Application Instructions (please remove this instruction sheet before filling in the application)

Thank you for your interest in Geisinger Gold.

Please read carefully before completing each section of this enrollment application to help ensure quick processing of your new Geisinger Gold membership.

Please remember to fill in all information requested.
Doing so will help us complete your enrollment as quickly as possible.

If you have any questions, or need any assistance, please contact the Customer Service Team at (800) 498-9731 (TDD 711) seven days a week from 8 a.m. to 8 p.m., (7 days a week, Oct. - Feb.) or 8 a.m. to 8 p.m., (Mon. - Fri., March - Sept.)

Section 1: Choose the plan you wish to enroll in. Please consult the Summary of Benefits or Guide to Geisinger Gold Medicare Advantage Plans for details on each plan option.

Section 2: Provide your name, address and other contact information.

Section 3: Provide your Medicare information, as it appears on your Medicare card.

Section 4: Tell us how you would like to pay your monthly plan premium. You can pay your monthly plan premium by mail, Electronic Funds Transfer (EFT) or credit card each month. You can also choose to pay your premium by automatic deduction from your monthly Social Security benefit check.

Section 5: Please answer these important questions which will help us confirm your eligibility to join a Geisinger Gold Medicare Advantage Plan.

Section 6: If you are enrolling in an HMO plan, please select a Primary Care Physician (PCP). You can consult our Provider List, visit *www.GeisingerGold.com* and click "Provider Search" at the top of the page, or call the Customer Service Team for assistance.

Section 7: Let us know if you would like to receive your member materials in a different language or Braille.

Section 8: Before signing, please read the additional important information about Geisinger Gold on the back of the application form. Your application must be signed for it to be considered complete.

Section 9: Attestation of Eligibility for an Enrollment Period will confirm your eligibility to enroll in a Geisinger Gold plan.

H3954_H3924_14196_2 CMS Approved 7/25/14

Original: Health Plan Duplicate: Applicant

PA_APP_2016

Office Use Only Application: Left with applicant ___ Mail ___ Office ___ Meeting ___

Effective Date of Coverage: _____ICEP/IEP: _____ AEP: _____ SEP (type): _____

Agent/Producer Signature

Agent/Producer Printed Name

Agent/Producer ID Number

Agency Name

GEISINGER GOLD®

Enrollment Application

Please contact Geisinger Gold if you need information in another language or format (Braille).
To enroll in Geisinger Gold, please provide the following information:

1. Please check which plan you want to enroll in

- ❑ Classic Advantage (HMO) $____ per month
- ❑ Classic Advantage Rx (HMO) $____ per month
- ❑ Classic Complete Rx (HMO) $____ per month
- ❑ Classic Complete Rx (HMO) with Health+ $____ per month
- ❑ Secure Rx (HMO SNP) $____ per month
- ❑ Preferred Advantage Rx (PPO) $____ per month
- ❑ Preferred Advantage Rx (PPO) with Health+ $____ per month
- ❑ Preferred Complete Rx (PPO) $____ per month
- ❑ Preferred Complete Rx (PPO) with Health+ $____ per month

2. Please Provide Your Information (Please Print and Complete all Information Below)

☐ Mr. ☐ Mrs. ☐ Ms.

➔ LAST Name: _____

➔ First Name: _____

➔ Middle Initial: ____

➔ Birth Date (M M / D D / Y Y Y Y):

__ __/__ __/__ __ __ __

Sex: ☐ M ☐ F

➔ Home Phone Number:

(__ __ __) __ __ __ - __ __ __ __

➔ Alternate Phone Number:

(__ __ __) __ __ __ - __ __ __ __

➔ E-mail Address (optional):

_____

➔ **Permanent Residence** Street Address (P.O. Box is not allowed):

_____

City: _____ State:___

ZIP Code: _____ County: _____

➔ **Mailing Address** Street Address (only if different from your Permanent Residence Address):

_____

City: _____ State:___

ZIP Code: _____

➔ Emergency Contact Name:

_____

Phone Number: (__ __ __) __ __ __ - __ __ __ __

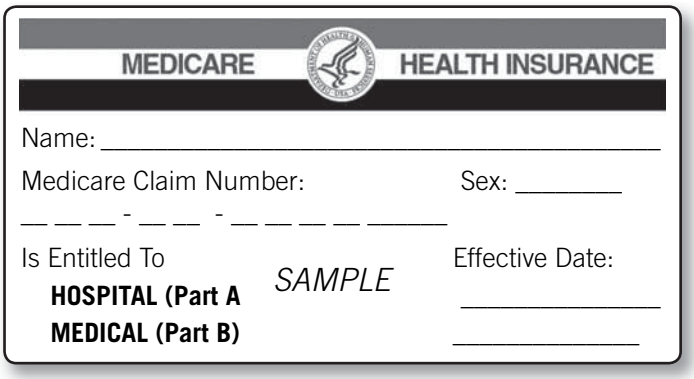
Relationship: _____

3. Please Provide Your Medicare Insurance Information

Please take out your Medicare card to complete this section. Please fill in these blanks so they match your red, white and blue Medicare card

- OR -

Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board. You must have Medicare Part A and Part B to join a Medicare Advantage plan.


MEDICARE HEALTH INSURANCE

Name: _____

Medicare Claim Number: _____ Sex: _____

__ __ __ - __ __ - __ __ __ __ _____

Is Entitled To

HOSPITAL (Part A

MEDICAL (Part B)

SAMPLE

Effective Date:

_____

_____

4. Please select a premium payment option (please see reverse for important premium payment information)

☐ Get a bill

☐ Electronic funds transfer (EFT) from your bank account each month. Please enclose a VOIDED check or provide the following:
Account holder name: _____ Bank routing number: __ __ __ __ __ __ __ __ __
Bank account number: __ __ __ __ __ __ __ __ __ __ __ __ Account type: ☐ Checking ☐ Saving

☐ Credit Card. Please provide the following information:
Type of Card: _____ Name of Account holder as it appears on card: _____
Account number: __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __
Expiration Date: __ __ / __ __ __ __ (MM/YYYY)

☐ Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check. (The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.

5. Please read and answer these important questions

a. Do you have End Stage Renal Disease (ESRD)? ☐ Yes ☐ No
If you have had a successful kidney transplant and/or you don't need regular dialysis any more, **please attach a note or records** from your doctor showing you have had a successful kidney transplant or you don't need dialysis, otherwise we may need to contact you to obtain additional information.

b. Some individuals may have other medical or drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs.
Will you have other **medical** coverage in addition to Geisinger Gold? ☐ Yes ☐ No
If "yes", please list your other coverage and your identification (ID) number(s) for this coverage:
Name of other coverage: ID # for this coverage: Group # for this coverage
_____ _____ _____
Will you have other **prescription drug** coverage in addition to Geisinger Gold? ☐ Yes ☐ No
If "yes", please list your other coverage and your identification (ID) number(s) for this coverage:
Name of other coverage: ID # for this coverage: Group # for this coverage
_____ _____ _____

c. Are you a resident in a long-term care facility, such as a nursing home? ☐ Yes ☐ No
If "yes," please provide the following information: Name of Institution: _____
Address & Phone Number of Institution (number and street): _____

d. Are you enrolled in your State Medicaid program? ☐ Yes ☐ No
If yes, please provide your Medicaid recipient number: _____

e. If you are changing from a current health care coverage plan to Geisinger Gold, please tell us about your current coverage (optional): Health Care Coverage Company Name: _____
Health Care Coverage Plan Name: _____

6. Geisinger Gold HMO Plans: Please choose a Primary Care Physician (PCP), clinic or health center:

_____ PCP# _____

7. Please check one of the boxes below:

If you would prefer us to send you information in a language other than English or in another format:
☐ Language (call for availability) ☐ Large print ☐ Audio tape
Please contact Geisinger Gold at (800) 498-9731 if you need information in another format or language than what is listed above. Our office hours are 8 a.m. to 8 p.m., (7 days a week, Oct. - Feb.) or 8 a.m. to 8 p.m., (Mon. - Fri., March - Sept.). TTY users should call 711.

8. Signature

Please read important information on reverse before signing.

Signature: _____ **Today's Date:** _____

If you are the authorized representative, you must sign above and provide the following information:

Name: _____

Address: _____

Phone Number: (_____) _____ - _____ Relationship to Enrollee: _____

9. Attestation of Eligibility for an Enrollment Period

Typically, you may enroll in a Medicare Advantage plan during the annual enrollment period between October 15 and December 7 of each year. This coverage is effective on the first day of the following year.

There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period.

Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

- ❑ Annual Enrollment Period (October 15 through December 7)
- ❑ I am new to Medicare.
- ❑ I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me. I moved on (insert date)_____.
- ❑ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) _____.
- ❑ I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.
- ❑ I get extra help paying for Medicare prescription drug coverage.
- ❑ I no longer qualify for extra help paying for my Medicare prescription drugs. I stopped receiving extra help on (insert date) _____.
- ❑ I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long term care facility). I moved/will move into/out of the facility on (insert date) _____.
- ❑ I recently left a Program of All-Inclusive Care for the Elderly (PACE) on (insert date) _____.
- ❑ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date) _____.
- ❑ I am leaving employer or union coverage on (insert date) _____.
- ❑ I belong to a pharmacy assistance program provided by my state.
- ❑ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
- ❑ I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on (insert date) _____.
- ❑ None of these statements applies to me.*

*Please contact Geisinger Gold at (800) 498-9731 (TTY users should call 711) to see if you are eligible to enroll. We are open 8 a.m. to 8 p.m., (7 days a week, Oct. - Feb.) or 8 a.m. to 8 p.m., (Mon. - Fri., March - Sept.)

A. Please Read This Important Information

Paying your plan premium: If we determine that you owe a late enrollment penalty or if you currently have a late enrollment penalty, we need to know how you would prefer to pay it. You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail, Electronic Funds Transfer (EFT) or credit card each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month.

If you are assessed a Part D-Income related Monthly Adjustment Amount (IRMAA), you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or the RRB. DO NOT pay Geisinger Gold the Part D-IRMAA.

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at www.socialsecurity.gov/prescriptionhelp. If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover. If you don't select a payment option, you will get a bill each month.

If you currently have health coverage from an employer or union, joining Geisinger Gold could affect your employer or union health benefits. ***You could lose your employer or union health coverage if you join Geisinger Gold.*** Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there isn't any information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

B. Please read before signing this application

By completing this enrollment application, I agree to the following:

Geisinger Gold is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and B. I can be in only one Medicare Advantage plan at a time, and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan or prescription drug plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year when an enrollment period is available (Example: October 15th through December 7th of every year), or under certain special circumstances.

Geisinger Gold serves a specific service area. If I move out of the area that Geisinger Gold serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of Geisinger Gold, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Geisinger Gold when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan.

I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date **Geisinger Gold Classic (HMO) or Geisinger Gold Secure (HMO SNP)** coverage begins, I must get all of my health care from **Geisinger Gold Classic (HMO) or Geisinger Gold Secure (HMO SNP)**, except for emergency or urgently needed services or out-of-area dialysis services. I understand that beginning on the date **Geisinger Gold Preferred (PPO)** coverage begins, using services in-network can cost less than using services out-of-network, except for emergency or urgently needed services or out-of-area dialysis services. If medically necessary, **Geisinger Gold Preferred (PPO)** provides refunds for all covered benefits, even if I get services out of network. Services authorized by Geisinger Gold and other services contained in my Geisinger Gold

Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR GEISINGER GOLD WILL PAY FOR THE SERVICES.**
I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Geisinger Gold, he/she may be paid based on my enrollment in Geisinger Gold.

C. Release of Information

By joining this Medicare health plan, I acknowledge that Geisinger Gold will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Geisinger Gold will release my information, including my prescription drug event data to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from 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.
I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request from Medicare.