Please return completed form to:

GEBA

P.O. Box 206
Annapolis Junction, MD 20701

Member Number

Retirement/Resignation 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:

Member's Name (First, MI, Last)		Member ID or Last 4 Digits of Social Security No.
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.

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.

I am: ☐ **Retiring** from Intelligence Community Date: _____

☐ **Resigning** from Intelligence Community Date: _____

Retirement/Resignation:

☐ **CONTINUE MY COVERAGE:** I am a **Term Life, Emergency Travel, Dental, Vision, and/or AFLAC** policyholder, and I wish to pay my premiums via Automatic Debit (see back of page) or Direct Bill:

	Monthly	Quarterly		Semi-Annual		Annual	
Term Life	☐ Auto-Debit	☐ Auto-Debit	☐ Direct Bill	☐ Auto-Debit	☐ Direct Bill	☐ Auto-Debit	☐ Direct Bill
Emergency Travel Plan	☐ Auto-Debit	☐ Auto-Debit	☐ Direct Bill	☐ Auto-Debit	☐ Direct Bill	☐ Auto-Debit	☐ Direct Bill
Dental	☐ Auto-Debit	☐ Auto-Debit	☐ Direct Bill	☐ Auto-Debit	☐ Direct Bill	☐ Auto-Debit	☐ Direct Bill
Vision	☐ Auto-Debit	☐ Auto-Debit	☐ Direct Bill	☐ Auto-Debit	☐ Direct Bill	☐ Auto-Debit	☐ Direct Bill
AFLAC Benefit Plans	☐ Auto-Debit	☐ Auto-Debit	☐ Direct Bill		☐ Direct Bill	☐ Auto-Debit	☐ Direct Bill

(***Choosing the direct billing option incurs a $2.00 charge per quarterly or semi-annual bill you receive.)***

If choosing Auto-Debit, please complete the reverse side of this form. If you are currently paying premium via automatic debits or direct billing, you will continue to have funds debited from your account or receive bills.

☐ **BECOMING A CONTRACTOR:** I am a Long Term Disability policyholder leaving the agency, but returning as a contractor assigned to the agency and I wish to continue my Long Term Disability coverage paying via direct billing or automatic debit. If choosing Auto-Debit, please complete the reverse side of this form.

☐ **CANCEL MY COVERAGE:** I am enrolled in and wish to cancel the following plans after my last payroll deduction:

☐ **Term Life Insurance** ☐ **Emergency Travel** ☐ **Dental** ☐ **AFLAC**
☐ **Vision** ☐ **Long Term Disability** ☐ **Professional Liability Insurance**

☐ I am a **Supplemental Retirement Plan** investor, and I understand that my payroll-deducted contributions will cease upon my retirement, but I would like to continue my contributions through automatic debit or check. If choosing Auto-Debit, please complete the reverse side of this form.
Plan: _____

☐ I am a **Supplemental Retirement Plan** investor, and I would like to cancel my contributions after my last payroll deduction.
Plan: _____

I UNDERSTAND: Unless otherwise specified Long Term Disability will terminate due to my departure from the agency after my last payroll deduction or at the end of the month in which I resign/retire and I will be refunded the unused portion of my paid premiums unless I am returning as a contractor. Professional Liability Insurance will terminate due to my departure from the agency after my last payroll deduction or at the end of the month in which I resign/retire and I will be refunded the unused portion of my paid premiums.

Signature: _____ **Date:** _____

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GEBA/GEMBA Automatic Debit Form

Solutions today for a secure financial tomorrow.

☐ **Change Existing Account Information** ☐ Change my Auto Debit as of _____ *(date)* ☐ Frequency ☐ Bank	☐ **Establish New Account** ☐ Start My Auto Debit _____ *(date)*

GEBA:

Plan Type	**Frequency**			
Term Life	☐ Monthly	☐ Quarterly	☐ Semi-Annually	☐ Annually
Long-Term Disability/LTD Dependent Coverage	☐ Monthly	☐ Quarterly	☐ Semi-Annually	☐ Annually
Emergency Travel Plan	☐ Monthly	☐ Quarterly	☐ Semi-Annually	☐ Annually
AFLAC Benefits Plan	☐ Monthly	☐ Quarterly		☐ Annually
Dental Coverage	☐ Monthly	☐ Quarterly	☐ Semi-Annually	☐ Annually
Vision Insurance	☐ Monthly	☐ Quarterly	☐ Semi-Annually	☐ Annually

GEMBA: ***Contribution form must be submitted.***

Plan Type	**Frequency**
SRP – SVA	
Group Annuity	Monthly $_____
IRA	Monthly $_____
Roth IRA	Monthly $_____
SRP – MetLife (Variable)	
Group Annuity	Monthly $_____
Traditional IRA	Monthly $_____

Bank Name: _____

Debit the Account Below Please check ONE item below:	**Account Information** Please complete BOTH ABA and account number below:
☐ Checking Account (enclose a copy or voided check)	Bank ABA #:_____
☐ Savings Account (complete account information)	Your Account #:_____

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.

Signature of Bank Account Holder: _____ Date: _____

NOTE: *Check with your bank to determine if additional charges for a debit apply, and ask how it will describe automatic debits on your bank statement. If you plan to have payments deducted from a savings account, please check with your bank to see if there are limitations (if any) on recurring debits.*

Date Received at GEBA Office: