

Section C: Employer groups with 2-50 eligible employees SKIP Section C
Employer groups with 51-99 eligible employees MUST complete Section C

Provide the answer to the following questions as they pertain to all eligible employees and/or covered dependents (including COBRA, any state continuation programs & eligible retirees). To your knowledge has any person, to be covered, been diagnosed or treated by a provider for any of the following conditions within the last five years? Please check yes or no, if yes please circle all that apply. For each item checked "YES", please explain in section below.

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|---|--------------------|--------------------|
| 1. Cancer: Type (if known) _____ | Yes _____ No _____ | # of people: _____ |
| 2. Heart Disease or Vascular Disease | Yes _____ No _____ | # of people: _____ |
| 3. Organ Transplant/Bone Marrow Transplant (planned or past) | Yes _____ No _____ | # of people: _____ |
| 4. Rheumatoid or Psoriatic Arthritis | Yes _____ No _____ | # of people: _____ |
| 5. Diabetes: Type (if known) _____ | Yes _____ No _____ | # of people: _____ |
| 6. Cystic Fibrosis, Emphysema, Asthma or other lung disease | Yes _____ No _____ | # of people: _____ |
| 7. Disorder of the spine, back, joints, bones | Yes _____ No _____ | # of people: _____ |
| 8. Epilepsy/seizure disorder | Yes _____ No _____ | # of people: _____ |
| 9. Blood disorders including hemophilia | Yes _____ No _____ | # of people: _____ |
| 10. HIV/AIDS | Yes _____ No _____ | # of people: _____ |
| 11. Kidney or bladder disease, kidney dialysis | Yes _____ No _____ | # of people: _____ |
| 12. Liver disease or hepatitis: Type (if known) _____ | Yes _____ No _____ | # of people: _____ |
| 13. Multiple Sclerosis, muscular dystrophy or cerebral palsy | Yes _____ No _____ | # of people: _____ |
| 14. High end specialty drugs / infusion therapy | Yes _____ No _____ | # of people: _____ |
| 15. Psychological or other mental disorder | Yes _____ No _____ | # of people: _____ |
| 16. Stroke or paralysis | Yes _____ No _____ | # of people: _____ |
| 17. Gaucher's Disease | Yes _____ No _____ | # of people: _____ |
| 18. Colitis or Chron's Disease | Yes _____ No _____ | # of people: _____ |
| 19. Any condition/disease not mentioned above or <i>anticipated surgery</i> | Yes _____ No _____ | # of people: _____ |

Have any employees, dependents or Cobra individuals who are eligible for coverage incurred claims that have exceeded \$10,000 (medical and/or pharmacy) during the past 12 months? _____ Yes _____ No. If yes, please explain below.

Are any employees currently disabled or otherwise not actively at work? _____ Yes _____ No. If yes, please explain below.

Are any eligible employees or dependents currently pregnant? _____ Yes _____ No. If yes, please explain below. List each person on a separate line, include age and due date. Also list, if it is a multiple birth pregnancy or if the birth is considered high risk.

***** Please explain any "YES" answers in this space. If more space is needed, attach a separate sheet. Please sign and date all attachments. *****

Description of condition	Is condition ongoing ? (Y or N)

My signature below verifies that the information contained on this application for group coverage is accurate and true to the best of my knowledge. I attest that the individuals listed above are active employees of the organization. I understand that Geisinger Health Plan has the right to perform annual renewal reviews of applicable tax form verifiers and/or payroll records in order to confirm employment of the individuals enrolled. I also understand that pending review of applications by Geisinger Health Plan underwriting, individual group rates to vary based upon age/gender factors and industry indexes. 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. Geisinger Health Plan will investigate information provided and take action against those involved with insurance fraud. The penalties include, but are not limited to, retroactive and/or immediate termination of group coverage, as well as criminal or civil action.

Section D: Required Signature(s)

Employer's Signature: _____ Broker Name (if applicable): _____

Employer's Name (print): _____ Broker Agency Name: _____

Title: _____ Date: _____