GEBA
Government Employees' Benefit Association

Complete this form and send to:
GEBA
1362 Mellon Road, #100
Hanover, MD 21076
For any questions, call (410) 657-8060 or (800) 826-1126
or email geba@geba.com

Member Number
(if unknown, leave blank)

Reduction in Coverage Form

General Information:

First Name | MI | Last Name | Social Security Number | Gender: ☐ Male ☐ Female

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

Date of Birth (mm/dd/yyyy) | Home E-mail Address

Address Line 1 | Address Line 2

City | State | Zip Code

Home Phone Number | Cell Phone Number | Office Phone Number

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 registered, 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.

Member:

☐ Group Term Life Insurance Plan

Current Coverage Amount:

New Coverage Amount:

☐ Group Long-Term Disability Insurance Plan

New Coverage Amount:

New Waiting Period:

Dependents:

☐ Group Term Life Insurance Plan

☐ Spouse/Domestic Partner: Current Coverage Amount: New Coverage Amount:

☐ Dependent Children: Current Coverage Amount: New Coverage Amount:

☐ Group Long-Term Disability Insurance Plan

☐ Spouse/Domestic Partner: New Coverage Amount: New Waiting Period:

Reason for Reduction in Coverage:

☐ Increase in premium

☐ Added coverage under a new plan

If yes, name of plan

☐ Retirement

☐ No longer needs coverage

☐ Have enough coverage with another plan

If yes, name of plan

☐ other:

Effective Date of Change:

☐ First of the next billing period

☐ First of the next month

☐ **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:

Revised: February 2021