Please return completed form to:
GEBA, Inc.
P.O. Box 206
Annapolis Junction, MD 20701
For any questions, call (800) 826-1126
or email geba@geba.com

Member Number
(if unknown, leave blank)

A REGISTERED MARK OF DELTA DENTAL PLAN ASSOCIATION

Dental Coverage Upgrade/Downgrade 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

Date of Birth

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 Enrollment:

☐Open Enrollment Coverage Change ☐Returning from Overseas Enrollment ☐Life Changing Event (select a reason below)

◯Marriage ◯Divorce ◯Death
◯Birth/Adoption ◯Loss of Benefit ◯Other

Plan And Payment Option:

Plan	Coverage	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 Upgrade/Downgrade Form

Applicant's Name (First, MI, Last)

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 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.

	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

Attach an additional piece of paper if necessary for additional dependents.
**Visit www.GEBA.com to print or call to request our Declaration of Domestic Partnership form. Application cannot be processed until this form is on file with GEBA.*

Do you have Coverage under Another Dental Plan? ☐ Yes ☐ No

Name of Carrier(s): Group Number:

Employer Insurance is Offered Through:

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:

Updated: September 2020