Geisinger Health Plan
100 N. Academy Avenue
Danville, PA 17822-3226

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.

Geisinger Health Plan
100 N. Academy Avenue
Danville, PA 17822-3226

GEISINGER HEALTH PLAN®

(PLEASE PRINT OR TYPE)

DEPENDENT CERTIFICATION FORM

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? ☐ Yes ☐ No

13a. If yes, please provide your Medicare number: ______________________________

13b. ☐ PART A ☐ 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 MONTH	DAY	YEAR	8. GEISINGER MEDICAL RECORD NUMBER (if any)	9. MARITAL STATUS	10. DATE OF MARRIAGE MONTH	DAY	YEAR
1. FIRST	2. M.I.	3. LAST	4. MAIDEN NAME				☐ SON ☐ DAUGHTER ☐ STEP					☐ SINGLE ☐ MARRIED			

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

DEPENDENT #2

LEGAL NAME				5. SOCIAL SECURITY NUMBER			6. RELATIONSHIP	7. DATE OF BIRTH MONTH	DAY	YEAR	8. GEISINGER MEDICAL RECORD NUMBER (if any)	9. MARITAL STATUS	10. DATE OF MARRIAGE MONTH	DAY	YEAR
1. FIRST	2. M.I.	3. LAST	4. MAIDEN NAME				☐ SON ☐ DAUGHTER ☐ STEP					☐ SINGLE ☐ MARRIED			

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

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					MONTH	DAY	YEAR			MONTH	DAY	YEAR
							☐ SON ☐ DAUGHTER ☐ STEP					☐ SINGLE ☐ MARRIED			

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.

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

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 E. STUDENT DEPENDENT CERTIFICATION (CONTINUED)

DEPENDENT #2

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.

DEPENDENT #3

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 F. MEDICALLY NECESSARY LEAVE OF ABSENCE CERTIFICATION FOR FULL-TIME STUDENTS

(This section to be completed by a treating physician only if you answered "YES" to Question 5 in Section E above.)

DEPENDENT #1

I am the treating physician for ______________________________ (dependent's full legal name). I hereby certify that she/he is suffering from a serious illness or injury and that a leave of absence or other change in enrollment from full-time student status is medically necessary.

Expected date to return to school as a full-time student: ____________________
(Month / Date / Year)

______________________________ (Name of treating physician)

______________________________ (Physician's Signature)

______________ (Date)

______________________________ (Address of Physician)

DEPENDENT #2

I am the treating physician for ______________________________ (dependent's full legal name). I hereby certify that she/he is suffering from a serious illness or injury and that a leave of absence or other change in enrollment from full-time student status is medically necessary.

Expected date to return to school as a full-time student: ____________________
(Month / Date / Year)

______________________________ (Name of treating physician)

______________________________ (Physician's Signature)

______________ (Date)

______________________________ (Address of Physician)

SECTION F. MEDICALLY NECESSARY LEAVE OF ABSENCE CERTIFICATION FOR FULL-TIME STUDENTS (CONTINUED)

(This section to be completed by a treating physician only if you answered "YES" to Question 5 in Section E above.)

DEPENDENT #3

I am the treating physician for ______________________________ (dependent's full legal name). I hereby certify that she/he is suffering from a serious illness or injury and that a leave of absence or other change in enrollment from full-time student status is medically necessary.

Expected date to return to school as a full-time student: ____________________
(Month / Date / Year)

______________________________ (Name of treating physician)
______________________________ (Physician's Signature)
______________ (Date)

______________________________ (Address of Physician)

SECTION G DISABLED DEPENDENT CERTIFICATION

Are any Dependents identified in this questionnaire incapable of self-sustaining employment by reason of disability resulting from mental retardation or physical disability which meets the criteria under Title 31, Pa. Code, Section 88.41 AND who became so prior to the attainment of age nineteen (19)? ❑ YES ❑ NO

DEPENDENT #1 Name: ______________________________

Explanation of disabilities ______________________________

____

____

Name of Primary Care Physician ______________________________
Physician's Signature ______________________________
Date ______________

Address of Physician ______________________________

DEPENDENT #2 Name: ______________________________

Explanation of disabilities ______________________________

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____

Name of Primary Care Physician ______________________________
Physician's Signature ______________________________
Date ______________

Address of Physician ______________________________

DEPENDENT #3 Name: ______________________________

Explanation of disabilities ______________________________

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____

Name of Primary Care Physician ______________________________
Physician's Signature ______________________________
Date ______________

Address of Physician ______________________________

SECTION H — GEISINGER HEALTH PLAN OFFICE USE ONLY

❑ APPROVED for Dependent #1 #2 #3 Other ______________________

❑ DISAPPROVED for Dependent #1 #2 #3 Other ______________________

______________________	______________________	______________
Name (Print)	Signature	Effective Date

SECTION I — DECLARATION OF SUBSCRIBER

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.

______________________	__________	______________________	__________
Signature of Applicant	Date Signed	Signature of Employer (if applicable)	Date Signed