Return completed form to: P.O. Box 206 Annapolis Junction, MD 20701-0206	Member Number (if available):

Term Life Insurance Enrollment & Change Form

Applicant's Name (Last, First, MI)	Social Security No.	Gender ☐ Male ☐ Female
Address (Street)	Date of Birth (mm/dd/yyyy)	Home Email Address
(City) (State) (Zip)	Home Phone No.	Black/Non-classified Phone No.

Type of Member:

☐ Active Employee — Hire Date: ______
☐ Retired Employee — Retirement Date: ______
☐ Military Assignee (Assigned to NSA-W) — Assignment Date: ______
☐ Spouse/Domestic Partner of Employee/Retiree — Employee/Retiree Name: ______
☐ Contractor (Assigned to NSA-W) — Assignment Date: ______
Contracting Company Name: ______

Indicate the organization you are with or were last with. (Please check only one.):

☐ Defense Information Systems Agency (DISA)
☐ Office of the Director of National Intelligence (ODNI)
☐ Other: ______

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 Corps Intelligence Activity
☐ U.S. Navy/Office of Naval Intelligence (ONI)

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 or investing in a product allows you to remain a GEBA member in good standing. Once a GEBA member, always a GEBA member. Visit www.geba.com to print, or call to request, our Declaration of Domestic Partnership form. Domestic Partner applications cannot be processed until this partnership form is on file.

Term Life Insurance Enrollment & Change 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
Call us with questions at (301) 688-7912 or (800) 826-1126.

APPLY FOR NEW COVERAGE

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

____

☐ Married ☐ Single Number of Children______________________ | Social Security No.

NEW COVERAGE REQUESTED

Member Coverage Amount (Please choose one amt.)

☐ $600,000	☐ $400,000	☐ $200,000	☐ $80,000
☐ $550,000	☐ $350,000	☐ $150,000	☐ $70,000
☐ $500,000	☐ $300,000	☐ $100,000	☐ $60,000
☐ $450,000	☐ $250,000	☐ $90,000	☐ $50,000

Spouse/Domestic Partner Coverage Amount
(Cannot exceed 100% of member's coverage or $300,000.)

☐ $300,000	☐ $200,000	☐ $100,000	☐ $80,000	☐ $60,000
☐ $250,000	☐ $150,000	☐ $90,000	☐ $70,000	☐ $50,000

Dependent Child Coverage (Covers all children)[1]

☐ $20,000 ☐ $40,000

PAYMENT OPTIONS

☐ Payroll Deduction (NSA & DIA Only)
☐ Automatic Debit (Complete the automatic debit section on the following page.)
  ☐ Quarterly ☐ Semi-Annual ☐ Annual
☐ Direct Billing (Include your first payment with this application.)
  ☐ Quarterly ☐ Semi-Annual ☐ Annual

If you choose direct billing, include your first payment for the billing period selected with this enrollment form. Choosing the direct billing option incurs a $2.00 charge per quarterly and semi-annual bill you receive. To avoid this fee, you can enroll in GEBA's automatic debit program or choose an annual bill payment.

COMPLETE IF APPLYING FOR SPOUSE/DOMESTIC PARTNER AND/OR DEPENDENT CHILD COVERAGE

Name of Spouse/Domestic Partner:______________________________ ☐ Spouse ☐ Domestic Partner

Social Security Number ______________________ Birth Date _____/_____/_____ Gender ☐ Male ☐ Female

Name of Dependent Child: ______________________________

Social Security Number ______________________ Birth Date _____/_____/_____ Gender ☐ Male ☐ Female
Disabled[1] ☐

Name of Dependent Child: ______________________________

Social Security Number ______________________ Birth Date _____/_____/_____ Gender ☐ Male ☐ Female
Disabled[1] ☐

For additional children, attach a separate sheet.
Visit www.geba.com to print, or call to request, our Declaration of Domestic Partnership Form. Partner's membership cannot be processed until GEBA has this form 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 FOR MEMBER COVERAGE

MEMBER IS AUTOMATICALLY DESIGNATED AS THE BENEFICIARY FOR ALL DEPENDENT CHILD AND SPOUSAL COVERAGE. TO CHANGE YOUR BENEFICIARIES, DOWNLOAD THE "TERM LIFE BENEFICIARY DESIGNATION FORM" FROM GEBA.COM.

☐ 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 FL and VA Residents	Social Security No.	% of Benefit

If additional room is required for beneficiary designation, use a separate sheet of paper.

CHANGE YOUR EXISTING COVERAGE

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

____

ADDITION OF DEPENDENT CHILDREN COVERAGE

1. Add dependent child(ren) to my group insurance coverage.
   Reason: ☐ Marriage ☐ Birth of Child ☐ Adoption ☐ Other (Explain)
2. Complete information on dependent child and choose dependent child coverage amount below.

Name of Dependent Child: ______________________________

Social Security Number ______________________ Birth Date _____/_____/_____ Gender ☐ Male ☐ Female
Disabled[1] ☐

Name of Dependent Child: ______________________________

Social Security Number ______________________ Birth Date _____/_____/_____ Gender ☐ Male ☐ Female
Disabled[1] ☐

Dependent Child Coverage (Choose one:)

☐ $20,000 ☐ $40,000

☐ Add my child's coverage to my existing dependent unit coverage.[2]

INCREASE COVERAGE REQUEST (CHECK AND COMPLETE ALL THAT APPLY)

☐ Increase **MEMBER** Coverage to:	☐ $600,000 ☐ $400,000 ☐ $200,000 ☐ $80,000 ☐ $550,000 ☐ $350,000 ☐ $150,000 ☐ $70,000 ☐ $500,000 ☐ $300,000 ☐ $100,000 ☐ $60,000 ☐ $450,000 ☐ $250,000 ☐ $90,000 ☐ $50,000
☐ Increase **SPOUSE/DOMESTIC PARTNER** Coverage to: **(Cannot exceed the lesser of the member's coverage amount or $300,000)**	☐ $300,000 ☐ $200,000 ☐ $100,000 ☐ $80,000 ☐ $60,000 ☐ $250,000 ☐ $150,000 ☐ $90,000 ☐ $70,000 ☐ $50,000
☐ Increase **DEPENDENT** Coverage to:	☐ $40,000

AUTOMATIC DEBIT PAYMENT REQUEST

AUTO DEBIT PAYMENT FREQUENCY: ☐ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually

DEBIT THE ACCOUNT BELOW (Check only one item:)	ACCOUNT INFORMATION (Complete all information below:)
☐ Checking Account (Enclose a copy or voided check)	Bank ABA Number: Bank Name:
☐ Savings Account (Complete account information)	Your Account #:

I hereby authorize Government Employees' Benefit Association, Inc. (GEBA) to debit my checking/savings account according to the published schedule. I understand that GEBA reserves the right, upon written notification, to terminate my participation in this payment option. If an automatic debit is returned for any reason including insufficient funds, closed or unauthorized account, GEBA will not be able to process payment. I understand that I may be subject to a $20 charge if payment is rejected, reversed, or refused by my financial institution. I may cancel participation in the GEBA Automatic Debit service with written notice 10 days prior to the premium due date.

PLEASE READ EVERYTHING BELOW THIS LINE BEFORE SIGNING

I hereby authorize GEBA to deduct from my wages or salary should I elect payroll allotment (NSA & DIA Employees Only) the amount of insurance premium, if any, required for all coverages requested.

Personalized Certificate of Coverage Page will be mailed to policyholder upon plan approval. Certificate of Insurance can be viewed, downloaded and printed at www.geba.com. If applying for new coverage or increasing existing coverage (AND NOT A NEW HIRE WITHIN 60 DAYS OF YOUR HIRE DATE), please complete an Evidence of Insurability Form available at www.geba.com.

By signing this document, I certify that I am an employee of the agency denoted on page one of this application which entitles me to become a member of GEBA.

_________ (Initial Here) Instructions on this form supercede all past GEBA term life insurance coverage requests.[2]

____
Signature Date

____
Signature of spouse/domestic partner (if enrolling for dependent coverage) Date

[1]**Continued Coverage for an Disabled Child:** *This applies only to the Dependents Insurance you have for a child. The insurance for the child will not end on the date the age limit in the definition of Qualified Dependent is reached if both of these are true: (1) The child is then mentally or physically incapable of earning a living. Prudential must receive Proof of this within 31 days of their 26th birthday. (2) The child otherwise meets the definition of Qualified Dependent. If these conditions are met, the age limit will not cause the child to stop being a Qualified Dependent. This will apply as long as the child remains so disabled. Please complete the "Statement of Dependent Eligibility" available at www.geba.com.*

[2]***See GEBA Term Life Insurance Product Brochure for more details.***

Form Updated: 2/17/11