Please return completed form to:
GEBA
1362 Mellon Road, #100
Hanover, MD 21076
or email: geba@geba.com
or fax: (410) 846-6420

Member Number
(if unknown, leave blank)

A REGISTERED MARK OF DELTA DENTAL PLAN ASSOCIATION

Dental Coverage Enrollment Form

General Information:

Applicant's Name (First, MI, Last)

Social Security Number

Gender ☐ Male ☐ Female

Marital Status ☐ Married ☐ Domestic Partner ☐ Divorced ☐ Widow/Widower ☐ Single ☐ Separated

Date of Birth (mm/dd/yyyy)

Email Address

Address Line 1

Address Line 2

City

State*

Zip Code

Home Phone

Cell Phone

Office Phone

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.

Not available in Alaska

Type of Member:

☐ Active Employee — Agency/Department/Bureau — Hire Date

☐ Retiree — Agency/Department/Bureau — Retirement Date

☐ Military — Branch of Service — Hire Date

☐ Surviving Spouse/Domestic Partner — Deceased GEBA Member Name

☐ Sponsored Family Member — Sponsoring Member ID — Sponsoring Member Name — Sponsoring Member City and State

Relationship to Member (includes step and in-laws)
☐ Adult Child ☐ Adult Grandchild ☐ Parent ☐ Grandparent ☐ Sibling

How Did You Hear About GEBA's Dental Plan?

☐ Advertisement ☐ Brochure ☐ Information Table ☐ Internal Agency Site

☐ Agency Announcement ☐ Email/Mailing ☐ Member Services Representative ☐ Seminar

☐ Briefing ☐ GEBA Website ☐ New Hire Orientation ☐ Word of Mouth

GEBA is a nonprofit member-governed association dedicated to serving federal employees and retirees, military and retirees, and Sponsored Family Members. GEBA never charges a membership fee - membership comes from simply enrolling in any of GEBA's insurance or investment plans.

Dental Coverage Enrollment Form

FOR GEBA USE ONLY

Government Employees' Benefit Association Group #: 7225- ________ Effective Date: ________

Applicant's Name (First, MI, Last) | Social Security No. | Date of Birth (mm/dd/yyyy)

Address Line 1 | Address Line 2 | City

State* | Zip Code

**Not available in Alaska*

Type of Enrollment:

☐ New Hire Enrollment

☐ Life Changing Event (select reason below)

☐ Marriage ☐ Divorce ☐ Birth/Adoption ☐ Loss of Benefits ☐ Retirement ☐ Returning from overseas ☐ Death

☐ Other:

Enrollment is limited to the first 60 days of hire date.
Enrollment is limited to 60 days from a Life Changing Event.

Please List All Covered Family Members:

Plan participants may elect coverage for a spouse or domestic partner* and dependent children up to age 26. Coverage for a dependent child cancels immediately upon attainment of age 26.

☐ Add dependents listed below to coverage

	First and Last Name	Date of Birth (mm/dd/yyyy)	Gender	Disabled?
Spouse/Domestic Partner			☐ Male ☐ Female	N/A
Child			☐ Male ☐ Female	☐ Yes ☐ No
Child			☐ Male ☐ Female	☐ Yes ☐ No
Child			☐ Male ☐ Female	☐ Yes ☐ No
Child			☐ Male ☐ Female	☐ Yes ☐ No
Child			☐ Male ☐ Female	☐ Yes ☐ No

Attach an additional piece of paper if necessary for additional dependents.

Plan And Payment Option:

		NSA/DIA Biweekly Payroll Allotment	Monthly Auto Debit from Bank	Quarterly Auto Debit from Bank	Semi-Annual Auto Debit from Bank	Annual Auto Debit from Bank
Standard Plan	**MEMBER**	☐ $13.00	☐ $28.17	☐ $84.50	☐ $169.00	☐ $338.00
	MEMBER PLUS ONE	☐ $25.00	☐ $54.17	☐ $162.50	☐ $325.00	☐ $650.00
	MEMBER PLUS FAMILY	☐ $32.00	☐ $69.33	☐ $208.00	☐ $416.00	☐ $832.00
Enhanced Plan	**MEMBER**	☐ $22.00	☐ $47.67	☐ $143.00	☐ $286.00	☐ $572.00
	MEMBER PLUS ONE	☐ $41.00	☐ $88.83	☐ $266.50	☐ $533.00	☐ $1,066.00
	MEMBER PLUS FAMILY	☐ $59.00	☐ $127.83	☐ $383.50	☐ $767.00	☐ $1,534.00

Dental Coverage Enrollment Form

FOR GEBA USE ONLY

Government Employees' Benefit Association Group #: 7225- ________ Effective Date: ________

Applicant's Name (First, MI, Last)

Do You Have Coverage Under Another Dental Plan?

☐ Yes ☐ No

Name of Carrier(s): Group Number:

Employer Insurance is Offered Through:

Automatic Debit Payment Information:

☐ Checking Account (Enclose a voided check) ☐ Savings Account

Bank Name:

Bank Routing Number: 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 Sign Below:

By signing below, I agree to pay a full year of premium payments. I understand that if I cancel coverage before paying for a full year of premium payments, the balance will be due at the time of cancellation. I certify that the above information is correct.

Signature: ________________________________ Date: