GEBA GOVERNMENT EMPLOYEES' BENEFIT ASSOCIATION	**Member Number:** **(if unknown leave blank)**	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

New Hire Group Long Term Disability 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				
Street Address:			Date of Birth (mm/dd/yyyy):	Home Email Address:
City:	State:	Zip:	Home Phone No.:	Work 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. 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:	Agency:
☐ Military	Hire Date:	Services:
☐ Contractor (Assigned to NSA-W)	Assignment Date:	Company:

How Did You Hear About GEBA's Long Term Disability Insurance Plan?

☐ Advertisement	☐ Brochure	☐ Information Table	☐ NSANet
☐ Agency Announcement	☐ Email/Mailing	☐ Member Services Representative	☐ Seminar
☐ Briefing	☐ GEBA Website	☐ New Hire Orientation	☐ Word of Mouth

At GEBA, there is no membership fee 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.

New Hire Offer:
If applying for coverage within 60 days of joining your agency or company, you are entitled to GUARANTEED* benefit of $1,600/month for yourself and $1,000/month for your spouse with a 60- or 90-day waiting period.

New Hire Group Long-Term Disability Application

The Company You Keep®

Request for Group Insurance from
NEW YORK LIFE INSURANCE COMPANY
51 Madison Avenue, New York, NY 10010

Complete this form and send to:
GEBA
P.O. Box 206
Annapolis Junction, MD 20701

GEBA
GOVERNMENT EMPLOYEES' BENEFIT ASSOCIATION

Spouse/Domestic Partner Information (Complete if applying for Spouse/Domestic Partner Coverage)

Name (First, MI, Last)	Occupation:	Date of Birth (mm/dd/yyyy):
Gender ☐ Male ☐ Female	Height/Weight: _____ft. _____in. _____lb	

Visit www.GEBA.com to print, or call to request, our Declaration of Domestic Partnership Form. Eligibility is determined by state law. Partner's membership cannot be processed until GEBA has this form on file. A spouse or domestic partner is not eligible for dependent coverage if he/she is insured as a member. If both you and your spouse are insured as members, only one may enroll children as dependents.

Coverage Request* (Check and Complete all that Apply)

I am a "New Hire" as defined on Page 1 and I am age 55 or younger. As such, I hereby apply for the following Group Long Term Disability coverage(s):

	Self	**Spouse/Domestic Partner**
Monthly Benefit Amount*:	☐ $1,600	☐ $1,000
Waiting Period:	☐ 60 Days ☐ 90 Days	☐ 60 Days ☐ 90 Days
	Member Benefit Amount $_____	Spouse/Domestic Partner Benefit Amount $_____

*The monthly benefit amount cannot exceed 67% of your gross monthly salary.

The Monthly Benefit Amount cannot exceed $1,600 or 67% of your gross monthly salary, whichever is less.

	Self	**Spouse/Domestic Partner**
1. Have you been actively engaged in the full-time duties (at least 30 hours per week) of your occupation for the 90-day period immediately before the date of this application?	☐ Yes ☐ No	☐ Yes ☐ No
2. Do you have any Disability Income Insurance in force or pending in this (New York Life) or any other company? If yes, give detail.	☐ Yes ☐ No	☐ Yes ☐ No
3. Is the Monthly Benefit Amount herein applied for equal to or less than 67% of your Basic Monthly Pay minus any Other Income Benefits?	☐ Yes ☐ No	☐ Yes ☐ No

Please fill out if answered yes to #2:

Name	**Company**	**Monthly Benefit**	**Benefit Period**	**To Be Replaced?**
		$_____		☐ Yes ☐ No
		$_____		☐ Yes ☐ No

Payment Options

☐ Payroll Deduction (NSA & DIA Only)
☐ Automatic Debit (Complete the automatic debit section on the following page.)
☐ Direct Billing (Include your first payment with this application.)
☐ Quarterly ☐ Semi-Annual ☐ Annual

If you choose direct billing, include your first payment for the billing period selected with this enrollment form. Choosing the direct billing option incurs a $2.00 charge per quarterly and semi-annual bill you receive. To avoid this fee, you can enroll in GEBA's automatic debit program or choose an annual bill payment.

Applicant Name: _____

Automatic Debit Payment Request

Auto Debit Payment Frequency:	☐ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually	
Debit the Account Below (Check only one item):	**Account Information (Complete all information below):**	
☐ **Checking Account (Enclosed a voided check)**	**Bank Routing Number:**	**Bank Name:**
☐ **Savings Account (Complete account information)**	**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 Read Everything Below this Line Before Signing

I hereby authorize GEBA to deduct from my wages or salary should I elect payroll allotment (NSA & DIA Employees Only) the amount of insurance premium, if any, required for all coverage requested.

Personalized Certificate of Coverage Page will be mailed to policyholder upon plan approval. Certificate of Insurance can be viewed, downloaded and printed at www.geba.com.

By signing and dating this application, I request the insurance indicated, attest to having read the Fraud Notices enclosed, and that to the best of my knowledge and belief, the answers to the questions are true and complete.

_____

Applicant Signature Date

_____

Signature of spouse/domestic partner (if enrolling for coverage) Date

FRAUD NOTICES:

For residents of all states <u>except</u> those listed below: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties. **RESIDENTS OF CO, the following also applies:** Any insurance company or agent who defrauds or attempts to defraud an insured shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

RESIDENTS OF AL/AR/LA/RI: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

RESIDENTS OF CA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties. The falsity of any statement in the application for any policy shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer.

FOR RESIDENTS OF D.C., WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

RESIDENTS OF FL: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

RESIDENTS OF KS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of insurance fraud as determined by a court of law.

RESIDENTS OF MD: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

RESIDENTS OF ME: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

RESIDENTS OF NJ: WARNING: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

RESIDENTS OF NY: Any person who knowingly and with intent to defraud any insurance company or any other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

RESIDENTS OF OK: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

RESIDENTS OF PUERTO RICO: Any person who, knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.

RESIDENTS OF TN/WA: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

RESIDENTS OF VA: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing false or deceptive statements may have violated state law.