


Please return completed form to: G E B A P.O. Box 206 Annapolis Junction, MD 20701	Serving Our Members For  1957 - 2007	Member Number
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Emergency Travel Plan Enrollment Form

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.

*Members/applicants having concerns about email communications should not provide their email address.
All correspondence with such members shall be conducted via regular mail.*

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"/> Spouse of Employee/Retiree	Employee/Retiree Name: _____
<input type="checkbox"/> Contractor (Assigned to NSA-W)	Assignment Date: _____
Contracting Company Name _____	

Indicate the Department of Defense (DoD) organization you are with or were last with (Please check only one):

- Defense Career Management Support Agency (DCMSA)
 Defense Information Systems Agency (DISA)

Intelligence Community

- Office of the Director of National Intelligence (ODNI)

Program Managers

- Central Intelligence Agency (CIA)
 Defense Intelligence Agency (DIA)
 Federal Bureau of Investigation, Directorate of Intelligence, National Security Branch (FBI)
 National Geospatial-Intelligence Agency (NGA)
 National Reconnaissance Office (NRO)
 National Security Agency (NSA)

Departmental

- Drug Enforcement Administration, Intelligence Division (DEA)
 Department of Energy, Office of Intelligence
 Department of Homeland Security, Office of Intelligence and Analysis (DHS)
 Department of State, Bureau of Intelligence and Analysis
 Department of Treasury, Office of Intelligence and Analysis

Services

- U.S. Air Force/ Intelligence and Air Intelligence Agency
 U.S. Army/DCS, G2 & Intelligence & Security Command
 U.S. Coast Guard/Intelligence & Criminal Investigations
 U.S. Marine Corps/Intelligence & Marine Corp Intelligence Activity
 U.S. Navy/Office of Naval Intelligence (ONI)
 Other: _____

How did you hear about us?

- | | |
|--|---|
| <input type="checkbox"/> New Hire/PCS Briefing or Packet | <input type="checkbox"/> Word of Mouth |
| <input type="checkbox"/> Website | <input type="checkbox"/> Member Services Representative |
| <input type="checkbox"/> Brochure | <input type="checkbox"/> Newsletter/Mailing |
| <input type="checkbox"/> Promotional Table | <input type="checkbox"/> Email |

Signature: _____ **Date:** _____

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 for at least one plan allows you to remain a GEBA member in good standing. Once a GEBA member, always a GEBA member.

Emergency Travel Plan Enrollment 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.

Member Information:

Name: _____ SSN: _____ Member #: _____
(If unknown, leave blank)

Requested Effective Date: _____

Option 1: Member

I want to be able to visit these members of my immediate family - spouse/domestic partner, parents and grandparents, children and grandchildren, brothers and sisters, brothers and sisters in-law (sibling's spouse), daughters and sons in-law. Adopted, foster and step members of the family are also include in immediate family.

Name	Relationship

* Please attach a separate signed and dated sheet of paper to list additional family members.

Option 2: Spouse (or domestic partner*)

Complete chart below if spouse or domestic partner * desires coverage.

Spouse's / Domestic Partner's Name: _____ DOB: _____

Address (if different from the member): _____

My spouse or domestic partner* wants to be able to visit these members of his or her immediate family – spouse/domestic partner, parents and grandparents, children and grandchildren, brothers and sisters, brothers and sisters in-law (sibling's spouse), daughters and sons in-law. Adopted, foster and step members of the family are also include in immediate family.

Name	Relationship

Please attach a separate signed and dated sheet of paper to list additional family members.

Option 3: Member and Spouse (or domestic partner*)

I want to travel with my spouse to visit my spouse's (or domestic partner's) immediate family not living with us and he/she wants to be able to travel with me to visit my immediate family not living with us. Their names are listed in the boxes under Options 1 & 2 above.

Option 4: Dependent(s) Information

This option expands my policy and includes my dependents listed below as additional policyholders. My dependents listed here will qualify for reimbursement when visiting *their* immediate family.

Dependent Age Limits

- Unmarried dependent children under age 19
- Unmarried dependent children age 19 or over, but under age 25 and are full-time students
- Unmarried dependent children over age 19 who are mentally impaired or physically handicapped and still dependent for support and maintenance

Name	Relationship	Birth Date
		____/____/____
		____/____/____
		____/____/____

Please attach a separate signed and dated sheet of paper to list additional family members.

*Visit www.geba.com to print, or call to request a Declaration of Domestic Partnership form. This application cannot be processed until GEBA has this form on file.

Option 4 (continued): Visitee(s) Information

My dependent wants to be able to visit these immediate family members (not already listed in Options #1 or #2) – Mother, stepmother, father, stepfather, grandparents, step-grandparents, brothers, stepbrothers, sisters, and stepsisters, sister-in-law and brother-in-law (sibling’s spouse).

Name	Relationship

Please attach a separate signed and dated sheet of paper to list additional family members.

Coverage Options & Payment Method:

Check coverage options desired below:

- Option 1. Member for his/her immediate family (\$2 biweekly) \$ _____
 - Option 2. Spouse or domestic partner for his/her immediate family (\$2 biweekly) \$ _____
 - Option 3. Cross Coverage – elect this option to travel with spouse and cover member for spouse’s or domestic partner’s immediate family and/or spouse or domestic partner to travel with member for member’s immediate family (\$2 biweekly - or \$2 biweekly per participant if Option #1 or #2 are not elected.) \$ _____
 - Option 4. Dependent(s) coverage for both mother or father’s immediate family (\$1 biweekly per dependent - Option #1, #2 or #3 must be selected to elect coverage under Option #4) \$ _____
- Total:** \$ _____

Check payment options desired below:

- Agency payroll allotment (NSA Employees Only) TOTAL PREMIUM PER AGENCY PAY PERIOD \$ _____
 - Quarterly billing QUARTERLY PREMIUM (TOTAL, multiplied by 26, divided by 4) \$ _____
 - Auto Debit QUARTERLY PREMIUM (TOTAL, multiplied by 26, divided by 4) \$ _____
- (Contact the GEBA office or www.geba.com for the Auto Debit form)*

I certify that the information presented on this application is true to the best of my knowledge and belief. I understand that any misrepresentation contained herein may be used to reduce or deny a future claim. I understand that any intent to defraud or knowingly facilitate a fraud, by submitting an application or filing a claim containing a false or deceptive statement is insurance fraud. I understand and agree that no coverage will be in force until GEBA receives this completed enrollment form (including Agency payroll allotment authorization) and assigns an effective date, of which I will be notified.

Signature: _____ **Date:** _____

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Main Address

9800 Savage Road
OPS 2A (VCC Rm. 201) Fort Meade
Maryland 20755-6104

Mailing Address

P.O. Box 206
Annapolis Junction
Maryland 20701-0206

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(301) 688-7912

Web: www.geba.com

Email: geba@geba.com