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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)		Email 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	☐ Group Long-Term Disability Insurance Plan
Current Coverage Amount:	New Coverage Amount:
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	☐ No longer needs coverage
☐ Added coverage under a new plan	☐ Have enough coverage with another plan
If yes, name of plan	If yes, name of plan
☐ Retirement	☐ Other:

Effective Date of Change:

☐ First of the next billing period	☐ First of the next month
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☐ 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: