

Please return completed form to:

G E B A

P.O. Box 206
Annapolis Junction, MD 20701

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

Fax: (301) 688-6694

Email: geba@geba.com

Member Number

Retirement/Resignation Form - Insurance

General Information:

Member's Name (First, MI, Last)		Member ID or Last 4 Digits of Social Security No.
Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Divorced <input type="checkbox"/> Widow/Widower <input type="checkbox"/> Single <input type="checkbox"/> 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 Date: _____
 Resigning Date: _____

Retirement/Resignation:

CONTINUE MY COVERAGE: You may keep your Group Term Life, Emergency Travel, Dental, and Vision Insurance. Please select your payment method in the table below.

Plan	Monthly	Quarterly		Semi-Annual		Annual	
Group Term Life	<input type="checkbox"/> Auto- Debit	<input type="checkbox"/> Auto- Debit	<input type="checkbox"/> Direct Bill	<input type="checkbox"/> Auto- Debit	<input type="checkbox"/> Direct Bill	<input type="checkbox"/> Auto- Debit	<input type="checkbox"/> Direct Bill
Emergency Travel Plan	<input type="checkbox"/> Auto- Debit	<input type="checkbox"/> Auto- Debit	<input type="checkbox"/> Direct Bill	<input type="checkbox"/> Auto- Debit	<input type="checkbox"/> Direct Bill	<input type="checkbox"/> Auto- Debit	<input type="checkbox"/> Direct Bill
Dental	<input type="checkbox"/> Auto- Debit	<input type="checkbox"/> Auto- Debit	<input type="checkbox"/> Direct Bill	<input type="checkbox"/> Auto- Debit	<input type="checkbox"/> Direct Bill	<input type="checkbox"/> Auto- Debit	<input type="checkbox"/> Direct Bill
Vision	<input type="checkbox"/> Auto- Debit	<input type="checkbox"/> Auto- Debit	<input type="checkbox"/> Direct Bill	<input type="checkbox"/> Auto- Debit	<input type="checkbox"/> Direct Bill	<input type="checkbox"/> Auto- Debit	<input type="checkbox"/> Direct Bill

(A \$2.00 charge is levied on Quarterly and Semi-Annual Direct Bill options)

If you are currently paying your premiums via auto-debit or direct billing, you will continue to have funds debited from your account or receive bills.

CANCEL MY COVERAGE: I wish to cancel the following plans after my last payroll deduction:

Group Term Life Insurance Dental Emergency Travel Plan
 Group Long Term Disability Vision Professional Liability Insurance

I UNDERSTAND: That my coverage for Long Term Disability and 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.

BECOMING A CONTRACTOR: I leaving the agency, but returning as a contractor assigned to the agency and I wish to continue my Group Long Term Disability coverage paying via auto-debit or direct billing.

Please complete the Payment Information if you selected Auto-Debit or if your banking information has changed.

Bank Name: _____ Please check ONE item below:	Account Information Please complete BOTH ABA and account number below:
<input type="checkbox"/> Checking Account (enclose a copy or voided check)	Bank ABA #: _____
<input type="checkbox"/> 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:** _____

Signature: _____ **Date:** _____