



Please return completed form to:
 GEBA, Inc.
 P.O. Box 206
 Annapolis Junction, MD 20701
 Or fax: (301) 688-6694
 Or email: geba@geba.com

Member Number
 (if unknown, leave blank)



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

Date of Birth Email Address

Address Line 1 Address Line 2

City State* Zip Code

Home Phone Cell Phone Office 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. 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 Agency/Department/Bureau Hire Date

Retiree Agency/Department/Bureau/Branch of Service Retirement Date

Military Branch of Service Hire Date

Contractor (assigned to NSA-W) Company Assignment Date

Surviving Spouse/Domestic Partner Deceased GEBA Member Name

Sponsored Family Member Sponsoring Member ID 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 Brochure Information Table Internal Agency Site
- Agency Announcement Email/Mailing Member Services Representative Seminar
- Briefing GEBA Website New Hire Orientation Word of Mouth

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.

Dental Coverage Enrollment Form

FOR GEBA USE ONLY

Government Employees' Benefit Association

Group #: 7225- _____

Effective Date: _____

Applicant's Name (First, MI, Last)

Social Security No.

Date of Birth

Address Line 1

Address Line 2

City

State

Zip Code

Type of Enrollment:

New Hire Enrollment If so, hire date:

Returning from Overseas Enrollment

Life Changing Event (select reason below)

Marriage Divorce 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 days from a Life Changing Event.

Do you have Coverage under Another Dental Plan? Yes No

Name of Carrier(s): Group Number:

Employer Insurance is Offered Through:

Plan And Payment Option:

	NSA/DIA Biweekly Payroll Allotment	Monthly Auto Debit from Bank	Quarterly Auto Debit from Bank	Semi-Annual Auto Debit from Bank	Annual Auto Debit from Bank	
Standard Plan Dental PPOSM	MEMBER	<input type="checkbox"/> \$12.00	<input type="checkbox"/> \$26.00	<input type="checkbox"/> \$78.00	<input type="checkbox"/> \$156.00	<input type="checkbox"/> \$312.00
	MEMBER PLUS ONE	<input type="checkbox"/> \$22.00	<input type="checkbox"/> \$47.67	<input type="checkbox"/> \$143.00	<input type="checkbox"/> \$286.00	<input type="checkbox"/> \$572.00
	MEMBER PLUS FAMILY	<input type="checkbox"/> \$29.00	<input type="checkbox"/> \$62.83	<input type="checkbox"/> \$188.50	<input type="checkbox"/> \$377.00	<input type="checkbox"/> \$754.00
Enhanced Plan Dental PPO	MEMBER	<input type="checkbox"/> \$22.00	<input type="checkbox"/> \$47.67	<input type="checkbox"/> \$143.00	<input type="checkbox"/> \$286.00	<input type="checkbox"/> \$572.00
	MEMBER PLUS ONE	<input type="checkbox"/> \$41.00	<input type="checkbox"/> \$88.83	<input type="checkbox"/> \$266.50	<input type="checkbox"/> \$533.00	<input type="checkbox"/> \$1,066.00
	MEMBER PLUS FAMILY	<input type="checkbox"/> \$59.00	<input type="checkbox"/> \$127.83	<input type="checkbox"/> \$383.50	<input type="checkbox"/> \$767.00	<input type="checkbox"/> \$1,534.00

Dental Coverage Enrollment Form

Applicant's Name (First, MI, Last)

Automatic Debit Payment Information:

Checking Account (Enclose a voided check) Savings Account

Bank Name:

Bank Routing Number:

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.

Please List All Covered Family Members:

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

					Disabled?
Spouse/Domestic Partner's Name*	<input type="text"/>	Date of Birth	<input type="text"/>	<input type="checkbox"/> Male <input type="checkbox"/> Female	
Child's Name	<input type="text"/>	Date of Birth	<input type="text"/>	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No
Child's Name	<input type="text"/>	Date of Birth	<input type="text"/>	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No
Child's Name	<input type="text"/>	Date of Birth	<input type="text"/>	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No
Child's Name	<input type="text"/>	Date of Birth	<input type="text"/>	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No
Child's Name	<input type="text"/>	Date of Birth	<input type="text"/>	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No
Child's Name	<input type="text"/>	Date of Birth	<input type="text"/>	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No
Child's Name	<input type="text"/>	Date of Birth	<input type="text"/>	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No
Child's Name	<input type="text"/>	Date of Birth	<input type="text"/>	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No
Child's Name	<input type="text"/>	Date of Birth	<input type="text"/>	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No
Child's Name	<input type="text"/>	Date of Birth	<input type="text"/>	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No

*Visit www.GEBA.com/forms to print or call to request our Declaration of Domestic Partnership form. Application cannot be processed until this form is on file with GEBA.

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: