GEBA GOVERNMENT EMPLOYEES' BENEFIT ASSOCIATION	Please return completed form to: GEBA, Inc. P.O. Box 206 Annapolis Junction, MD 20701 Or fax to: (301) 688-6694 Or email to: geba@geba.com	**Member Number:** **(if unknown leave blank)** DELTA DENTAL A REGISTERED MARK OF DELTA DENTAL PLAN ASSOCIATION

Dental Coverage Enrollment Form

General Information:

Applicant's Name (First, MI, Last):	Social Security No.:	Gender ◯ Male ◯ Female
Marital Status: ◯ Married ◯ Domestic Partner ◯ Divorced ◯ Widow/Widower ◯ Single ◯ Separated		
Street Address:	Date of Birth (mm/dd/yyyy):	Email Address:
City:	State*:	Zip:
Home Phone:	Work Phone:	

By providing your email address to us, you expressly consent to receive emails from us. We may use email to communicate with you, to send information that you have requested or to send information about other products or services developed or provided by us, provided that, we will not give your email address to another party to promote their products or services directly to you.

Not available in Alaska.

Type of Member:

◯ Active Employee	Hire Date:	Agency and/or Department:
◯ Retiree	Retirement Date:	Agency:
◯ Military	Hire Date:	
◯ Contractor (Assigned to NSA-W)	Assignment Date:	Company:
◯ Surviving Spouse/Domestic Partner	Deceased GEBA Member Name:	
◯ Sponsored Family Member	Sponsoring Member Name:	Sponsoring Member City and State
	Relationship to Member (includes step and in-laws): ◯ Adult Child ◯ Adult Grandchild ◯ Parent ◯ Grandparent ◯ Sibling	

How Did You Hear About GEBA's Dental Plan?

- ☐ Advertisement
- ☐ Agency Announcement
- ☐ Briefing
- ☐ Brochure
- ☐ Email/Mailing
- ☐ GEBA Website
- ☐ Information Table
- ☐ Member Services Representative
- ☐ New Hire Orientation
- ☐ NSANet
- ☐ Seminar
- ☐ Word of Mouth

At GEBA, there are no membership fees required to be a member. After enrolling in 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.

Dental Coverage Enrollment Form

FOR GEBA USE ONLY
Government Employee's Benefit Association Group #: 7225-_____ Effective Date: _____

Applicant's Name: (Leave space between First, MI, Last)

_____

Address: _____

SSN: _____ **Date of Birth:** _____

TYPE OF ENROLLMENT (please check one):

◯ New Hire Enrollment If so, hire date:_____

◯ Coverage Change Returning from Overseas Enrollment

◯ Life Changing Event (select reason below)

◯ Marriage ◯ Divorce ◯ Death ◯ Birth/Adoption ◯ Loss of Benefits ◯ Other:_____

New Hire: *Enrollment is limited to the first 60 days of hire to an Agency.*

Life Changing Events*: Enrollment is limited to 60 day from a Life Changing Event.*

YOUR PLAN AND PAYMENT OPTIONS (please check one):

Which Plan?	Who will be Covered?	Please Check Your Choice of Payment Method Below. *(Shaded options are not available.)*					
			Biweekly	Monthly	Quarterly	Semiannual	Annual
Standard Delta Dental PPO℠	**Member**	NSA/DIA Payroll Allotment	◯ $12				
		Direct bill from GEBA			◯ $78	◯ $156	◯ $312
		Auto Debit from bank		◯ $26	◯ $78	◯ $156	◯ $312
	Member Plus One	NSA/DIA Payroll Allotment	◯ $22				
		Direct bill from GEBA			◯ $143	◯ $286	◯ $572
		Auto Debit from bank		◯ $47.67	◯ $143	◯ $286	◯ $572
	Member Plus Family	NSA/DIA Payroll Allotment	◯ $29				
		Direct bill from GEBA			◯ $188.50	◯ $377	◯ $754
		Auto Debit from bank		◯ $62.83	◯ $188.50	◯ $377	◯ $754
Enhanced Delta Dental PPO	**Member**	NSA/DIA Payroll Allotment	◯ $21				
		Direct bill from GEBA			◯ $136.50	◯ $273	◯ $546
		Auto Debit from bank		◯ $45.50	◯ $136.50	◯ $273	◯ $546
	Member Plus One	NSA/DIA Payroll Allotment	◯ $40				
		Direct bill from GEBA			◯ $260	◯ $520	◯ $1,040
		Auto Debit from bank		◯ $86.67	◯ $260	◯ $520	◯ $1,040
	Member Plus Family	NSA/DIA Payroll Allotment	◯ $58				
		Direct bill from GEBA			◯ $377	◯ $754	◯ $1,508
		Auto Debit from bank		◯ $125.67	◯ $377	◯ $754	◯ $1,508

Note: For new enrollees, if selecting direct bill from GEBA as your payment method, please include your first premium payment with this enrollment form. Choosing the direct billing option incurs a $2.00 charge per quarterly or semiannual bill you receive. To avoid this fee, you can enroll in GEBA's automatic debit program or choose an annual bill payment.

APPLICANT'S NAME (First, MI, and Last Name): _____

AUTOMATIC DEBIT PAYMENT REQUEST		
AUTO DEBIT PAYMENT FREQUENCY: ◯ Monthly ◯ Quarterly ◯ Semiannually ◯ Annually		
DEBIT THE ACCOUNT BELOW (Check only one item):	**ACCOUNT INFORMATION (Complete all information below):**	
◯ Checking Account (Enclose voided check)	Bank Routing Number:	Bank Name:
◯ Savings Account (Complete account information)	Your Account Number:	
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.		

Do You Have Coverage Under Another Dental Plan? ◯ Yes ◯ No

If yes, please complete:

Name of Carrier(s):_____ Group Number:_____

Employer Insurance is Offered Through:_____

DEPENDENTS:

Plan participants may elect coverage for a spouse, domestic partner, and dependent children up to age 26. Coverage for a dependent child cancels immediately upon attainment of age limit, 26.

☐ Add dependents listed below to coverage

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.

List all family members to be covered:

	Last Name (if different)	First Name	MI	Sex	Birth Date	Disabled?
Spouse/Domestic Partner				◯M ◯F	____/____/____	◯Y ◯N
Child				◯M ◯F	____/____/____	◯Y ◯N
Child				◯M ◯F	____/____/____	◯Y ◯N
Child				◯M ◯F	____/____/____	◯Y ◯N
Child				◯M ◯F	____/____/____	◯Y ◯N
Child				◯M ◯F	____/____/____	◯Y ◯N
Child				◯M ◯F	____/____/____	◯Y ◯N

PLEASE SIGN BELOW

By signing below, I agree to pay a full year of premium payments. I understand that if I cancel coverage before paying for a full year of premium payments, the balance will be due at the time of cancellation. I certify that the above information is correct.

Signature: _____ **Date:** _____