



DEPENDENT CERTIFICATION FORM

PURPOSE OF FORM: The purpose of this Dependent Certification Form is to verify eligibility of proposed new Dependent enrollees and/or existing Dependent enrollees under Geisinger Health Plan.

INSTRUCTIONS

Please complete this Dependent Certification Form on behalf of any named Dependents (age 19 years and older), excluding spouses, who you have listed on your application for healthcare coverage under the Geisinger Health Plan.

- Return the fully-completed form in the enclosed envelope within thirty-one (31) days of the following date: _____.

First Time Enrollees:

- Please note that your family member's enrollment will not be able to be finalized until we receive this completed form.

Current Enrollees:

- Please note that if we do not receive this completed form, along with the applicable documentation, within 31 days of the date noted above, your family member will be disenrolled.
- If disenrolled, he or she may be eligible for coverage through a Geisinger Health Plan direct-pay non-group policy or through conversion. To obtain further information on coverage options, contact the Customer Service Team at the number listed on the back of your identification card. Your family member may also be eligible for continued coverage under the Consolidated Omnibus Reconciliation Act (COBRA). You will need to contact your employer, if applicable, to determine if this is an option.

For questions concerning the completion of this form, please contact the Customer Service Team at the number listed on the back of your Identification Card.

DEPENDENT CERTIFICATION FORM

(PLEASE PRINT OR TYPE)

SECTION A. SUBSCRIBER INFORMATION													
1. LEGAL NAME (LAST)				2. (MAIDEN NAME)				3. (FIRST)			4. (M.I.)		
5. ADDRESS (NUMBER)			(STREET)			(APT. NO.)		6. (CITY)			7. (STATE)	8. (ZIP)	
9. SOCIAL SECURITY NUMBER			10. DATE OF BIRTH			11. GROUP NUMBER			12. INSURANCE ID NUMBER				
13. While enrolled in Geisinger Health Plan, will Subscriber also be covered by Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No													
13a. If yes, please provide your Medicare number: _____													
13b. <input type="checkbox"/> PART A <input type="checkbox"/> PART B (Check one, as applicable)													

SECTION B. DEPENDENT INFORMATION (Attach additional sheets as necessary.)																
DEPENDENT #1																
LEGAL NAME				5. SOCIAL SECURITY NUMBER			6. RELATIONSHIP			7. DATE OF BIRTH		8. GEISINGER MEDICAL RECORD NUMBER (if any)		9. MARITAL STATUS	10. DATE OF MARRIAGE	
1. FIRST	2. M.I.	3. LAST		4. MAIDEN NAME					<input type="checkbox"/> SON				<input type="checkbox"/> SINGLE			
									<input type="checkbox"/> DAUGHTER				<input type="checkbox"/> MARRIED			
									<input type="checkbox"/> STEP							
11. Is dependent employed: <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, <input type="checkbox"/> FULL-TIME <input type="checkbox"/> PART-TIME <input type="checkbox"/> SCHOOL VACATION ONLY																
12. Dependent is chiefly (more than 50%) dependent on Subscriber for support and maintenance <input type="checkbox"/> YES <input type="checkbox"/> NO																
13. Do you claim this dependent as an income tax exemption? <input type="checkbox"/> YES <input type="checkbox"/> NO																
14. Is Dependent covered by Medicare? <input type="checkbox"/> YES <input type="checkbox"/> NO If Yes, provide Medicare number _____ <input type="checkbox"/> Part A <input type="checkbox"/> Part B																
DEPENDENT #2																
LEGAL NAME				5. SOCIAL SECURITY NUMBER			6. RELATIONSHIP			7. DATE OF BIRTH		8. GEISINGER MEDICAL RECORD NUMBER (if any)		9. MARITAL STATUS	10. DATE OF MARRIAGE	
1. FIRST	2. M.I.	3. LAST		4. MAIDEN NAME					<input type="checkbox"/> SON				<input type="checkbox"/> SINGLE			
									<input type="checkbox"/> DAUGHTER				<input type="checkbox"/> MARRIED			
									<input type="checkbox"/> STEP							
11. Is dependent employed: <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, <input type="checkbox"/> FULL-TIME <input type="checkbox"/> PART-TIME <input type="checkbox"/> SCHOOL VACATION ONLY																
12. Dependent is chiefly (more than 50%) dependent on Subscriber for support and maintenance <input type="checkbox"/> YES <input type="checkbox"/> NO																
13. Do you claim this dependent as an income tax exemption? <input type="checkbox"/> YES <input type="checkbox"/> NO																
14. Is Dependent covered by Medicare? <input type="checkbox"/> YES <input type="checkbox"/> NO If Yes, provide Medicare number _____ <input type="checkbox"/> Part A <input type="checkbox"/> Part B																

SECTION B. DEPENDENT INFORMATION (CONTINUED)

DEPENDENT #3

LEGAL NAME			5. SOCIAL SECURITY NUMBER			6. RELATIONSHIP			7. DATE OF BIRTH			8. GEISINGER MEDICAL RECORD NUMBER (if any)			9. MARITAL STATUS			10. DATE OF MARRIAGE				
1. FIRST	2. M.I.	3. LAST	4. MAIDEN NAME						<input type="checkbox"/> SON							<input type="checkbox"/> SINGLE						
									<input type="checkbox"/> DAUGHTER							<input type="checkbox"/> MARRIED						
									<input type="checkbox"/> STEP													

11. Is dependent employed: YES NO IF YES, FULL-TIME PART-TIME SCHOOL VACATION ONLY
 12. Dependent is chiefly (more than 50%) dependent on Subscriber for support and maintenance YES NO
 13. Do you claim this dependent as an income tax exemption? YES NO
 14. Is Dependent covered by Medicare? YES NO If Yes, provide Medicare number _____ Part A Part B

PLEASE NOTE: IF ANY ABOVE NAMED DEPENDENT LIVES WITH A CUSTODIAL PARENT, PLEASE IDENTIFY THE APPLICABLE DEPENDENT AND PROVIDE THE NAME AND ADDRESS OF THE CUSTODIAL PARENT IN THE SPACE BELOW.

SECTION C. OTHER INSURANCE COVERAGE INFORMATION

While enrolled in Geisinger Health Plan, will you or any dependent(s) listed on this form also be covered by other health insurance? Yes No
 If Yes, please complete the following information:

1. Name of Insurance Company: _____ 5. I.D. or Social Security Number: _____
 2. Subscriber Name: _____ 6. Group Name (Employer): _____
 3. Type of Plan: Family Self 7. Group Number: _____
 4. Effective Date of Coverage: _____

SECTION D. LEGAL CUSTODIANSHIP/LEGAL GUARDIANSHIP

The Subscriber or the Subscriber's spouse is:

LEGAL CUSTODIAN of the following dependent listed above.* _____ (Insert name of Dependent(s))
 LEGAL GUARDIAN of the dependent listed above.* _____ (Insert name of Dependent(s))

*** Please attach a copy of the court order document (a) appointing the Subscriber/Subscriber's spouse as legal guardian/legal custodian or (b) obligating the Subscriber to provide health care coverage through a court order or qualified medical support order.**

SECTION E. STUDENT DEPENDENT CERTIFICATION

DEPENDENT #1

1. Name of accredited school in which dependent is enrolled _____
 2. Address of accredited school _____
 3. Type of school * UNIVERSITY COLLEGE HIGH SCHOOL TRADE ***Correspondence school is not accepted**
 4. Is dependent currently enrolled at and attending school as a full-time student? Yes No
 If you answered "NO" to this Question 4, please complete Question #5.
 5. Is dependent's less than full-time enrollment status due to a serious illness or injury to him/her? Yes No This Question is Not Applicable
 If you answered "YES" to this Question 5, Section F must be completed by dependent's treating physician.
 6. Student is currently on active Military Duty YES NO
 7. Beginning date of school term _____ MO. _____ YR. 8. Expected date of graduation _____ MO. _____ YR.

SECTION H	GEISINGER HEALTH PLAN OFFICE USE ONLY			
<input type="checkbox"/> APPROVED for Dependent #1 #2 #3 Other _____ <input type="checkbox"/> DISAPPROVED for Dependent #1 #2 #3 Other _____				
Name (Print)	Signature		Effective Date	

SECTION I				DECLARATION OF SUBSCRIBER			
<p>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, Agreement and/or Rider(s), if applicable, issued by Geisinger Health Plan 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.</p>							
Signature of Applicant		Date Signed		Signature of Employer (if applicable)		Date Signed	