GEBA BENEFITS

Please return completed form to:
1362 Mellon Road, #100
Hanover, MD 21076
Fax: (410) 846-6420
Email: geba@geba.com
Phone: (410) 657-8060

Member Number
(if unknown, leave blank)

DELTA DENTAL®
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
☐ Agency Announcement
☐ Briefing
☐ Brochure
☐ Email/Mailing
☐ GEBA Website
☐ Information Table
☐ Member Services Representative
☐ New Hire Orientation
☐ Internal Agency Site
☐ Seminar
☐ 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	◯ $26.00	◯ $56.34	◯ $169.00	◯ $338.00	◯ $676.00
	MEMBER PLUS FAMILY	◯ $33.00	◯ $71.50	◯ $214.50	◯ $429.00	◯ $858.00
Enhanced Plan	**MEMBER**	◯ $23.00	◯ $49.84	◯ $149.50	◯ $299.00	◯ $598.00
	MEMBER PLUS ONE	◯ $45.00	◯ $97.50	◯ $292.50	◯ $585.00	◯ $1,170.00
	MEMBER PLUS FAMILY	◯ $66.00	◯ $143.00	◯ $429.00	◯ $858.00	◯ $1,716.00

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: _____

Account Holder Signature:_____

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: _____