GEISINGER GOLD®

Application Instructions

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 Reserve (MSA).

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: Please answer these important questions which will help us confirm your eligibity to join a Geisinger Gold Medicare Advantage Plan. You can also let us know if you would like to receive your member materials in a different language or Braille.

Section 5: Before signing, please read the additional important information about Geisinger Gold. Your application must be signed for it to be considered complete.

Original: Health Plan Duplicates: Applicant and Representative
HPM50 2012 MSA App H8468 11203_1 CMS Approved 8/18/11

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:

❑ Reserve (MSA) $0 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

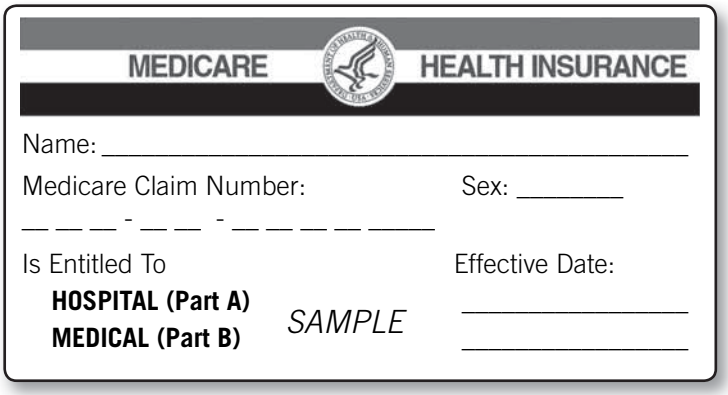
Please take out your Medicare card to complete this section.

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.



4. Please read and answer these important questions

1. Do you have End Stage Renal Disease (ESRD)? ☐ Yes ☐ No
   Generally, if you answered "yes" you aren't eligible to enroll in Geisinger Gold Reserve (MSA).
   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

2. To enroll in Geisinger Gold Reserve (MSA), you may not have other health coverage as described below. Please answer each of the following questions:
   a. Are you enrolled in your State Medicaid program? ☐ Yes ☐ No
   b. Do you have Medicare Part B Buy In (state pays part or all of your Part B premium)? ☐ Yes ☐ No
   c. Are you receiving Medicare Hospice benefits? ☐ Yes ☐ No
   d. Some individuals may have other health coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or other health benefits that cover all or part of the annual Medicare MSA deductible.
   If you have any other such coverage, you aren't eligible to enroll in Geisinger Gold Reserve (MSA).
   Will you have other health coverage in addition to Geisinger Gold Reserve (MSA)? ☐ Yes ☐ No
   If "yes", please list your other coverage and your identification (ID) number(s) for this coverage so we can decide if you are eligible to enroll in Geisinger Gold Reserve (MSA):
   Name of other coverage: _____ ID # for this coverage: _____ Group # for this coverage: _____

3. Will you reside in the United States for at least 183 days during each year you are enrolled in Geisinger Gold Reserve (MSA)? ☐ Yes ☐ No
4. Do you or your spouse work? ☐ Yes ☐ No

Please check one of the boxes below if you would prefer that we send you information in a language other than English or in another format: ☐ Language/Braille *(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 PA Relay at 711.

5. Signature

Please read important information on the reverse side 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_____
Keeping records - As an authorized representative, it is important that you keep records of when funds in the MSA account are used, as well as how the funds are used.

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

Geisinger Gold Reserve (MSA) 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. It is my responsibility to inform you of any health 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. I may leave this plan ("disenroll") during the Annual Enrollment Period that is October 15th through December 7th of every year (effective the following January 1st) or under certain limited special circumstances, by sending a request in writing to Geisinger Gold Reserve (MSA). If I choose a Medicare MSA plan and haven't before joined an MSA plan, then change my mind, I may cancel my enrollment by December 15 of the same year by contacting my plan to cancel my enrollment request. I understand that my enrollment into an MSA plan isn't complete until the bank account is established.
I understand that I am enrolling in a plan that doesn't pay for Medicare covered services until a high deductible is met, but Geisinger Gold Reserve (MSA) allows me to use funds in my MSA account to pay for health services. Withdrawals made from the MSA bank account aren't taxed when used for IRS-qualified medical expenses. I would owe income tax and up to a 50% penalty for withdrawals used for non-medical expenses. After the deductible is met the plan pays 100% of Medicare-covered services.

If I have any questions regarding the initial set-up of my MSA bank account or any of the information in this enrollment form, I should contact the Geisinger Gold Reserve (MSA) at 1-800-498-931 (TTY users should call PA Relay at 711).

Geisinger Gold Reserve (MSA) serves a specific service area. If I move out of the area that Geisinger Gold Reserve (MSA) 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 Reserve (MSA), 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 Reserve (MSA) when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan.

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Geisinger Gold Reserve (MSA), he/she may be paid based on my enrollment in Geisinger Gold Reserve (MSA).

I understand that if I disenroll before the end of the plan year (December 31st), Geisinger Gold Reserve (MSA) may debit my MSA bank account for a prorated share of the current year's deposit to be returned to Medicare. The debit amount is based on the number of months left in the year after the disenrollment date. I understand that, if I die, my estate will be responsible for any money owed to Medicare. My estate keeps any amount over what is owed to Medicare.

Release of Information: By joining this Medicare health plan, I acknowledge that the Medicare health plan 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 Reserve (MSA) will release my information 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.

Do not write in this space

Master Signature Card — Medical Savings Account
The Bank of New York Mellon

Name (1): _____

SSN: _____ Date: _____

Name (2): _____ (Please print name of any additional "Authorized Signature" signed below.)

REQUEST FOR TAX CERTIFICATION

Under penalties for perjury, I certify that the SSN number shown on this form is my correct taxpayer identification number and I am a citizen or resident of the United States.

The IRS does not require you to consent to any provision of this document.

By signing this card and opening a Medical Savings Account with The Bank of New York Mellon (the "Bank"), I agree: (a) To be bound by the Deposit Agreement & Disclosure Statement applicable to the Medical Savings Account established by this card, as that agreement may be amended from time to time; (b) To be bound by the Bank's agreements and disclosures applicable to any additional accounts that I establish with the Bank in the future as an individual, custodian, or single trustee.

This Master Signature Card Agreement will remain in effect as long as I continuously maintain at least one covered account with the Bank.

Authorized Signature(s): Please sign your authorized signature(s) in the boxes below.

1. _____ 2. _____

If this signature card was delivered to a P.O. Box, please indicate your residential address below:

Street Address: _____

City: _____ State: _____ Zip: _____

Beneficiary Designation Form

I hereby certify that, if I die before distribution has been completed, the value of my account shall be distributed to the person(s) named below.

Primary Beneficiary(ies)			
Name		Name	
Address		Address	
City, State, and Zip		City, State, and Zip	
Relationship	SSN	Relationship	SSN
Date of Birth	Percent (%)	Date of Birth	Percent (%)
Contingent Beneficiary(ies)			
Name		Name	
Address		Address	
City, State, and Zip		City, State, and Zip	
Relationship	SSN	Relationship	SSN
Date of Birth	Percent (%)	Date of Birth	Percent (%)

Important:

Return the completed form with your Medicare Advantage high deductible plan enrollment form to your agent or by **Mail** by using the prepaid envelope provided, or sending to Geisinger Health Plan, Gold Enrollment, 100 North Academy Avenue, Danville PA, 17822-3229.