Geisinger Health Plan

# Submission Requirements
# ACA Eligible Groups

| | |
|---|---|
| **Employer Group Application** | |
| Employee Enrollment / Census | |
| Date of birth (including dependents) | |
| Zip Code (including dependents) | |
| Dependents | |
| Tobacco usage | |
| **Group Subscriber Application** | |
| **Group Size Certification** | To determine group size and ACA eligibility |
| **Wage and Tax Documents** | |
| PA Form UC-2A (most recent quarter) | To verify group size and employees |
| Local Earned Income Tax Withholding form | To verify group employees if not listed on the UC-2A |
| Schedule C (Schedule F for farms) | To verify the owner of a sole proprietorship |
| Schedule K-1 | To verify the owners of a partnership; must submit one per partner |
| PA Rev-1605 or RCT - 101 | To verify corporate officers for corporations |
| Form SS-4 or PA 100 Form and a new business letter with owner's signature | To verify employees and owner(s) of a new company |
| Payroll Records | To verify any new hires not listed on UC-2A |
| Form W-2 Wage and Tax Statement | To verify individual employees |
| **Broker of Record Letter** | In addition to including on the Group Application. |
| **CSA (Confirmation of Sales Agreement)** | Include roster and rates |

**Submission deadline for new business is the last business day on or before the 15th of the month prior to the requested effective date.**

**GEISINGER HEALTH PLAN**
100 North Academy Avenue
Danville, PA 17822

# Marketplace Employer Group Application

**GEISINGER QUALITY OPTIONS, INC.**
100 North Academy Avenue
Danville, PA 17822

## General Group Information

| | | |
|---|---|---|
| Employer Group Name: | Doing Business As: | |
| Business Description: | EIN (Tax Id): | SIC Code: |
| Physical Address: | Financial Address:(leave blank if same as physical) | |
| City: State: Zip: | City: State: Zip: | |
| Physical Address County: | Current Health Carrier: | |

## Primary Contact Information

| | | | |
|---|---|---|---|
| First Name: | M. Init: | Last Name: | Title: |
| Email Address: | Phone: | Fax: | |

(The email address you provide on this application helps the Health Plan to conduct business and provide good service. It is used to facilitate activities such as member satisfaction surveys. Please note that if you provide your e-mail address, it will be stored in a secure database and will not be sold to any entity outside of the Health Plan. You will be given an opportunity to opt-out of the e-mail communications)

## Eligibility & Enrollment

| | | |
|---|---|---|
| Effective Date: | Open Enrollment Start Date: | Open Enrollment End Date: |
| New Hire Waiting Period (can't exceed 90 days from date of hire): | Part Time Hours to Qualify for Benefits if Less than 30: (Optional) | |
| Total Company Employees Working Over 30 Hours: | Number of Employees Waiving Coverage: | |
| Total Company Employees Working Less than 30 Hours: | Number of Employees on COBRA: | |

## Monthly Contribution

Group agrees, at a minimum, to contribute 50% of the cost of the employee only rate for the lowest benefit plan offered.

☐ By marking this check box, I confirm that I understand, and will comply with, the above requirement as part of the terms and conditions of purchasing employer group sponsored coverage through the Geisinger Health Plan/Geisinger Quality Options, Inc. Marketplace.

## Producer of Record

| | | |
|---|---|---|
| General Agency Name: | General Agency Number: | General Agency Phone Number: |
| Agency Name: | Agency Number: | Agency Phone Number: |
| Producer Name: | Producer Number: | Producer Phone Number: |

## Employee and Dependent Roster

Instructions:
1. Please use the form below to submit your full roster of both employees and dependents. We also accept the information below in electronic format.

2. For "TYPE" please use the following codes:
[Employee=E, Spouse=S, Employee Child=C, Disabled Dependent over age 26=DD, Other Dependent=OD]

3. Tobacco use means use of tobacco on average four or more times per week within no longer than the past 6 months (excludes religious or ceremonial use of tobacco).

4. Please copy this page if additional space is required.

Employer Group Name:

| First Name | M. I. | Last Name | Gender (M/F) | Date of Birth | Date of Hire | Tobacco Use Y/N | Postal Code | Type | Employer Division |
|---|---|---|---|---|---|---|---|---|---|
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# Discrimination is against the law

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The Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call the Health Plan at 800-447-4000 or TTY: 711.

If you believe that the Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation, you can file a grievance with:

Civil Rights Grievance Coordinator
Geisinger Health Plan Appeals Department
100 North Academy Avenue, Danville, PA 17822-3220
Phone: 866-577-7733, TTY: 711
Fax: 570-271-7225
GHPCivilRights@thehealthplan.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Grievance Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW., Room 509F
HHH Building, Washington, DC 20201
Phone: 800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 800-447-4000 or TTY: 711.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-447-4000 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 800-447-4000（TTY：711）。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 800-447-4000 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 800-447-4000 (телетайп: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 800-447-4000 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-447-4000 (TTY: 711) 번으로 전화해 주십시오.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 800-447-4000 (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 800-447-4000 (رقم هاتف الصم والبكم: 711.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 800-447-4000 (ATS : 711).

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UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 800-447-4000 (TTY: 711).

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ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 800-447-4000 (TTY: 711)។

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 800-447-4000 (TTY: 711).

HPM 50 alb: Nondiscrimination dev. 9.12.16
Y0032_16242_2 File and Use 9/2/16

## Summary of Benefits Coverage

Following the Affordable Care Act regulations, the Health Plan will be preparing the Summary of Benefits and Coverage and Uniform Glossary (SBC) and providing these documents for each finalized quote provided to a group. I understand that I may request an SBC at any time for any preliminary quote already received.

## Fraud Statement

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.

## Premium Payment

At any time during the benefit year, should the Group's enrollment be terminated with premium payments due ("past-due premiums") to either Geisinger Health Plan or Geisinger Quality Options, Inc., the Group may be required to pay any past-due premiums owed from the period not to exceed 12 months prior to the effective date of new coverage, in order to effectuate new coverage. Payment of past-due premiums may be required if the Group is applying for the same or different coverage either with Geisinger Health Plan and past-due premiums are owed to Geisinger Quality Options, Inc. or if the Group is applying for the same or different coverage with Geisinger Quality Options, Inc. and past-due premiums are owed to Geisinger Health Plan.

**Please note**: Prior coverage will not be reinstated. A new policy will be written.

## Required Signatures

I understand that the 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 the Health Plan, individual group rates to vary based upon age factors and tobacco status.

The 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.

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 and dependents thereof.

_____ Broker's Signature if Applicable

_____ Employer Representative's Signature

_____ Employer Representative's Name (print)

_____ Employer Representative's Title

_____ Date

**GEISINGER HEALTH PLAN**
100 North Academy Avenue
Danville, PA 17822

# Group Marketplace Subscriber Application

**GEISINGER QUALITY OPTIONS, INC.**
100 North Academy Avenue
Danville, PA 17822

## General Administrative Information (for completion by Employer)

| | |
|---|---|
| Group Number: | Insurance ID Number: |
| Segment/Division: | Effective Date of Change: (MM/DD/YYYY) |
| Group Employee ID#: | Annual Salary |

This Application is being submitted as a result of: **(Check One)**

- ☐ Group Initial Enrollment
- ☐ Group Open Enrollment Period
- ☐ Employee New Hire
- ☐ Change due to Qualifying Event (If you checked this box, please specify type of event)

  Specify type of event: _____

  Is the Subscriber or Subscriber's eligible Dependent(s) electing continuation coverage under COBRA and/or Mini-COBRA?

  **(Check One)** ☐ Yes ☐ No ☐ Not Applicable

- ☐ I declare that I have coverage under another group health plan or have other health insurance coverage and, therefore, decline enrollment for myself and any family dependents

| **Marketplace Plan Selection:** | PCP Copay | Specialist Copay | Deductible |
|---|---|---|---|
| HMO ☐ | | | |
| HMO QHDHP POS ☐ | | | |
| PPO ☐ | | | |
| PPO Extra ☐ | | | |
| PPO QHDHP ☐ | | | |
| PPO Options ☐ | | | |
| | | | |
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## Applicant (Employee) Information (Please Print Clearly)

| | | |
|---|---|---|
| Primary Care Physician (PCP) Name: | PCP Location (Town): | PCP Number: |

Are you an existing patient of selected primary care physician? [ ] Yes [ ] No

| | | | |
|---|---|---|---|
| Legal Name: (Last) (Maiden Name) | First Name: | M. Init: | Gender: (M or F) |

| | | | | |
|---|---|---|---|---|
| Home Address: | City: | State: | Zip Code: | County: |
| Mailing Address: (if different than Home Address) | City: | State: | Zip Code: | County: |

| | | |
|---|---|---|
| Home Phone Number: (###) ###-#### | Cell Phone Number: (###) ###-#### | Work Phone Number: (###) ###-#### |

Email Address:

(The email address you provide on this application helps the Health Plan to conduct business and provide good service. It is used to facilitate activities such as member satisfaction surveys. Please note that if you provide your e-mail address, it will be stored in a secure database and will not be sold to any entity outside of the Health Plan. You will be given an opportunity to opt-out of the e-mail communications)

| | | |
|---|---|---|
| Social Security Number: ___ - ___ - ___ | Date of Birth: MM/DD/YYYY | Employment Status: [ ] Active [ ] Terminated |
| Job Description : | Date of Hire: MM/DD/YYYY | Tobacco Use in Past 6 Months*: [ ] Yes [ ] No |

Employer Name, City, and Phone Number:

| | | |
|---|---|---|
| Working Hours: (per week) | Employment Type: (FT/PT/Other) | Geisinger Medical Record Number: (if any) |

## Dependent Information

| Legal Name (List last name if different than applicant) | | | Social Security Number | Relationship | Date of Birth | Tobacco Use in Past 6 Months?* | Primary Care Physician (PCP) Name | PCP Number |
|---|---|---|---|---|---|---|---|---|
| First | MI | Last<br>Maiden | | [ ] Husband<br>[ ] Wife | | [ ] Yes [ ] No | | |
| First | MI | Last | | [ ] Son<br>[ ] Daughter<br>[ ] Other** | | [ ] Yes [ ] No | | |
| First | MI | Last | | [ ] Son<br>[ ] Daughter<br>[ ] Other** | | [ ] Yes [ ] No | | |
| First | MI | Last | | [ ] Son<br>[ ] Daughter<br>[ ] Other** | | [ ] Yes [ ] No | | |
| First | MI | Last | | [ ] Son<br>[ ] Daughter<br>[ ] Other** | | [ ] Yes [ ] No | | |

*Tobacco use means use of tobacco on average four or more times per week within no longer than the past 6 months (excludes religious or ceremonial use of tobacco)

**In the space below, please list any disabled child over the age of 26 and/or describe instances where you selected 'Other' as your dependent relationship. NOTE: Documentation obligating the applicant or the applicant's spouse, if applicable, to provide health care coverage to Dependent(s) will be required. All Dependent(s) must meet eligibility criteria.

| Dependent(s) Name | Gender | Disabled | Description of Legal Relationship |
|---|---|---|---|
| | [ ] Female [ ] Male | [ ] Yes [ ] No | |
| | [ ] Female [ ] Male | [ ] Yes [ ] No | |
| | [ ] Female [ ] Male | [ ] Yes [ ] No | |
| | [ ] Female [ ] Male | [ ] Yes [ ] No | |

PLEASE NOTE: If any of your Dependent(s), for which you are applying, do not live at the address listed in the Applicant (Employee) Information section, please indicate name(s), current address(es) and reason(s) why your Dependent(s) do not live at such address, in the space provided below. If your Dependent(s) live with a custodial parent, please provide name of custodial parent.

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## Declarations

I hereby apply to the Health Plan for the coverage now being offered for myself and the dependent(s), if any, as shown above. I understand that this application is subject to acceptance by the Health Plan and that if a Subscription Certificate is issued, services will be available subject to the exclusions, limitations and other conditions of the Subscription Certificate and/or Rider(s), if applicable. In the event it is determined that one (1) or more of my dependent(s) is/are ineligible for enrollment in the Health Plan pursuant to the Subscription Certificate, I authorize the Health Plan to process this application, omitting the names of such ineligible dependent(s). I further understand that rates for the Subscription Certificate and/or Rider(s), if applicable, issued to me are subject to change by the Health Plan, in accordance with terms of the agreement with my employer, and upon thirty (30) days prior notice to my employer acting on my behalf. I authorize my employer to make periodic deductions from my salary or wages of the amount, if any, I am required to contribute toward the rates for the coverage provided under my Subscription Certificate and/or Rider(s). 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 Subscription Certificate and/or Rider(s), if applicable, issued by the Health Plan in consideration of this application. I have read this document or it has been read to me. I understand that I should retain a duplicate copy of this application for my own records. A photographic copy of this acknowledgement shall be as valid as the original. I authorize the Health Plan to electronically transmit the information contained herein. If this application was taken over the phone or on the computer, I acknowledge that I, myself, have not actually signed this application but instead hereby authorize the Health Plan to print an electronic acknowledgement on the signature line of the application and I agree that such printing shall be treated as a valid signature for all purposes of this form. I acknowledge that the Health Plan has verified my identity for this purpose in accordance with any applicable law or regulation.

| Signature of Applicant | Date Signed | Signature of Employer | Date Signed |
|---|---|---|---|
| | | | |

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You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
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HPM 50 alb: Nondiscrimination dev. 9.12.16
Y0032_16242_2 File and Use 9/2/16

Geisinger Health Plan

# Employer Group Size Certification

The Affordable Care Act (ACA) requires health insurance carriers to follow regulations based on employer group size. Using the employer group size certification, health insurers must apply specific rating methods to determine premium and approved benefit plans. Additionally, each health insurance carrier must report on medical loss ratios and potentially issue premium rebates based on the group size certification.

**In order for Geisinger Health Plan to follow ACA regulations on group size certification, you're required to report your 2018 average number of employees to us.**

A small employer is defined as an employer who employed an average of at least 1 but not more than 50 employees on business days during the preceding calendar year. An employee is any individual employed by an employer (based on the common-law employee definition), including individuals who receive a W-2 form. **This includes full-time, part-time, and seasonal employees who may or may not have been eligible for or covered by your medical plan in 2018.** Independent contractors receiving a Form 1099 are not to be included in the employee count. Similarly, sole proprietors and their spouses should not be included in the employee count.

To calculate the average number of employees, determine the total number of employees for each month, add each month's number to get an annual total, and then divide by 12. In the example below, 252 / 12 = 21.

| Month | Jan | Feb | Mar | Apr | May | June | July | Aug | Sept | Oct | Nov | Deb | Total | Average (Total/12) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Full-time | 14 | 15 | 14 | 15 | 14 | 14 | 15 | 15 | 14 | 14 | 14 | 14 | | |
| Part-time | 5 | 6 | 4 | 4 | 6 | 7 | 7 | 7 | 5 | 5 | 4 | 5 | | |
| Seasonal | 0 | 0 | 0 | 0 | 0 | 4 | 4 | 4 | 2 | 1 | 0 | 0 | | |
| Total | 19 | 21 | 18 | 19 | 20 | 25 | 26 | 26 | 21 | 20 | 18 | 19 | 252 | 21 |

Please enter your calculated 2018 average number of employees in the box to the right. (Whole numbers only, no decimals)

By signing below, I certify that:

- ☐ I am an authorized representative of the plan(s) for which this information is being provided.
- ☐ The information I have provided is true and correct. I understand that providing false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company may violate applicable insurance statutes and may result in cancellation or rescission of coverage. I further understand that Geisinger Health Plan reserves the right to audit all information provided at any time.

First name (please print):

Last name (please print):

Title:

Company name:

Group number:

Email address (optional):

Signature:

Today's date:

Please return this completed form by mailing in the postage paid envelope enclosed, emailing to **inquiries@thehealthplan.com** or faxing to 570-808-7899.

# Broker of record request form

Geisinger Health Plan

## Group information

Group name: _____

Group number: _____

Group authorized representative's name: _____

## Broker of record information

The general agent, agency and selling agent listed below must have a valid appointment with Geisinger Health Plan (GHP) in order to be processed as broker of record. If no current appointment exists, appointment paperwork must be submitted in a timely manner.

Agent name: _____

Agency name (if applicable): _____

General agency (if applicable): _____

Broker of record effective date: _____

## Required signatures

☐ I hereby authorize the agent above to electronically sign and submit my employer application for health care coverage to GHP.

Employer name (print): _____ Date: _____

Employer signature: _____

☐ I acknowledge that any contract for provision of group healthcare coverage must be entered into between GHP and the group. The broker/agent cannot bind coverage for GHP. I understand that all payments should be sent directly to GHP.

Broker name (print): _____ Date: _____

Broker signature: _____