SUBSCRIBER APPLICATION CHANGE FORM

Effective Date of Change ___/___/___

GEISINGER HEALTH PLAN®
M.C. 30-29
100 NORTH ACADEMY AVENUE
DANVILLE, PA 17822

☐ **Check if you are a member of Geisinger Health Plan Gold**

SUBSCRIBER

GROUP NUMBER DIVISION NUMBER INSURANCE I.D. NUMBER

LEGAL NAME (LAST) (FIRST) (M.I.)

ADDRESS (NUMBER) (STREET) (APT. NO.)

CITY STATE ZIP CODE

COUNTY

SOCIAL SECURITY NUMBER

CHANGES:

Check which change(s) apply:

☐ Adding Dependent(s)
☐ Name Change

_____
(Previous last name)

☐ Address Change
☐ New Home Telephone Number
(_____)_____
☐ Changing Primary Care Physician

Reason for PCP Change:
(check one)

☐ Medical care dissatisfaction
☐ Access dissatisfaction
☐ Provider service dissatisfaction
☐ Failure to establish relationship
☐ PCP leaves the Health Plan
☐ PCP moves
☐ Error in PCP selection
☐ Convenience

DISENROLLMENT

Check which reason may apply

☐ **SUBSCRIBER** **OR** ☐ **DEPENDENT**

☐ Termination of employment (TE)
☐ Lay off (LO)
☐ Leave of absence (LA)
☐ Reduction in work hours (RH)
☐ Retired (RT)
☐ Moved out of service area (OA)
☐ Deceased (DD)
(Date of Death)___/___/___
☐ Personal preference (PP)
☐ Dissatisfaction with Plan (DI)
☐ Non payment of premium
☐ Selected other insurance (SO)
☐ Open enrollment ___/___/___ (OE)
☐ Loss of dependent status (LS)

SUBSCRIBER AND DEPENDENT CHANGES (PLEASE PRINT OR TYPE)									CHECK REASON (NOTE DATE)						
CHECK ONE		LEGAL NAME				BIRTHDATE			RELATION-SHIP TO SUBSCRIBER	DATE OF MAR-RIAGE	DATE OF DIVORCE	OTHER CHANGE OF STATUS	SOCIAL SECURITY NUMBER	MEDICAL RECORD NUMBER	PRIMARY CARE PHYSICIAN NAME/ LOCATION (TOWN)
ADD	RE-MOVE	LAST	FIRST	MAIDEN NAME	M.I.	MO.	DAY	YR.							

I HEREBY apply for amendment of my subscriber application.
IT is mutually agreed as follows: That these changes shall not become effective unless and until accepted by the Plan. That this application for change in coverage will become a part of my original application and if accepted will be subject to THE TERMS OF A CERTIFICATE OR AGREEMENT in effect with the Plan.
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.

_____ _____ _____ _____
SUBSCRIBER SIGNATURE DATE SIGNED GROUP BENEFITS ADMINISTRATOR / GROUP NAME (if applicable) DATE SIGNED