

Solutions today for a secure financial tomorrow.

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.

Instructions:

- **Claim must be submitted within 90 days of the eligible travel event.**
- Please print legibly or type and complete ALL requested information on this claim form.
- If the claim is submitted within 12 months of the coverage effective date, and/or travel is due to an illness, please include the Physician's Statement (available at GEBA.com) with the claim form.
- If travel was due to a death, attach a certified copy of the death certificate.
- Documentation of travel, including costs, is required. You must either include your original ticket, and the electronic ticket or some form of documentation reflecting the names of the travelers, dates of travel and ticket prices. GEBA will reimburse checked baggage fees for 1 bag per person. Please include receipt of the checked baggage fees paid.
- If your ticket was purchased with foreign currency, please specify and provide the exchange rate on the date of purchase.
- Travel must be completed prior to filing a claim.
- Benefit payments will be made directly to the Plan participant/member.

Member Information:

Name: _____ SSN: _____ Member #: _____
 Address: _____ DOB: _____
 City: _____ State: _____ ZIP: _____
 Home Phone: _____ Work Phone (black number): _____
 Email Address: _____

- I would like to have *Solutions* mailed directly to my home address.
- I do not wish to receive GEBA marketing emails, which may or may not include our monthly newsletter, promotion information, and plan details.

Membership Status:

If you are retiring/resigning and working as an Agency Contractor, please indicate.

- Agency Employee NSA/CSS Military Assignee Agency Retiree
- Agency Contractor: Contractor's name _____
- Spouse of employee/retiree/military: Spouse's name _____ SSN: _____

Claimant Information:

Please list each claimant separately.

1. Claimant Name: _____
 Relationship: Plan Participant Spouse Dependent Designate _____
2. Claimant Name: _____
 Relationship: Plan Participant Spouse Dependent Designate _____
3. Claimant Name: _____
 Relationship: Plan Participant Spouse Dependent Designate _____

Please attach another sheet of paper if you have additional claimants.

Travel Information:

Reason for Travel: Serious Illness Serious Injury Death

Name of Immediate Family Member visited: _____

Relationship to Plan Participant: _____ Date of illness/injury/death: _____

Nature of illness/injury/death: _____

Attending physician's Name and Address: _____

Dates of hospitalization: _____

Hospital Name and Address: _____

Travel Itinerary:

Departure	Return
Date _____	Date _____
Airline/Rail Name: _____	Airline/Rail Name: _____
Depart From: _____	Depart From: _____
Arrive At: _____	Arrive At: _____

Total Fares/Fees:

Total fare as appears on attached documentation: \$ _____

Total checked baggage fees (1 per person with receipt): \$ _____

Is this a foreign currency? Yes No

If yes, please list currency type and USD conversion rate on day of purchase: _____

1. Was a travel voucher used towards the purchase of this fare? Yes No

If yes, amount refunded: \$ _____ For which claimant(s): _____

2. Has any part of this fare been refunded by an airline or travel agency? Yes No

If yes, amount refunded: \$ _____ For which claimant(s): _____

3. Has (or will) any portion of this fare been (be) reimbursed by any government agency? Yes No

If yes, amount refunded: \$ _____ For which claimant(s): _____

Signature:

I have attached the following necessary documentation:

- Airline/train ticket confirmation or official travel agency documentation signed by agent
- Attending physician's statement
- Certified copy of death certificate (if travel due to a death)
- Attending Physician's Statement (if travel is within 12 months of coverage effective date, or due to a serious illness or accident)

I request benefits for these expenses and certify that the above information is complete and true to the best of my knowledge and belief. I understand that any misrepresentation contained herein may be used to reduce or deny this claim. I also understand that any intention to defraud or knowingly facilitate fraud against GEBA, by submitting a false or deceptive statement is insurance fraud.

Plan Participant's Signature: _____ Date: _____