



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)

Individual Life Insurance & Long Term Care Inquiry/Quote Request

General Information:

Applicant's Name (First, MI, Last)	Social Security No.	Gender ☐ Male ☐ Female
Marital Status ☐ Married ☐ Domestic Partner ☐ Divorced ☐ Widow/Widower ☐ Single ☐ 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:

☐ Active Employee	Hire Date:	Agency:
☐ Retiree	Retirement Date:	Agency:
☐ Military	Hire Date:	Services:
☐ Contractor (Assigned to NSA-W)	Assignment Date:	Company:
☐ Surviving Spouse/Domestic Partner	Deceased GEBA Member Name:	
☐ Sponsored Family Member	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 Insurance Options?

- | | | | |
|--|--|---|--|
| ☐ Advertisement | ☐ Brochure | ☐ Information Table | ☐ NSANet |
| ☐ Agency Announcement | ☐ Email/Mailing | ☐ Member Services Representative | ☐ Seminar |
| ☐ Briefing | ☐ GEBA Website | ☐ New Hire Orientation | ☐ 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.



Government Employees' Benefit Association

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)

Insurance Inquiry/Quote Request

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: ☐ Single ☐ Married ☐ Partner ☐ Divorced ☐ Widow			

Please indicate what insurance you're interested in:

Life Insurance: ☐ Term ☐ Whole ☐ With Long Term Care Rider ☐ Universal Desired Amount of Life Insurance? _____ Length of Term? _____	Long Term Care Insurance: ☐ Traditional ☐ Annuity with Long Term Care Rider ☐ Unknown/Unsure ☐ Other: _____
---	--

- 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.