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

Term Life Insurance Enrollment and Change 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):	Email Address:	
City:	State:	ZIP:	Home Phone No.:	Work Phone No.:	Cell 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:
☐ Retiree	Retirement Date:	Agency:
☐ Military	Hire Date:	Services:
☐ Contractor (Assigned to NSA-W)	Assignment Date:	Company:

How Did You Hear About GEBA's Term Life 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 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 allows you to remain a GEBA member in good standing. Once a GEBA member, always a GEBA member.

Group Term Life 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

Member Information

First Name:	MI:	Last Name:	
Address:			Apt.
City:		State:	Zip:
Date of Birth (mm/dd/yyyy):	Social Security Number:		Daytime Telephone Number:
Sex: ☐ Male ☐ Female	Height:	Weight:	Evening Phone Number

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

First Name:	MI:	Last Name:	
☐ Same address as Member Address	If different, Address:		City, State, Zip:
Date of Birth (mm/dd/yyyy):	Social Security Number:		Daytime Telephone Number:
Sex: ☐ Male ☐ Female	Height:	Weight:	Evening Phone Number

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.

Dependent Child(ren) Information (Complete if applying for or changing Dependent Child(dren) Coverage)

Add dependent child(ren) to my group insurance coverage.
Reason ☐ Marriage ☐ Birth of a Child ☐ Adoption ☐ Other (Explain): _____

1	First Name:	MI:	Last Name:		
	☐ Same address as Member Address	If different, Address:		City, State, Zip:	
	Telephone Number:	Date of Birth (mm/dd/yyyy):	Social Security Number:	Sex: ☐ Male ☐ Female	☐ Disabled[1]
2	First Name:	MI:	Last Name:		
	☐ Same address as Member Address	If different, Address:		City, State, Zip:	
	Telephone Number:	Date of Birth (mm/dd/yyyy):	Social Security Number:	Sex: ☐ Male ☐ Female	☐ Disabled[1]

[1]**Continued Coverage for a Disabled Child:** *This applies only to the Dependents Insurance you have for a child. The insurance for the child will not end on the date the age limit in the definition of Qualified Dependent is reached if both of these are true: (1) The child is then mentally or physically incapable of earning a living. New York Life must receive Proof of this within 31 days of their 26th birthday. (2) The child otherwise meets the definition of Qualified Dependent. If these conditions are met, the age limit will not cause the child to stop being a Qualified Dependent. This will apply as long as the child remains so disabled. Please complete the "Statement of Dependent Eligibility" available at www.geba.com/forms.*

Applicant Name: _____

3	First Name:	MI:	Last Name:		
	☐ Same address as Member Address	If different, Address:	City, State, Zip:		
	Telephone Number:	Date of Birth (mm/dd/yyyy):	Social Security Number:	Sex: ☐ Male ☐ Female	☐ Disabled[1]
4	First Name:	MI:	Last Name:		
	☐ Same address as Member Address	If different, Address:	City, State, Zip:		
	Telephone Number:	Date of Birth (mm/dd/yyyy):	Social Security Number:	Sex: ☐ Male ☐ Female	☐ Disabled[1]

For additional children, attach a separate sheet.

Coverage Request* (Check and Complete all that Apply)

I hereby apply for the following coverage(s)

☐ Apply for **NEW** MEMBER Coverage: ☐ Apply to **INCREASE** MEMBER Coverage to:	☐ $600,000 ☐ $400,000 ☐ $200,000 ☐ $80,000 ☐ $550,000 ☐ $350,000 ☐ $150,000 ☐ $70,000 ☐ $500,000 ☐ $300,000 ☐ $100,000 ☐ $60,000 ☐ $450,000 ☐ $250,000 ☐ $90,000 ☐ $50,000
☐ Apply for **NEW** SPOUSE Coverage: ☐ Apply to **INCREASE** SPOUSE Coverage to: (Cannot exceed the lesser of the member's coverage amount or $300,000)	☐ $300,000 ☐ $200,000 ☐ $100,000 ☐ $80,000 ☐ $60,000 ☐ $250,000 ☐ $150,000 ☐ $90,000 ☐ $70,000 ☐ $50,000
☐ Apply for **NEW** DEPENDENT Coverage: ☐ Apply to **INCREASE** DEPENDENT Coverage to: (Children are eligible dependents from birth to age 26.)	☐ $20,000

*Refer to the brochure for eligibility and coverage descriptions

	Member	Spouse
Do you have other life insurance in force? If "Yes" total amount in all companies:	☐ Yes ☐ No $: _____	☐ Yes ☐ No $: _____
Do you have other life insurance applications pending? If "Yes" indicate amount and company:	☐ Yes ☐ No $: _____ Company: _____	☐ Yes ☐ No $: _____ Company: _____

Residents of New York – IMPORTANT REPLACEMENT INFORMATION: It may not be in your best interest to replace existing life insurance policies or annuity contracts in connection with the purchase of a new life insurance policy, whether issued by the same or different insurance company. A replacement will occur if, as part of your purchase of a new life insurance policy, existing coverage has been, or is likely to be, lapsed, surrendered, forfeited, assigned, terminated, changed or modified into paid-up insurance or other forms of benefits, loaned against or withdrawn from, reduced in value, by use of cash values or other policy values, changed in the length of time or in the amount of insurance that would continue or continued with a stoppage or reduction in the amount of premium paid. Prior to completing a replacement transaction, you may want to contact the insurance company or agent who sold you the life insurance or annuity contract that will be replaced to help decide whether the replacement is in your best interest.

RESIDENTS OF NEW YORK: I have read the Important Replacement Information above.

Is the life insurance applied for intended to replace, in whole or in part, any existing insurance or annuity?

Member ☐ Yes ☐ No Spouse ☐ Yes ☐ No

Applicant Name: _____

RESIDENTS OF ALL OTHER STATES:

Is the insurance applied for intended to replace, discontinue or change an existing policy?

Member ☐ Yes ☐ No Spouse ☐ Yes ☐ No

Statement of Health

To the best of your knowledge and belief, answer the following questions as they apply to you and your spouse/domestic partner to be insured. Please answer these questions by checking "Yes" or "No."

Health Questions	Member	Spouse (if applicable)
1. Are you or your spouse disabled or receiving any disability or workers compensation benefits or on waiver of premium for life or health insurance?	☐ Yes ☐ No	☐ Yes ☐ No
2. Are you or your spouse now ill, or receiving medical attention or surgical treatment?	☐ Yes ☐ No	☐ Yes ☐ No
3. During the past five years, have you or your spouse consulted any physician or other medical care practitioner other than for a routine physical examination, or checkup, or been hospitalized or had an operation or had any illness, disease or injury?	☐ Yes ☐ No	☐ Yes ☐ No
4. Are you or your spouse taking any kind of medication or so far as you know, in impaired physical or mental health?	☐ Yes ☐ No	☐ Yes ☐ No
5. Are you or your spouse now pregnant?	☐ Yes ☐ No	☐ Yes ☐ No
6. During the past five years, has any person to be insured ever been medically diagnosed by a physician as having or been treated for:		
a. Heart or circulatory trouble, high blood pressure, pain or pressure in chest?	☐ Yes ☐ No	☐ Yes ☐ No
b. Arthritis, back trouble, bone or joint disorder?	☐ Yes ☐ No	☐ Yes ☐ No
c. Fainting spells, convulsions or epilepsy?	☐ Yes ☐ No	☐ Yes ☐ No
d. Sugar, blood, albumin or pus in urine?	☐ Yes ☐ No	☐ Yes ☐ No
e. Diabetes, kidney trouble, ulcers or digestive disorder?	☐ Yes ☐ No	☐ Yes ☐ No
f. Disorder of breast or reproductive organs or functions?	☐ Yes ☐ No	☐ Yes ☐ No
g. Nervous or mental disorder, emotional conditions or psychiatric care?	☐ Yes ☐ No	☐ Yes ☐ No
h. Cancer, tumor or cyst?	☐ Yes ☐ No	☐ Yes ☐ No
i. Varicose veins, hemorrhoids or hernia?	☐ Yes ☐ No	☐ Yes ☐ No
j. Disorder of eyes, ears, nose or sinuses?	☐ Yes ☐ No	☐ Yes ☐ No
k. Thyroid, liver or respiratory disorder?	☐ Yes ☐ No	☐ Yes ☐ No
l. Alcoholism or drug habit?	☐ Yes ☐ No	☐ Yes ☐ No
m. Disorder of the blood?	☐ Yes ☐ No	☐ Yes ☐ No
n (i). Other health or physical impairment including: Being medically diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	☐ Yes ☐ No	☐ Yes ☐ No
n (ii). Other health or physical impairment including: Chronic cough, persistent diarrhea, enlarged lymph glands, chronic fatigue in the past five years?	☐ Yes ☐ No	☐ Yes ☐ No
n (iii). Other health or physical impairment including: Any other impairment?	☐ Yes ☐ No	☐ Yes ☐ No

If you answered "Yes" to any of previous questions 1-6, please provide full details below.

(If more space is needed, please attach an additional sheet.)

Member	Spouse	Question Number	Date of Illness	Date of Full Recovery	Details of nature of illness, number of attacks, duration, severity, treatments, and medications prescribed and taken	Names, complete addresses, and phone numbers of physicians
☐	☐					

Applicant Name: _____

Member	Spouse	Question Number	Date of Illness	Date of Full Recovery	Details of nature of illness, number of attacks, duration, severity, treatments, and medications prescribed and taken	Names, complete addresses, and phone numbers of physicians
☐	☐					
☐	☐					
☐	☐					

Primary Care Physician Information (For Member)		
Name	Date Last Seen	Telephone
Address		
City	State	Zip

Primary Care Physician Information (For Spouse/Domestic Partner)		
Name	Date Last Seen	Telephone
Address		
City	State	Zip

Authorization and Signature

I understand that New York Life Insurance Company has the right to require additional information and, if necessary, an examination by a physician. I ask New York Life to rely on all such statements made on this form, and any supplements to it, while considering this request. I also understand that the coverage afforded will be in consideration of the answers and statements set forth above.

AUTHORIZATION: I hereby authorize any licensed physician, medical practitioner, hospital, pharmacy, clinic or other medical or medically related facility, laboratory, insurance company, MIB, Inc. ("MIB"), or other organization, institution or person, that has any records or knowledge of me or my health to release information, including prescription drug records, maintained by physicians, pharmacy benefit managers, and other sources of information to New York Life Insurance Company, its reinsurers, its subsidiaries or the plan administrator about the physical and mental health of any persons proposed for insurance, including significant history, findings, diagnosis and treatment, but excluding psychotherapy notes for the purpose of evaluating my application for insurance. Health information obtained will not be re-disclosed without my authorization unless permitted by law, in which case it may not be protected under federal privacy rules. For example, New York Life may be required to provide it to insurance, regulatory, or other government agencies. In this case, the information may no longer be protected by the rules governing your AUTHORIZATION.

A photocopy of this AUTHORIZATION and request form shall be as valid as the original. In all circumstances, my authorized agent, representative, or I may request a copy of this AUTHORIZATION. This AUTHORIZATION shall be valid for a period of 24 months from the date signed, unless sooner revoked. The AUTHORIZATION may be revoked at any time by sending written notice to New York Life Insurance Company. My revocation will not be effective to the extent that New York Life or any other person already has disclosed or collected information or taken other action in reliance on it, or to the extent that New York Life has a legal right to contest a claim under an insurance certificate or the certificate itself.

By signing and dating this application, the member **requests** the insurance indicated; and the member and any person proposed for insurance **consent** to authorize the disclosure of information to and from the providers noted above and in the IMPORTANT NOTICE, including making a brief report of [my/our] protected health information to MIB, Inc.; and **attest** to having read the IMPORTANT NOTICE and Fraud Notices indicated enclosed, including how my/our information is exchanged with MIB, and that to the best of my/our knowledge and belief, the answers provided to the questions are true and complete.

Applicant Signature _____ Date _____

Spouse/Domestic Partner Signature _____ Date _____
(Necessary only if spouse/domestic partner coverage is requested)

G-29555-1

GMA-PR1

Applicant Name: ____________________

Beneficiary Designation for Member Coverage

Member is automatically designated as the beneficiary for all dependent child and spousal coverage.

☐ Primary First MI Last	Relationship	Date of Birth (mm/dd/yyyy)

Beneficiary Address (Number, Street, City, State, Zip Code)	Social Security No.	Telephone No.	% of Benefit 0%

☐ Primary ☐ Contingent First MI Last	Relationship	Date of Birth (mm/dd/yyyy)

Beneficiary Address (Number, Street, City, State, Zip Code)	Social Security No.	Telephone No.	% of Benefit 0%

☐ Primary ☐ Contingent First MI Last	Relationship	Date of Birth (mm/dd/yyyy)

Beneficiary Address (Number, Street, City, State, Zip Code)	Social Security No.	Telephone No.	% of Benefit 0%

☐ Primary ☐ Contingent First MI Last	Relationship	Date of Birth (mm/dd/yyyy)

Beneficiary Address (Number, Street, City, State, Zip Code)	Social Security No.	Telephone No.	% of Benefit 0%

If additional room is required for beneficiary designation, use a separate sheet of paper.

Payment Options

☐ Payroll Deduction (NSA & DIA Only)
☐ Automatic Debit (Complete the automatic debit section below.)

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 (Enclose 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 this document, I certify that I am an employee of the agency denoted on page one of this application which entitles me to become a member of GEBA.

_________ (Initial Here) Instructions in this application supercede all past GEBA term life insurance coverage requests.[2]

____
Applicant Signature Date

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

[2]*See GEBA Term Life Insurance Product Brochure for more details.*

FRAUD NOTICE – ***For Residents of all states except 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.

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 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 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 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.