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 Dental PPO℠	**MEMBER**	☐ $12.00	☐ $26.00	☐ $78.00	☐ $156.00	☐ $312.00
	MEMBER PLUS ONE	☐ $22.00	☐ $47.67	☐ $143.00	☐ $286.00	☐ $572.00
	MEMBER PLUS FAMILY	☐ $29.00	☐ $62.83	☐ $188.50	☐ $377.00	☐ $754.00
Enhanced Plan Dental Dental PPO	**MEMBER**	☐ $22.00	☐ $47.67	☐ $143.00	☐ $286.00	☐ $572.00
	MEMBER PLUS ONE	☐ $41.00	☐ $88.83	☐ $266.50	☐ $533.00	☐ $1,066.00
	MEMBER PLUS FAMILY	☐ $59.00	☐ $127.83	☐ $383.50	☐ $767.00	☐ $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		Date of Birth	☐ Male ☐ Female	
Child's Name		Date of Birth	☐ Male ☐ Female	☐ Yes ☐ No
Child's Name		Date of Birth	☐ Male ☐ Female	☐ Yes ☐ No
Child's Name		Date of Birth	☐ Male ☐ Female	☐ Yes ☐ No
Child's Name		Date of Birth	☐ Male ☐ Female	☐ Yes ☐ No
Child's Name		Date of Birth	☐ Male ☐ Female	☐ Yes ☐ No
Child's Name		Date of Birth	☐ Male ☐ Female	☐ Yes ☐ No
Child's Name		Date of Birth	☐ Male ☐ Female	☐ Yes ☐ No
Child's Name		Date of Birth	☐ Male ☐ Female	☐ Yes ☐ No
Child's Name		Date of Birth	☐ Male ☐ Female	☐ Yes ☐ No
Child's Name		Date of Birth	☐ Male ☐ Female	☐ Yes ☐ No

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: