Please return completed form to:	Member Number
GEBA P.O. Box 206 Annapolis Junction, MD 20701	

Reduction in Coverage Form

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

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 Intelligence Community Employee Hire Date: _____
☐ Retired Intelligence Community Employee Hire Date: _____ Retirement Date: _____
☐ Military Assignee (Assigned to NSA-W) Assignment Date: _____
☐ Spouse of Employee/Retiree Employee/Retiree Name: _____
☐ Contractor (Assigned to NSA-W) Assignment Date: _____
Contracting Company Name _____

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

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

Current coverage amount: _____ New coverage amount requested: _____

☐Term Life dependent coverage for: _____

Current coverage amount: _____ New coverage amount requested: _____

Reason for Reduction in Coverage:

☐ Received notification of premium and/or coverage change ☐ Coverage is no longer needed
☐ Retirement ☐ Other: _____

Effective Date of Change:

☐ First of the next billing period ☐ First of the next month ☐ Specific Date: _____

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

_____

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: 9/20/2012