I.)	<input type="checkbox"/> FEMALE <input type="checkbox"/> MALE
ADDRESS (NUMBER)	(STREET)	(APT. NO.)	CITY	STATE	ZIP CODE	COUNTY	PHONE NUMBER	
SOCIAL SECURITY NUMBER		DATE OF BIRTH			MARITAL STATUS			
		MONTH	DAY	YEAR	<input type="checkbox"/> MARRIED	<input type="checkbox"/> SINGLE	<input type="checkbox"/> DIVORCED/SEPARATED	<input type="checkbox"/> WIDOWED
EMPLOYER (NAME, CITY, AND PHONE NUMBER)					DATE OF EMPLOYMENT		MEDICAL RECORD NUMBER (if any)	
WHILE ENROLLED IN GEISINGER CHOICE PPO WITH NO REFFERAL, WILL YOU OR YOUR SPOUSE, IF LISTED ON THIS FORM, 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		

DEPENDENT

LEGAL NAME	LIST LAST NAME IF DIFFERENT FROM APPLICANT		SOCIAL SECURITY NO.	RELATIONSHIP	DATE OF BIRTH	MEDICAL RECORD NUMBER (if any)
FIRST	M.I.	LAST		<input type="checkbox"/> HUSBAND <input type="checkbox"/> WIFE		
		MAIDEN NAME				
FIRST	M.I.	LAST		<input type="checkbox"/> (STEP) <input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER		
FIRST	M.I.	LAST		<input type="checkbox"/> (STEP) <input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER		
FIRST	M.I.	LAST		<input type="checkbox"/> (STEP) <input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER		
FIRST	M.I.	LAST		<input type="checkbox"/> (STEP) <input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER		

I hereby apply to Geisinger Quality Options, Inc. 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 Quality Options, Inc., 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 Choice PPO with no Referral pursuant to the Subscription Certificate, I authorize Geisinger Quality Options, Inc. 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 Quality Options, Inc., 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 Quality Options, Inc. 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	Date Signed
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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.

*White - Geisinger Quality Options, Inc.
c/o Geisinger Choice PPO with no Referral*

Yellow - Employer

Pink - Applicant