


Please return completed form to: G E B A P.O. Box 206 Annapolis Junction, MD 20701	Serving Our Members For  1957 - 2007	FOR GEBA Use Only Date Received (mm/dd/yyyy)
		Member Number

Term Life Insurance Designation of Beneficiary Form

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

General Information:

Applicant's Name (First, MI, Last)	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 _____	

- Beneficiaries may be a person(s), estate, trust, or organization. If a trust is named, the legal documentation must be submitted with this form.
- If your primary beneficiary(ies) is(are) unable to accept the distribution, your contingent beneficiary(ies) will receive proceeds of the account.
- Please be sure that percentages listed in each beneficiary category add up to 100%. Use a separate sheet to list any additional beneficiaries. You must sign and date all attachments.

At GEBA, there are no membership fees required to be a member. After enrolling into at least one of GEBA's insurance or investment plans, you are considered a GEBA member. Continuing to pay your premium at least one plan allows you to remain a GEBA member in good standing.

Primary Beneficiary:

First Name, MI, Last Name	DOB	SSN	Relationship	Street Address	City, State & ZIP	% of Benefit
TOTAL:						100%

Secondary Beneficiary:

First Name, MI, Last Name	DOB	SSN	Relationship	Street Address	City, State & ZIP	% of Benefit
TOTAL:						100%

*Attach a separate sheet of paper to designate additional beneficiaries. Attachments must be signed and dated.

Signature: _____ Date: _____

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