

Please return completed form to: G E B A P.O. Box 206 Annapolis Junction, MD 20701	Serving Our Members For 	Member Number <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
--	---	---

Cancellation Form

Please return this form to: *GEBA, P.O. Box 206, Annapolis Junction, MD 20701-0206.* Telephone: (301) 688-7912 or (800) 826-1126.

General Information:

Member's Name (First, MI, Last)	Member ID or Last 4 Digits of Social Security No.	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Address (Street)	Date of Birth (mm/dd/yyyy)	Home Email Address
(City) (State) (ZIP)	Home Phone No.	Black/Non-Classified Phone No.

Type of Member:

<input type="checkbox"/> Active Intelligence Community Employee	Hire Date: _____
<input type="checkbox"/> Retired Intelligence Community Employee	Hire Date: _____ Retirement Date: _____
<input type="checkbox"/> Military Assignee (Assigned to NSA-W)	Assignment Date: _____
<input type="checkbox"/> Surviving Spouse* of Employee/Retiree	Employee/Retiree Name: _____
<input type="checkbox"/> Contractor (Assigned to NSA-W)	Assignment Date: _____
Contracting Company Name: _____	

Please cancel the following INSURANCE plan effective: (Date) _____

<input type="checkbox"/> Term Life Insurance	<input type="checkbox"/> Group Vision Plan	Reason for Cancelling: <input type="checkbox"/> Recent rate increase <input type="checkbox"/> Coverage no longer needed <input type="checkbox"/> Not satisfied <input type="checkbox"/> Found coverage elsewhere <input type="checkbox"/> Retired <input type="checkbox"/> Resigned
<input type="checkbox"/> Long Term Disability	<input type="checkbox"/> Delta Dental	
<input type="checkbox"/> Aflac Cancer Plan	<input type="checkbox"/> LTC Cigna	
<input type="checkbox"/> Aflac Hospital Indemnity Plan	<input type="checkbox"/> Professional Liability Insurance	
<input type="checkbox"/> Aflac Accident Plan		
<input type="checkbox"/> Emergency Travel Plan		

Please cancel the following DEPENDENT INSURANCE plan effective: (Date) _____

Name of Dependent: _____	Birth Date of Dependent: _____
Name of Dependent: _____	Birth Date of Dependent: _____
Name of Dependent: _____	Birth Date of Dependent: _____
Name of Dependent: _____	Birth Date of Dependent: _____

<input type="checkbox"/> Term Life Insurance	<input type="checkbox"/> Group Vision Plan	Reason for Cancelling: <input type="checkbox"/> No longer eligible <input type="checkbox"/> No longer needed <input type="checkbox"/> Resigned <input type="checkbox"/> Retired
<input type="checkbox"/> Long Term Disability	<input type="checkbox"/> Delta Dental	
<input type="checkbox"/> Aflac Cancer Plan		
<input type="checkbox"/> Aflac Hospital Indemnity Plan		
<input type="checkbox"/> Aflac Accident Plan		
<input type="checkbox"/> Emergency Travel Plan		

Please cancel the following AUTOMATIC CONTRIBUTION: (Date) _____

- Supplemental Retirement Plan GIC Automatic Debit
- Supplemental Retirement Plan GIC Payroll Allotment
- Supplemental Retirement Plan MetLife Variable Annuity Contract Automatic Debit
- Supplemental Retirement Plan MetLife Variable Annuity Contract Payroll Allotment

Reason for Cancelling: _____

Signature: _____ Date: _____