

SMALL BUSINESS SUBSCRIBER APPLICATION AND MEDICAL DISCLOSURE QUESTIONNAIRE

FOR OFFICE USE ONLY

GROUP NUMBER	DIVISION NUMBER	EFFECTIVE DATE	INSURANCE ID NUMBER	SALES REP	S	S+	SIGNATURE AND DATE MEDICAL DIRECTOR OFFICE
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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? <input type="checkbox"/> Yes <input type="checkbox"/> No											
	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			HEIGHT	WEIGHT		MARITAL STATUS		
										<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 HEALTH PLAN, 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 COMPANY				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				

LEGAL NAME	LIST LAST NAME IF DIFFERENT FROM APPLICANT		SOCIAL SECURITY NUMBER	RELATIONSHIP	DATE OF BIRTH			HEIGHT	WEIGHT	MEDICAL RECORD NUMBER (if any)	PRIMARY CARE PHYSICIAN NAME	PRIMARY CARE PHYSICIAN NUMBER	LOCATION (TOWN)
	FIRST	M.I.			LAST								
		MAIDEN NAME		<input type="checkbox"/> HUSBAND <input type="checkbox"/> WIFE									
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									
FIRST	M.I.	LAST		<input type="checkbox"/> (STEP) <input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER									



Wilkes-Barre Telemarketing
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DIRECTIONS: INCLUDE INFORMATION ONLY FOR THOSE APPLYING FOR COVERAGE ON THIS POLICY. BE SURE TO FILL OUT ENTIRE SHEET OR IT WILL BE RETURNED FOR COMPLETION, WHICH WILL DELAY THE REVIEW. IF YOU HAVE ANY QUESTIONS, **CALL 1-800-554-4907.**

PLEASE INDICATE "YES" OR "NO" IF ANY PERSON LISTED HAS RECEIVED MEDICAL ADVICE OR BEEN TREATED BY A HEALTHCARE PROFESSIONAL FOR ANY OF THE FOLLOWING CONDITIONS WITHIN THE PAST 180 DAYS:								
CONDITION	YES	NO	CONDITION	YES	NO	CONDITION	YES	NO
AIDS			DRUG ABUSE			LUNG TROUBLE		
ALCOHOLISM			ENDOCRINE/GLANDULAR DISORDERS			MENSTRUAL PROBLEMS		
ALLERGY			EYE PROBLEM <small>(EXCLUDING CORRECTIVE LENSES)</small>			NERVOUS CONDITION		
ARTERY OR VEIN PROBLEM			GALL BLADDER TROUBLE			PREGNANCY (due date _____)		
ARTHRITIS			HEADACHES			PROSTATE OR URINARY TROUBLE		
ASTHMA			HEART TROUBLE			PSYCHIATRIC PROBLEM		
BACK TROUBLE			HERNIA			SKIN DISEASE		
BLOOD DISORDERS			HIGH BLOOD PRESSURE			STOMACH OR DUODENAL ULCERS		
BOWEL TROUBLE			HIV REACTIVE			STROKE OR PARALYSIS		
CANCER			IMMUNE DISORDER			OTHER _____		
CATARACT(S)			JOINT PROBLEMS			OTHER _____		
CONVULSIONS			KIDNEY DISEASE			OTHER _____		
DIABETES			LIVER TROUBLE			DO YOU SMOKE?		

IF YOU CHECKED "YES" TO ANY OF THE ABOVE CONDITIONS, OR IF **YOU OR ANYONE** LISTED HAS HAD MEDICAL OR SURGICAL ADVICE, TREATMENT OR HOSPITAL CARE FOR CONDITIONS NOT LISTED ABOVE, **PLEASE GIVE DETAILS BELOW.**

FIRST NAME	ILLNESS OR CONDITION	DATE	OPERATION (Yes or No)	MEDICATIONS	PHYSICIAN/HOSPITAL

Are you currently receiving Disability/Worker's Compensation Benefits? ___ YES ___ NO

Condition _____

List any medications or treatment anyone listed is now receiving:

FIRST NAME:	MEDICATIONS:	TREATMENTS:

GEISINGER HEALTH PLAN PRE-EXISTING CONDITION LIMITATION DISCLOSURE STATEMENT

NOTICE: The following question must be answered: Do you understand that Geisinger Health Plan will not provide coverage during the first twelve (12) months of enrollment for health care services required for the treatment of any disease or physical condition which required medical advice or treatment within one hundred eighty (180) days prior to enrollment?

Geisinger Health Plan health benefits, for which you are applying, have a pre-existing condition exclusion. It is important that you fully understand the coverage limitations of this plan. Your signature certifies your understanding and acceptance of the conditions and limitations of this policy.

Pre-Existing Conditions Limitation Period:

If you have received medical advice or treatment for any condition in the past one hundred eighty (180) days, you probably have a pre-existing condition. Your coverage under this plan may be limited during the first twelve (12) months of coverage after your enrollment.

Geisinger Health Plan will not cover non-primary care services obtained during the first (12) months of coverage after enrollment, when the services are related to a disease, illness, injury or physical condition for which you have been recommended or received medical advice, treatment (including diagnostic services) or care within one hundred eighty (180) days immediately prior to enrollment in this plan.

The pre-existing condition limitation period does not apply to primary care services. Visits to your primary care physician and/or any routine diagnostic testing performed by your primary care physician will be covered even if it is determined to be related to a pre-existing condition.

If you are intending to obtain this insurance for purposes of covering medical services which you anticipate as a result of a recent disease, illness, injury, or physical condition for which you have been recommended or received medical advice, the services will not be covered for a twelve (12) month period. You will be given credit towards the twelve (12) month limitation period if you can demonstrate that you have had comprehensive medical insurance coverage with no lapse in coverage of sixty-three (63) consecutive days or more preceding the effective date of this policy. Each day of appropriate medical insurance coverage that meets certain requirements will shorten the period of the pre-existing condition exclusion by one (1) day.

You may shorten the exclusion by providing Geisinger Health Plan with evidence of your prior medical insurance coverage. You should also provide information on any waiting periods that have applied to you (including any waiting period between the date you applied for an individual health insurance policy and the date coverage under that policy actually began).

You may have already received a certificate with information about prior creditable coverage from your prior employer, insurer or other health benefits provider. This certificate is extremely useful for demonstrating such coverage (attach the certificate of creditable coverage obtained from your previous employer or insurer). If you do not have such a certificate, you have the right to request one (within twenty-four (24) months after coverage ceases). At your request, Geisinger Health Plan will help you obtain this certificate.

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, and any subsequent 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 in Geisinger Health Plan pursuant to the 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 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, 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).

I acknowledge that the pre-existing conditions limitation, as identified herein, conforms with my understanding of the program. I fully understand the implications of a pre-existing condition limitation period and its potential impact on me and any dependents currently listed on this application, as well as any dependents that subsequently apply for coverage.

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 Geisinger Health Plan 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.

IMPORTANT

Have you or any of your dependents who are listed on this application had any prior health insurance coverage in the previous eighteen (18) months? Yes No If yes, please list those individuals below and enclose proof of that coverage, such as a copy of the insurance card, certificate of coverage or premium statement from previous carrier. This information will be used to determine the length of your pre-existing condition exclusion period.

Applicant or Dependents Name

Name of Previous Carrier

Date Signed

Signature of Applicant

THANK YOU FOR CHOOSING GEISINGER HEALTH PLAN.