



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)

--	--	--	--	--	--



Vision Insurance 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 GEBA products or services. We will not give your email address to another party to promote their products or services directly to you.

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 Vision 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.

Vision Insurance Enrollment Form

Applicant's Name (First, MI, Last)

Email Address

Home Phone

Effective Date of Coverage

(must be the first of the month)

Please List All Covered Family Members:

Plan participants may elect coverage for a spouse or domestic partner* and dependent children up to age 26.

	First and Last Name	Date of Birth (mm/dd/yyyy)	Gender	Disabled?
Spouse/Domestic Partner			<input type="checkbox"/> Male <input type="checkbox"/> Female	N/A
Child			<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No
Child			<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No
Child			<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No
Child			<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> 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	<input type="checkbox"/> \$4.00	<input type="checkbox"/> \$8.67	<input type="checkbox"/> \$26.00	<input type="checkbox"/> \$52.00	<input type="checkbox"/> \$104.00
	MEMBER PLUS ONE	<input type="checkbox"/> \$7.00	<input type="checkbox"/> \$15.17	<input type="checkbox"/> \$45.50	<input type="checkbox"/> \$91.00	<input type="checkbox"/> \$182.00
	MEMBER PLUS FAMILY	<input type="checkbox"/> \$10.00	<input type="checkbox"/> \$21.67	<input type="checkbox"/> \$65.00	<input type="checkbox"/> \$130.00	<input type="checkbox"/> \$260.00
Enhanced Plan	MEMBER	<input type="checkbox"/> \$5.00	<input type="checkbox"/> \$10.84	<input type="checkbox"/> \$32.50	<input type="checkbox"/> \$65.00	<input type="checkbox"/> \$130.00
	MEMBER PLUS ONE	<input type="checkbox"/> \$11.00	<input type="checkbox"/> \$23.83	<input type="checkbox"/> \$71.50	<input type="checkbox"/> \$143.00	<input type="checkbox"/> \$286.00
	MEMBER PLUS FAMILY	<input type="checkbox"/> \$15.00	<input type="checkbox"/> \$32.50	<input type="checkbox"/> \$97.50	<input type="checkbox"/> \$195.00	<input type="checkbox"/> \$390.00

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: _____