

LUZERNE COUNTY COURTHOUSE HEALTH INSURANCE FORM

(Please Print)

LAST NAME _____ FIRST NAME _____ M.I. _____ SEX (M or F) _____

STREET _____ CITY _____ PA _____ ZIP _____

SS# _____ DATE OF BIRTH _____ HOME PHONE _____

HIRE DATE _____ DEPARTMENT _____ UNION _____ *PCPNAME _____

JOB CLASSIFICATION _____ ANNUAL SALARY _____

MARITAL STATUS: SINGLE MARRIED SEPARATED DIVORCED WIDOWED
(CIRCLE ONE)

SPOUSE LAST NAME _____ FIRST _____ M.I. _____ *PCNAME _____

SS# _____ DATE OF BIRTH _____ SEX (M or F) _____

Please list below any unmarried dependent children age 23 and under. Answer yea or no concerning full-time College student status for children between ages 19 and 23.

	LAST NAME	FIRST NAME	M.I.	SEX	DOB	SS#	*PCP NAME	FULL-TIME COLLEGE
1.	_____	_____	_____	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____	_____	_____	_____
5.	_____	_____	_____	_____	_____	_____	_____	_____

List the primary care physician (PCP) name for you and each family member

CHECK PLAN TO BE COVERED UNDER

* FIRST PRIORITY _____ * GEISINGER _____ OPT – OUT INSURANCE _____
(Proof of group coverage required)

SELF PAY DENTAL – DELTA DENTAL

(CHECK ONE) INDIVIDUAL COVERAGE _____ FAMILY COVERAGE _____ NO PRE-TAX _____

NOTE: New enrollments are subject to two initial double deductions, then reduced to the regular rate. Deductions will be pre-taxed unless specified otherwise.

VISION (DAVIS VISION)

(CHECK ONE) INDIVIDUAL COVERAGE _____ FAMILY COVERAGE (if applicable) _____

EMPLOYEE SIGNATURE _____ DATE _____