Enrollment Questionnaire

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The Enrollment Questionnaire helps us process your medical claims accurately and quickly.
Questions? Call **800.821.6136** or email **enroll@geha.com.**

Mail to:	GEHA, P.O. Box 21542, Eagan, MN 55121-9930	**or Fax to:** **or Email to:**	816.257.3302 enroll@geha.com

Subscriber information		
Subscriber ID:	Date subscriber began employment with the federal government: _____	
Subscriber name (first, middle initial, last):		
Subscriber address:		
City:	State:	Zip:
Phone number:	Email address:	

Enrollment information

Plan option:
- ☐ Elevate
- ☐ Elevate Plus
- ☐ HDHP (High Deductible Health Plan)
- ☐ High Option
- ☐ Standard Option

Enrollment Type:
- ☐ Self Only
- ☐ Self Plus One
- ☐ Self and Family

Family enrollment – Spouse and dependent information

Please list all eligible individuals (spouse, children under 26, and applicable disabled 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.

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

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

Name of spouse: _____

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.

Plan Name: _____ Phone number: _____ Cancellation Date: _____

Does anyone covered by your plan have other medical 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: _____

Policy number: _____ Group number:_____ HMO? ☐ Yes ☐ No

COBRA ☐ Yes ☐ No Effective date: _____ Termination date: _____

Prescription plan ☐ Yes ☐ No Plan name: _____

Phone number: _____ Policy number: _____

Dental plan ☐ Yes ☐ No Plan name: _____

Phone number: _____ Policy number: _____

Covered members	Relationship to Policy holder 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? _____

High Deductible Health Plan If you are enrolled in a High or Standard Option plan, please skip this section.

If you are enrolled in the High Deductible Health Plan, please answer the questions below.

As of the effective date of coverage, will you be covered as a dependent on someone else's tax return? ☐ Yes ☐ No

As of the effective date of coverage will you have received VA benefits in the past 3 months? ☐ Yes ☐ No

As of the effective date of coverage, are you or your family eligible for TRICARE? ☐ Yes ☐ No

As of the effective date of coverage, 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) _____

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

Signature of GEHA subscriber: _____ Date: _____

Email: _____ Daytime phone number: _____