

Return completed form to:

G E B A

P.O. Box 206
Annapolis Junction, MD 20701-0206

Serving Our Members For



Member Number

Long-Term Care Inquiry/Quote Request

Applicant's Name (First, MI, Last)			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 Employee	Hire Date: _____
<input type="checkbox"/> Retired 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 |

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 a GEBA member. Paying 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.

Long-Term Care Inquiry/Quote Request (Member Information)

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.

Basic Information

Name (First, MI, Last)		Member # (if available):
Number of children and ages:	Goals (Why are you choosing Long-Term Care Insurance?) _____ Maintain Wealth _____ Not a Burden _____ Peace of Mind _____ Other: _____	
Do you have any dependent adult children? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Height: _____ Weight: _____	Date of Birth (mm/dd/yyyy): _____	
Marital/Partner Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Partner <input type="checkbox"/> Divorced <input type="checkbox"/> Widow		

Health Information and History

Within the last 10 years, have you received medical advice, diagnosis or treatment or consulted with a medical professional for any medical conditions? Please explain the details here or, if necessary, use a separate sheet of paper.

Conditions	Date of Onset	Details

Have you been treated for diabetes or elevated blood sugar? If yes, please provide the following information: Medications taken for diabetes or elevated blood sugar: _____ _____	Insulin: Number of units taken daily _____ Fasting Blood Sugar: _____
	Have you smoked in the last three (3) years? <input type="checkbox"/> Yes <input type="checkbox"/> No

Prescription Medications Used Within the Last 12 Months

Medications	Dosage	Reason for Taking

Hospitalization

Have you been hospitalized in the last 10 years? Please include residual conditions or, if necessary, use a separate sheet of paper.

Date	Detail

Signature: _____ Date: _____

Is your spouse or domestic partner also applying? Yes No
 If "Yes", please complete Spouse/Domestic Partner Application on the following page.

If you require additional room to write, please attach a separate piece of paper to this application.

Long-Term Care Inquiry/Quote Request (Spouse/Domestic Partner Information)

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.

Basic Information

Name (First, MI, Last)		Member # (if available):
Number of children and ages:	Goals (Why are you choosing Long-Term Care Insurance?)	
Do you have any dependent adult children? <input type="checkbox"/> Yes <input type="checkbox"/> No	_____ Maintain Wealth	_____ Not a Burden
Height: _____ Weight: _____	_____ Peace of Mind	_____ Other: _____
Date of Birth (mm/dd/yyyy): _____		
Marital/Partner Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Partner <input type="checkbox"/> Divorced <input type="checkbox"/> Widow		

Health Information and History

Within the last 10 years, have you received medical advice, diagnosis or treatment or consulted with a medical professional for any medical conditions?

Conditions	Date of Onset	Details

Insulin: Number of units taken daily _____ Fasting Blood Sugar: _____	Have you been treated for diabetes or elevated blood sugar? If yes, please provide the following information:
Have you smoked in the last three (3) years? <input type="checkbox"/> Yes <input type="checkbox"/> No	Medications taken for diabetes or elevated blood sugar: _____ _____

Prescription Medications Used Within the Last 12 Months

Medications	Dosage	Reason for Taking

Hospitalization

Have you been hospitalized in the last 10 years? Please include any residual conditions.

Date	Detail

Signature: _____ Date: _____

If you require additional room to write, please attach a separate piece of paper to this application.

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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