GEBA
GOVERNMENT EMPLOYEES' BENEFIT ASSOCIATION

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)

Call us with questions:
(301) 688-7912 or (800) 826-1126

Emergency Travel Plan (ETP) 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

Address Line 1

Date of Birth

Email Address

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 provided by us. We will not give your email address to another party to promote their products or services directly to you.

Type of Member:

☐ Active Employee
Agency/Department/Bureau
Hire Date

☐ Retiree
Agency/Department/Bureau
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 Emergency Travel 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.

Emergency Travel Plan (ETP) Enrollment Form

Applicant's Name (First, MI, Last)

Enrollment Options:

☐ **Option 1: Member Only**

This option allows the member to visit their immediate family - spouse/domestic partner, parents and grandparents, children and grandchildren, brothers and sisters, brothers in-law and sisters in-law (sibling's spouse), daughters in-law and sons in-law. Adopted, foster and step members of the family are also include in immediate family.

☐ **Option 2: Member plus Spouse or Domestic Partner***

This option allows for the spouse or domestic partner (of the member) to visit his or her immediate family – spouse/domestic partner, parents and grandparents, children and grandchildren, brothers and sisters, brothers in-law and sisters in-law (sibling's spouse), daughters in-law and sons in-law. Adopted, foster and step members of the family are also include in immediate family.

☐ **Option 3: Member plus Spousal/Domestic Partner Coverage plus Cross Coverage**

This option allows for the member to travel to visit the spouse's immediate family and for the spouse to visit the member's immediate family.

☐ **Option 4: Dependent(s) Coverage (up to age 26)**

This option allows dependent children listed below as additional policyholders. Dependent children listed will qualify for reimbursement when visiting defined family members of the member and spouse/domestic partner or other family members defined on page 3.

*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 List All Covered Family Members:

Coverage for a dependent child cancels immediately upon attainment of age limit, 26. At age 26, dependent children can enroll in their own plan as a Sponsored Family Member.

Spouse/Domestic Partner's Name		Date of Birth	
Address (if different from the member)			
Dependent Child's Name		Date of Birth	
Dependent Child's Name		Date of Birth	
Dependent Child's Name		Date of Birth	
Dependent Child's Name		Date of Birth	

Plan And Payment Option:

Select Option 1, 2, or 3. Add Option 4 for dependent child coverage. Option 4 is cost per child.

		NSA/DIA Biweekly Payroll Allotment	Monthly Auto Debit from Bank	Quarterly Auto Debit from Bank	Semiannual Auto Debit from Bank	Annual Auto Debit from Bank
SELECT ONE	**OPTION 1: Member**	☐ $3.00	☐ $6.50	☐ $19.50	☐ $39.00	☐ $78.00
	OPTION 2: Member plus spousal coverage	☐ $6.00	☐ $13.00	☐ $39.00	☐ $78.00	☐ $156.00
	OPTION 3: Member plus spousal coverage plus cross coverage	☐ $9.00	☐ $19.50	☐ $58.50	☐ $117.00	☐ $234.00

OPTION 4: Add Dependent Coverage:

Cost per dependent child	☐ $3.00 each	☐ $6.50 each	☐ $19.50 each	☐ $39.00 each	☐ $78.00 each

# of Children ____ X cost per dependent child Dependent Coverage Subtotal: $ ____

Total (Option 1, Option 2, OR Option 3) + (Option 4 [Dependent Coverage] if applicable): $ ____

Emergency Travel Plan (ETP) Enrollment Form

Applicant's Name (First, MI, Last)

Option 4: Dependent Coverage Visitee(s) Information

Dependent children may be eligible to visit family members that are not immediate family members of the Member or the Spouse/Domestic Partner due to (re)marriage and/or divorce. Please list immediate family members of the dependent (not included under immediate family members of the Member or the Spouse/Domestic Partner coverage). Immediate family member of the dependent child include: Mother, stepmother, father, stepfather, grandparents, step-grandparents, brothers, stepbrothers, sisters, and stepsisters, sister-in-law and brother-in-law (sibling's spouse).

Dependent's Name		Name of Family Member		Relationship	
Dependent's Name		Name of Family Member		Relationship	
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Dependent's Name		Name of Family Member		Relationship	
Dependent's Name		Name of Family Member		Relationship	
Dependent's Name		Name of Family Member		Relationship	
Dependent's Name		Name of Family Member		Relationship	

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 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: