

|   |   |   |                               |
|---|---|---|-------------------------------|
| Return completed form to:<br><br>P.O. Box 206<br>Annapolis Junction, MD 20701-0206 |  | Serving Our Members For<br> | <b>Member Number:</b><br><br> |
|---|---|---|-------------------------------|

## Term Life Insurance Enrollment Form

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

### 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                          |

**IF ENROLLING INTO TERM LIFE INSURANCE DURING A GEBA OPEN ENROLLMENT PERIOD:**

You're **GUARANTEED** to receive \$250,000 of term life insurance. If you require more, please list the amount in the "Coverage Requested" section on the next page.

**REMEMBER:** Regardless of the decision, you are **GUARANTEED** \$250,000 of term life insurance coverage if enrolling during an open enrollment.

**Open enrollment offer only available to those under the age of 65.**

**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 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.*

# Term Life Insurance Enrollment Form

Sponsor Name and Address: GEBA - P.O. Box 206, Annapolis Junction, MD 20701-0206

Please return this form to: GEBA, P.O. Box 206, Annapolis Junction, MD 20701-0206 - OR - Fax to (301) 688-6694.  
Call us with questions at (301) 688-7912 or (800) 826-1126.

Employee Name: (Leave space between Last, First, MI)

Married  Single  
# Children \_\_\_\_\_

Social Security No. \_\_\_\_\_

## COVERAGE REQUESTED

Term Life - Coverage: \$ \_\_\_\_\_  
Bi-weekly Rate: \$ \_\_\_\_\_

\*\* Spousal/Dependent Term Life - Coverage: # of Units \_\_\_\_\_  
Bi-Weekly Rate: \$ \_\_\_\_\_

## PAYMENT OPTIONS

Payroll Deduction (NSA and DIA Only)  
 Automatic Debit (Please include a GEBA auto-debit form)  
 Direct Billing

Quarterly  Semi-Annual  Annual

*If you choose direct billing, please include your first payment for the billing period selected with this enrollment form.*

## PLEASE COMPLETE IF APPLYING FOR DEPENDENT COVERAGE

Name and relationship of Spouse/Domestic Partner\* \_\_\_\_\_  
Social Security Number \_\_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex  Male  Female

Name of Dependent Child: \_\_\_\_\_  
Social Security Number \_\_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex  Male  Female

Name of Dependent Child: \_\_\_\_\_  
Social Security Number \_\_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex  Male  Female

*For additional children, please attach a separate sheet.*

*\*Must complete a Declaration of Domestic Partnership form at [www.geba.com](http://www.geba.com). This application cannot be processed until this form is on file.  
\*\*A spouse or domestic partner is not eligible for dependent coverage if he/she is insured as a member. If both you and your spouse are insured as members, only one may enroll children as dependents.*

## BENEFICIARY DESIGNATION

Primary  Contingent First MI Last Relationship Date of Birth (mm/dd/yyyy)

Beneficiary Address (Number, Street, City, State, Zip Code) Social Security No. % of Benefit

Primary  Contingent First MI Last Relationship Date of Birth (mm/dd/yyyy)

Beneficiary Address (Number, Street, City, State, Zip Code) Required for Florida and Virginia Residents Social Security No. % of Benefit

## REQUEST FOR CHANGE

1. Please add dependents to my group insurance coverage. Date I acquired eligible dependents (mm/dd/yyyy)  
Reason:  Marriage  Birth of son/daughter  Other (Explain)

2. Please  Reduce my coverage  Increase my coverage  
Current Amount: \$ \_\_\_\_\_ New Amount: \$ \_\_\_\_\_

*I understand that if I request coverage under the group policy, coverage will not go into effect unless I am actively at work on or after the proposed effective date of coverage, unless retired. I hereby authorize GEBA to deduct from my wages or salary should I elect payroll allotment (NSA Employees Only) the amount of contributions, if any, required for all coverages requested. I further understand that if I refuse any coverage under the group policy, I may apply at a later date and I must submit evidence of insurability. Such coverage will become effective on the date evidence of insurability is approved by UnumProvident.*

Signature \_\_\_\_\_ Date \_\_\_\_\_

Signature of spouse/domestic partner\* (if enrolling for dependent coverage) \_\_\_\_\_ Date \_\_\_\_\_