



Please return completed form to: GEBA
 1362 Mellon Road, #100
 Hanover, MD 21076
 Or: Fax: (301) 688-6694
 Or Email: geba@geba.com

Member Number:
 (if unknown leave blank)

Insurance Inquiry/Quote Request

General Information:

Applicant's Name (First, MI, Last)		Social Security No.	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
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. / Black/Non-Classified 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.

Type of Member:

<input type="checkbox"/> Active Employee	Hire Date:	Agency:
<input type="checkbox"/> Retiree	Retirement Date:	Agency:
<input type="checkbox"/> Military	Hire Date:	Services:
<input type="checkbox"/> Contractor (Assigned to NSA-W)	Assignment Date:	Company:
<input type="checkbox"/> Surviving Spouse/Domestic Partner	Deceased GEBA Member Name:	
<input type="checkbox"/> Sponsored Family Member	Sponsoring Member Name:	Sponsoring Member City and State:
Relationship to Member (includes step and in-laws): <input type="checkbox"/> Adult Child <input type="checkbox"/> Adult Grandchild <input type="checkbox"/> Parent <input type="checkbox"/> Grandparent <input type="checkbox"/> Sibling		

How Did You Hear About GEBA's Insurance Options?

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Advertisement | <input type="checkbox"/> Brochure | <input type="checkbox"/> Information Table | <input type="checkbox"/> NSANet |
| <input type="checkbox"/> Agency Announcement | <input type="checkbox"/> Email/Mailing | <input type="checkbox"/> Member Services Representative | <input type="checkbox"/> Seminar |
| <input type="checkbox"/> Briefing | <input type="checkbox"/> GEBA Website | <input type="checkbox"/> New Hire Orientation | <input type="checkbox"/> 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 or investing in a product allows you to remain a GEBA member in good standing. Once a GEBA member, always a GEBA member.



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GEBA Consultant's Name: _____ E-mail: _____

Name (First, MI, Last):		Date of Birth:	
Email:		Phone:	
		Best method of contact: () Email () Phone	
		Best time to contact: _____	
Height: ____ ft. ____ in.	Weight: ____ lbs.	Weight Change in past year? ____ lbs. () Lost () Gained	Sex: () Male () Female
Marital/Partner Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Partner <input type="checkbox"/> Divorced <input type="checkbox"/> Widow			

Please indicate what insurance you're interested in:

Life Insurance: <input type="checkbox"/> Term <input type="checkbox"/> Whole <input type="checkbox"/> With Long Term Care Rider <input type="checkbox"/> Universal Desired Amount of Life Insurance? _____ Length of Term? _____	Long Term Care Insurance: <input type="checkbox"/> Traditional <input type="checkbox"/> Annuity with Long Term Care Rider <input type="checkbox"/> Unknown/Unsure <input type="checkbox"/> Other: _____
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- Tobacco use in any form in last 12 months? () Yes () No If yes, give form and frequency: _____
- Have you recently stopped using tobacco? () Yes () No If yes, when: _____
- Adverse motor vehicle report? () Yes () No If yes, please detail: _____
- Any family history of heart or vascular disease, or cancer? () Yes () No If yes, list family member, age if living or age at death and cause: _____
- Any family history of Alzheimer or dementia? () Yes () No If yes, list family member, age if living or age at death and cause: _____
- Are you adopted? () Yes
- High blood pressure or elevated cholesterol? () Yes () No If yes, current reading: BP _____ /Chol _____
- Ever been hospitalized? () Yes () No If yes, please detail: _____

- Any history of the following? (check all that apply)

() Cancer history	If yes, date diagnosed? _____	Stage of cancer at diagnosis? _____
() Diabetes history	If yes, date diagnosed? _____	Last A1C reading? _____
	Do you use insulin? () Yes () No	Daily number of units: _____
() Alcohol or drug abuse history	If yes, date diagnosed? _____	Last date of in-treatment? _____
() Heart history / condition	Heart attack – date? _____	By pass – how many vessels and date? _____
() Sleep apnea	If yes, date diagnosed? _____	On CPAP? _____

- Does you have foreign travel plans? () Yes () No If yes, when, where, and for what duration?: _____

- Does you participate in aviation or hazardous activities? () Yes () No If yes, when, where, and for what duration?: _____

- Have you had a routine medical check-up within the past year? () Yes () No If yes, () Normal () Other _____

- List other illnesses or impairments: _____

- List any prescribed medications taken (including dosage and frequency): _____

NOTE: If you are interested in a quote for as spouse/domestic partner, please fill out an additional questionnaire.