Enrollment Questionnaire

GEHA

5E

Member information		
Member ID:		
Member name (first, middle initial, last):		
Member address:		
City:	State:	Zip:
Phone number:	Email address:	

Important information needed by GEHA.
Questions? 800.821.6136, enroll@geha.com

Please mail to GEHA, P.O. Box 21542,
Eagan, MN 55121-9930;
fax to 816.257.3302;
or email a copy to enroll@geha.com.

Enrollment Information	
Plan option enrolled:	Plan option name:

Family enrollment – Spouse and dependent information

Listed are all eligible individuals (spouse, children under 26, and applicable disable children over age 26). If the relationship of any family member listed below is other than spouse, son, daughter, stepchild, or legally adopted child, your personnel office/OPM must determine eligibility for coverage. If there are any missing and/or incorrect information please provide in space below.

First name	Middle initial	Last name	Preferred name	Date of birth	Relationship to member	Gender M/F	Social Security number

Date employed with the federal government: _____

Please advise if any family member(s) are now or have been previously covered by another federal plan. [ ] Yes* [ ] No

*If yes, advise name of plan, phone number and date of cancellation.

Name: _____ Phone number: _____ Date: _____

Are you married? [ ] Yes* [ ] No *If yes, date of marriage: _____

Name of spouse: _____

Does any member on your plan have any other health insurance coverage through an employer group plan, a student health plan, or an active duty military plan? If so, please list the information below.

Name of policy holder	Social Security number	Date of birth	Telephone number	Relationship to GEHA subscriber

Company/Employer name: _____

Is the policy holder retired from this employer? [ ] Yes* [ ] No *If yes, date of retirement: _____

Medical plan [ ] Yes [ ] No Insurance plan name: _____ Phone number: _____

Policy number: _____ Group number: _____ HMO? [ ] Yes [ ] No

COBRA [ ] Yes [ ] No Effective date: _____ Termination date: _____

Prescription plan [ ] Yes [ ] No Insurance plan name: _____

Phone number: _____ Policy number: _____

Dental plan [ ] Yes [ ] No Insurance plan name: _____

Phone number: _____ Policy number: _____

Covered members	Relationship to Policyholder Child / Step child / Spouse	Original effective date	Termination date	Check *all* that apply **Medical**	**RX**	**Dental**
_____	_____	_____	_____	___	___	___
_____	_____	_____	_____	___	___	___
_____	_____	_____	_____	___	___	___
_____	_____	_____	_____	___	___	___

Were there any breaks in coverage? [ ] Yes [ ] No Dates: _____

Is this seasonal coverage? [ ] Yes [ ] No **Please enclose a copy of both the front and back of your other coverage insurance card and return with the form.**

For dependent children

Is there a divorce decree or court order that states who is to carry the primary insurance for the child/children? [ ] Yes [ ] No* [ ] NA

*If not, does the divorce decree/court order state that both parents are to carry insurance on the child/children? [ ] Yes [ ] No

Does one parent have custody? [ ] Yes* [ ] No *If yes, name of parent: _____

Do parents share joint custody? [ ] Yes [ ] No

Name and birth date of other natural parent not listed on the GEHA plan: _____

Please provide us with a copy of the court decree that assigns financial responsibility for the child's health insurance and/or designates custody.

Worker's compensation claims

If you or a covered dependent has filed a claim with worker's compensation, please enter the information below:

Name of family member who has filed a claim: _____

Case number: _____ Date of injury: _____ Diagnosis(s): _____

Insurance carrier name: _____ Insurance carrier phone number: _____

Is the member/dependent currently receiving worker's compensation benefits under the claim? [ ] Yes [ ] No*

*If no, please indicate the date the case was closed: _____

Medicare coverage If you or any covered dependent is eligible for Medicare please enter information below.

Name	Medicare number – copy exactly as it is on your card – include all numbers and any letters	Coverage reason (age, disabled, ESRD)	Hospital coverage (part A) eff. date MO/YR	Medical coverage (part B) eff. date MO/YR	Prescription drug coverage (part D) eff. date MO/YR
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

If you or any eligible family member is covered by Medicare part D, please provide the name and phone number of the prescription drug plan (PDP) in which you are enrolled: Name: _____ Phone number: _____

Is this a Medicare Advantage plan? [ ] Yes* [ ] No

*If yes, what is the name: _____ *If yes, what is the phone number? _____

Health Savings Advantage℠ HDHP Questions

If you are enrolling in the Health Savings Advantage℠ HDHP plan, please answer the questions below.

As of the first of the new benefit period*, will you be covered as a dependent on someone else's tax return? [ ] Yes [ ] No

As of the first of the new benefit period, will you have received VA benefits in the past 3 months? [ ] Yes [ ] No

As of the first of the new benefit period, are you or your family eligible for TRICARE? [ ] Yes [ ] No

As of the first of the new benefit period, will you or your spouse have a flexible spending account (FSA)? [ ] Yes* [ ] No

*If yes, what type of FSA will you have?

___ General medical FSA ___ Limited-purpose FSA ___ Post-deductible FSA

___ Other (please describe) _____

**First of the new benefit period is defined as the effective date of the coverage for which you are enrolling.*

I hereby certify that the information I have provided is true, complete and correct to the best of my knowledge.

Signature of GEHA member: _____ Date: _____

Email: _____ Daytime phone number: _____