

SECTION C. SPOUSE/DEPENDENT INFORMATION

| LEGAL NAME | LIST LAST NAME IF DIFFERENT FROM APPLICANT | | | SOCIAL SECURITY NO. | RELATIONSHIP | DATE OF BIRTH | GEISINGER MEDICAL RECORD # |
|--------------|--|------|-------------|---------------------|--|---------------|----------------------------|
| SPOUSE | (FIRST) | M.I. | LAST | | <input type="checkbox"/> HUSBAND | | |
| | | | MAIDEN NAME | | <input type="checkbox"/> WIFE | | |
| DEPENDENT #1 | (FIRST) | M.I. | LAST | | <input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER <input type="checkbox"/> OTHER* | | |
| DEPENDENT #2 | (FIRST) | M.I. | LAST | | <input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER <input type="checkbox"/> OTHER* | | |
| DEPENDENT #3 | (FIRST) | M.I. | LAST | | <input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER <input type="checkbox"/> OTHER* | | |
| DEPENDENT #4 | (FIRST) | M.I. | LAST | | <input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER <input type="checkbox"/> 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 health care coverage to Dependent(s) will be required. All Dependents must meet eligibility criteria.

| | |
|--------------------|------------------------------------|
| Dependent(s) Name: | Description of Legal Relationship: |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

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 the above address, in the space provided below. If your Dependent(s) live with a custodial parent, please provide name of custodial parent.

SECTION D. DECLARATIONS

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 |
|---------------------------------|----------------------|--------------------------------|----------------------|