Phone: (800) 826-1126 or (301) 688-7912

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)

Reduction in Coverage 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 (Street)	Date of Birth (mm/dd/yyyy)	Home Email Address
(City) (State) (ZIP)	Home Phone No.	Black/Non-Classified Phone No.

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.

Plan Information (Please indicate which plan you would like this change applied to):

Member:

☐ Group Term Life Insurance Plan ☐ Group Long-Term Disability Insurance Plan

Current coverage amount: ____________________ New coverage amount: ____________________

Dependents:

☐ Group Term Life Insurance Plan ☐ Group Long-Term Disability Insurance Plan

Dependent coverage for:

☐ Spouse/Domestic Partner: Current coverage amount: ______________ New coverage amount: ______________
☐ Dependent Children: Current coverage amount: ______________ New coverage amount: ______________

Reason for Reduction in Coverage:

☐ Increase in premium
☐ Added coverage under a new plan
If yes, name of plan ________________________
☐ Retirement
☐ No longer needs coverage
☐ Have enough coverage with a different plan
If yes, name of plan ________________________
☐ Other: ____________________________________

Effective Date of Change:

☐ First of the next billing period ☐ First of the next month

☐ **Please have a GEBA Member Services Representative contact me regarding:** ________________________

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I hereby authorize GEBA to change my insurance coverage according to the information I have provided on this form. A new certificate will be sent to confirm reduction in coverage.

Signature: ____ **Date:** ______________________

Updated 2/13/2017