



**Geisinger Health Options**  
**100 North Academy Avenue**  
**Danville, PA 17822-3027**

**FOR OFFICE USE ONLY**

|              |                     |              |                |     |
|--------------|---------------------|--------------|----------------|-----|
| Group Number | Insurance ID Number | Benefit Code | Effective Date | Rep |
|--------------|---------------------|--------------|----------------|-----|

**SUBSCRIBER APPLICATION**

(Please Print or Type)

APPLICANT PRIMARY CARE SITE NO. \_\_\_\_\_ (Please Note Dependent Primary Care Location No. Below)

|                   |               |       |      |                |
|-------------------|---------------|-------|------|----------------|
| Legal Name (last) | (Maiden Name) | First | M.I. | Female<br>Male |
|-------------------|---------------|-------|------|----------------|

|                  |      |       |          |        |       |
|------------------|------|-------|----------|--------|-------|
| (Address) Street | City | State | Zip Code | County | Phone |
|------------------|------|-------|----------|--------|-------|

|                        |               |  |
|------------------------|---------------|--|
| SOCIAL SECURITY NUMBER | DATE OF BIRTH | MARITAL STATUS                                       |
|                        | Mo. Day Year  | Married Single Divorced/Seperated Widowed Common Law |

|   |                    |                             |
|---|--------------------|-----------------------------|
| Employer (Name, City and Telephone No.) | Date of Employment | Medical Record No. (If Any) |
|---|--------------------|-----------------------------|

Have you or any dependent(s) ever been at a Geisinger Site? YES \_\_\_ NO \_\_\_ If Yes, Where? \_\_\_\_\_  
 (If more than one, please attach a separate sheet of paper.)

To assist in coordinating benefits, please answer the following questions:

WHILE ENROLLED, WILL YOU OR YOUR SPOUSE, IF LISTED ON THIS FORM, ALSO BE COVERED BY:

|                        |                            |                           |                       |                          |           |        |
|------------------------|----------------------------|---------------------------|-----------------------|--------------------------|-----------|--------|
| Medicare               | Your Medicare Number       | Part A                    | Part B                | Spouse's Medicare Number | Part A    | Part B |
| Other Health Insurance | Name of Insurance          | Subscriber                |                       | Family Plan              | Self Only |        |
|                        | Effective Date of Coverage | I.D. or Soc. Security No. | Group Name (Employer) |                          | Group No. |        |

**DEPENDENT INFORMATION**

| Legal Name    | List Last Name if Different from Applicant | Soc. Sec. No. | Relationship | D.O.B. | Medical Record Number (if any) | Primary Care Source |
|---------------|--|---------------|--------------|--------|--------------------------------|---------------------|
| First MI Last | Maiden Name                                |               |              |        |                                |                     |
| First MI Last |  |               |              |        |                                |                     |
| First MI Last |  |               |              |        |                                |                     |
| First MI Last |  |               |              |        |                                |                     |
| First MI Last |  |               |              |        |                                |                     |

I understand that this application is subject to acceptance by my employer and that, if accepted, services will be available subject to the exclusions, limitations, and other conditions of my Employer's Health Benefit Plan, 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. I authorize and request any hospital, clinic, institution, physician, or other person to furnish Geisinger Health Options full particulars of diagnosis, treatment, medical history and related information about myself and/or any dependent enrolled above, but only as necessary for the determination of claims or requests for services or benefits under my Employer's Health Benefit Plan or for establishment and maintenance of proper medical records for myself and enrolled dependents, if any. 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.

The information recorded above is true and correct to the best of my knowledge and belief.

Signature of Employer: \_\_\_\_\_  
 Signature of Applicant: \_\_\_\_\_

Date: \_\_\_\_\_

**PLEASE NOTE:** If any of the above listed dependents do not live at home, please indicate why (i.e. college) name(s) and address(es) below.

---



---