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)**

Long-Term Care Inquiry/Quote Request

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.

Type of Member:

☐ Active Employee	Hire Date:	
☐ Retiree	Retirement Date:	
☐ 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	

Indicate the Organization You are with or were last with (Please check only one):

(to be completed by Active Employee, Retiree, and Military only)

Department of Defense (DoD) or Intelligence Community

- ☐ Central Intelligence Agency (CIA)
- ☐ Communications-Electronics Command (CECOM)
- ☐ Defense Career Management Support Agency (DCMSA)
- ☐ Defense Contract Management Agency (DCMA)
- ☐ Defense Information Systems Agency (DISA)
- ☐ Defense Intelligence Agency (DIA)
- ☐ Defense Media Activity (DMA)
- ☐ Department of Energy, Office of Intelligence
- ☐ Department of Homeland Security, Office of Intelligence and Analysis (DHS)
- ☐ Department of Treasury, Office of Terrorism and Financial Intelligence
- ☐ Drug Enforcement Administration, Intelligence Division (DEA)
- ☐ National Geospatial-Intelligence Agency (NGA)
- ☐ National Reconnaissance Office (NRO)
- ☐ National Security Agency (NSA)
- ☐ Naval Sea Systems Command (NAVSEA)
- ☐ Office of the Director of National Intelligence (ODNI)
- ☐ DOD Other: _____

Services

- ☐ U.S. Air Force
- ☐ U.S. Army
- ☐ U.S. Coast Guard
- ☐ U.S. Marine Corps
- ☐ U.S. Navy

- ☐ **Department of State**
- ☐ **United States Agency for International Development (USAID)**
- ☐ **Federal Bureau of Investigation (FBI)**

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
- ☐ Seminar
- ☐ 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 or investing in a product allows you to remain a GEBA member in good standing. Once a GEBA member, always a GEBA member.

Long-Term Care Inquiry/Quote Request (Member Information)

Please return this form to: GEBA, P.O. Box 206, Annapolis Junction, MD 20701-0206
Call us with questions at (301) 688-7912 or (800) 826-1126.

Basic Information

Name (First, MI, Last)	Member # (if available):
Number of children and ages:	Goals *(Why are you choosing Long-Term Care Insurance?)* _____Maintain Wealth _____Not a Burden
Do you have any dependent adult children? ☐ Yes ☐ No	_____Peace of Mind _____Other:_____
Height:_____ Weight: _____	Date of Birth (mm/dd/yyyy): _____
Marital/Partner Status: ☐ Single ☐ Married ☐ Partner ☐ Divorced ☐ Widow	

Health Information and History

Within the last 10 years, have you received medical advice, diagnosis or treatment or consulted with a medical professional for any medical conditions? Please explain the details here or, if necessary, use a separate sheet of paper.

Conditions	Date of Onset	Details

Have you been treated for diabetes or elevated blood sugar? If yes, please provide the following information: Medications taken for diabetes or elevated blood sugar*:* _____ _____	Insulin: Number of units taken daily _____ Fasting Blood Sugar: _____ Have you smoked in the last three (3) years? ☐ Yes ☐ No

Prescription Medications Used Within the Last 12 Months

Medications	Dosage	Reason for Taking

Hospitalization

Have you been hospitalized in the last 10 years? Please include residual conditions or, if necessary, use a separate sheet of paper.

Date	Detail

Signature: _____ ***Date:*** _____

Is your spouse or domestic partner also applying? ☐ Yes ☐ No
If "Yes", please complete Spouse/Domestic Partner Application on the following page.

If you require additional room to write, please attach a separate piece of paper to this application.

Long-Term Care Inquiry/Quote Request (Spouse/Domestic Partner Information)

Please return this form to: GEBA, P.O. Box 206, Annapolis Junction, MD 20701-0206
Call us with questions at (301) 688-7912 or (800) 826-1126.

Basic Information

Name (First, MI, Last)	Member # (if available):
Number of children and ages:	Goals *(Why are you choosing Long-Term Care Insurance?)* _____Maintain Wealth _____Not a Burden
Do you have any dependent adult children? ☐ Yes ☐ No	_____Peace of Mind _____Other:_____
Height:_____ Weight: _____	Date of Birth (mm/dd/yyyy): _____
Marital/Partner Status: ☐ Single ☐ Married ☐ Partner ☐ Divorced ☐ Widow	

Health Information and History

Within the last 10 years, have you received medical advice, diagnosis or treatment or consulted with a medical professional for any medical conditions?

Conditions	Date of Onset	Details

Insulin: Number of units taken daily _____ Fasting Blood Sugar: _____	Have you been treated for diabetes or elevated blood sugar? If yes, please provide the following information: Medications taken for diabetes or elevated blood sugar*:* _____
Have you smoked in the last three (3) years? ☐ Yes ☐ No	_____

Prescription Medications Used Within the Last 12 Months

Medications	Dosage	Reason for Taking

Hospitalization

Have you been hospitalized in the last 10 years? Please include any residual conditions.

Date	Detail

Signature: _____ ***Date:*** _____

If you require additional room to write, please attach a separate piece of paper to this application.

GEBA®
GOVERNMENT EMPLOYEES' BENEFIT ASSOCIATION

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