

Please return completed form to:

**G E B A**

P.O. Box 206  
Annapolis Junction, MD 20701  
Not available in all states.



Hartford Life and  
Accident Insurance  
Company  
Simsbury, CT 06089  
Policy # AGP-5610

Serving Our Members For



Member Number

## Long Term Disability Insurance Application

### 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:

Active Employee Hire Date: \_\_\_\_\_

Retired Intelligence Community Employee Hire Date: \_\_\_\_\_ Retirement Date: \_\_\_\_\_

Military Assignee (Assigned to NSA-W) Assignment Date: \_\_\_\_\_

Spouse of Employee/Retiree Employee/Retiree Name: \_\_\_\_\_

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?

- New Hire/PCS Briefing or Packet
- Website
- Brochure
- Promotional Table
- Word of Mouth
- Member Services Representative
- Newsletter/Mailing
- 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.*

### DURING GEBA'S OPEN ENROLLMENT:

You're **GUARANTEED** to receive \$1,000 of monthly long term disability coverage. If you require more, list the amount in the "Coverage Requested" section on the next page.

**REMEMBER:** Regardless of the decision for additional coverage, you are **GUARANTEED** \$1,000 of monthly coverage if enrolling during an open enrollment.

**PERSONAL INFORMATION (ALL Applicants Complete this section):**

Applicant's Full Name <input type="checkbox"/> Dr. <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.			Date of Birth	Place of Birth(City, State, Country)	
Street Address			Height Weight ___ft. ___in. ___lbs	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	
City State ZIP		Occupation		Home Phone Number	
[Membership/Eligibility No.:]		Member SSN:			
Spouse Name (if Applying)		Height Weight ___ft. ___in. ___lbs	Occupation	Date of Birth	Place of Birth(City, State, Country)

**COVERAGE REQUESTED (ALL Applicants Complete this section):**

Monthly Benefit Amount Member \$ _____ Spouse \$ _____	Waiting Period Option <i>(Member)</i> <input type="checkbox"/> 30 Days <input type="checkbox"/> 90 days <input type="checkbox"/> 180 Days <input type="checkbox"/> 365 Days	Waiting Period Option <i>(Spouse)</i> <input type="checkbox"/> 180 Days <input type="checkbox"/> 365 Days	Payment Period Option <input type="checkbox"/> Payroll deduction <i>(NSA Only)</i> <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-Annual
<input type="checkbox"/> New Coverage <input type="checkbox"/> Change in Coverage New Benefit Amount = \$ _____	Beneficiary:		

**ALL Applicants Read and Answer the following questions:**

1. Have you been actively engaged in the full-time duties of your occupation for the last 90-day period immediately before the date of this application?  
 You:  Yes  No Spouse:  Yes  No
  2. Does anyone proposed for coverage have any Disability Income Insurance in force or pending in this or any other company?  
 If yes give details  
 Name Company Monthly Benefit \$ Benefit period To Be replaced ?  
 You:  Yes  No Spouse:  Yes  No  
 Yes  No
- Is the Monthly Benefit Amount herein applied for equal to or less than [67%] of your Basic Monthly Pay minus any Other Income Benefits?  
 You:  Yes  No Spouse:  Yes  No
- At any time during the past 12 months to the present, has anyone proposed for coverage smoked cigarettes, cigars, or used a pipe, chewing tobacco, nicotine chewing gum or snuff?  
 You:  Yes  No Spouse:  Yes  No
- If Yes, amount used daily? Member \_\_\_\_\_ Spouse \_\_\_\_\_

**Use This Section When Applying for a monthly benefit of \$4,000 or LESS**

1. During the last 5 years, have you been diagnosed or been treated for cancer, tumor, high blood pressure, nervous system disorder, diabetes, any heart, blood or circulatory disorder, autoimmune disorder, gastro-intestinal disorder, any lung or respiratory disorder, kidney or genitourinary disorder, alcohol or drug dependency, mental or nervous disorder, bone, joint, back, muscle or connective tissue disorder, or chronic fatigue syndrome?  
 You:  Yes  No Spouse:  Yes  No
2. Have you ever been diagnosed or been treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)\* or any other immune deficiency disorder (see reverse for complete definition)?  
 You:  Yes  No Spouse:  Yes  No
3. Have you been confined in a hospital, nursing home, sanitarium or similar institution in the last 6 months (excluding maternity)?  
 You:  Yes  No Spouse:  Yes  No

**AUTHORIZATION:** Please review your answer to these questions to be sure that you have answered them fully and truthfully. A misrepresentation on these questions could void your coverage. Answering "Yes" to any of these questions disqualifies you from acceptance for coverage at this time. I understand that my coverage will become effective after approval by the Company and receipt of the first payment of premium. By signing this application, I acknowledge that the Application is true and accurate for each person to be insured.

By signing below, I acknowledge that I have read and agree to all terms on the reverse of this form.

X \_\_\_\_\_ X \_\_\_\_\_  
 Signature required Date Spouse Signature required if applying Date

**Use This Section When Applying for a monthly benefit of \$4,001 or MORE**

	YOU	SPOUSE
1. Has anyone proposed for coverage ever been diagnosed or treated by a member of the medical profession for:		
a. A heart murmur, high blood pressure, stroke, or any disease or disorder of the heart, blood or circulatory system?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Asthma, shortness of breath, tuberculosis or any disease or disorder of the lungs or respiratory system?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Colitis, ulcer, kidney disease, or any disease or disorder of the digestive, urinary or reproductive system?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. Alcoholism, drug abuse, severe headaches, epilepsy, dizziness or any disease or disorder of the brain or nervous system including mental or emotional disorders?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
e. Cancer, tumor, diabetes, blood or sugar in urine, or any disease or disorder of the glands?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
f. Arthritis, impaired sight or hearing, or any disease or disorder of the skin, bones, or joints, including neck or back disorders?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
g. Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or any other immune deficiency disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. During the past 5 years has anyone proposed for coverage consulted any physician, surgeon, psychologist, psychiatrist or other practitioner for any reason not previously noted on this application; or been confined or treated in any hospital, sanatorium or similar institution?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Is anyone proposed for coverage Pregnant? If yes, Name:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are there any medical complications?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

**If you answered Yes to any of the above questions, please explain the details (Attach sheet of paper if additional space is needed)**

Question Number	Name	Disorder or Reason	Dates To/From	Nature of illness, number of attacks, duration, severity, treatment, names & addresses of physicians, hospitals, & date of full recovery.

(Attach sheet of paper if additional space is needed).

**AUTHORIZATION:** I hereby certify that I have read or have had read to me all statements and answers in this application, and in any other application or medical form required by the Company, and that they are full, complete, and true to the best of my knowledge and belief. I also understand that any misrepresentation contained herein or relied on by the Company may be used to reduce or deny a claim or void the contract within the contestable period if such misrepresentation materially affects the acceptance of the risk. I understand that any intent to defraud or knowingly facilitate a fraud against the Company, by submitting an application or filing a claim containing a false or deceptive statement is insurance fraud. I also agree that a copy of this application shall be attached to and form a part of any certificate issued. I also understand that the Company may request whatever additional evidence of insurability it needs. Subject to the deferred effective date provision I understand that coverage will not become effective until the Company grants its underwriting approval. I do not receive temporary or conditional insurance coverage just because I submit an application and pay the first premium. I authorize any: doctor or counselor; health practitioner; hospital, clinic or medical facility; insurer or reinsurer; consumer reporting agency; Medical Information Bureau, Inc.; or employer; to give The Hartford or its legal representative information about my physical or mental health, (including history, condition, diagnosis and treatment), drug or alcohol use history, other insurance coverage or employment status.

The Hartford will use the information to decide if and to what extent I am eligible for insurance coverage or benefits under the policy. This information will be treated as confidential. I understand the Medical Information Bureau, Inc. will release records or information only to The Hartford. I authorize The Hartford to give information about me to: its reinsurer(s), the Medical Information Bureau, Inc., any other insurance company to whom I may apply for Life or Health Insurance, or other persons or organizations handling a claim, [underwriting coverage applied for] or administering coverage issued as a result of this application or as required by law. I understand that upon written request I may revoke this authorization except to the extent that action has already been taken in reliance on the authorization. This authorization expires two (2) years from the effective date of my coverage or, if no coverage has been issued one (1) year from the date of this application. I understand that a photocopy of this form is as valid as the original, and that I have a right to receive a copy of this form upon request. I certify that I have received the Notice of Insurance Information Practices.

I understand that any injury or sickness, diagnosed or undiagnosed, for which I have received medical advice or treatment in the 12 month period prior to my effective date of coverage will not be covered until I have gone 12 months ending on or after my effective date of coverage without medical advice or treatment for that condition, or until two (2) years after my effective date of coverage, whichever comes first, provided that the condition is not specifically excluded or limited by the policy or by a Health Waiver attached to my certificate. Applications to increase coverage will be subject to a new pre-existing conditions limitation. I further understand that any condition excluded or limited by the policy or by a Health Waiver attached to my certificate will not be covered under this policy at any time.

Signature of Applicant \_\_\_\_\_ Date \_\_\_\_\_

Signature of Spouse (if applying) \_\_\_\_\_ Date \_\_\_\_\_

**STATE NOTICE**

Any person who includes any false or misleading information on an application or filing a claim for an insurance policy is subject to criminal and civil penalties. It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. In certain states, penalties may include imprisonment, fines, denial of insurance, and civil damages.

Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the State Insurance Regulatory Agency and/or Division of Insurance. If while in the state of Florida, a person knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information, the person is guilty of a felony in the third degree. Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false, misleading or deceptive information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall be subject to substantial civil and/or criminal penalty where and to the extent allowed by state law.

Policy Form # SRP-1311 AP (A)(HLA)5610)

uid#GDI02.10

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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

**Phone:** (800) 826-1126  
(301) 688-7912

**Fax:** (301) 688-6694

**Web:** [www.geba.com](http://www.geba.com)

**Email:** [geba@geba.com](mailto:geba@geba.com)