

Member Number: (if unknown leave blank)

## Long Term Care or Individual Life Insurance 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:**

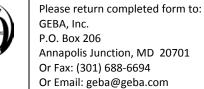
Active Employee	Hire Date:	Agency:	
🖸 Retiree	Retirement Date:	Agency:	
🖸 Military	Hire Date:	Services:	
Contractor (Assigned to NSA-W)	Assignment Date:	Company:	
Surviving Spouse/Domestic Partner	Deceased GEBA Member Name:		
Sponsored Family Member	Sponsoring Member Name:	Sponsoring Member City and State:	
	Relationship to Member (includes step and in-laws):		

#### How Did You Hear About GEBA's Long-Term Care Insurance or Individual Life Insurance Plan?

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.





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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: Weight:lbs.	Weight Change in past year? lbs. O Lost O Gained		Sex: O Male O Female		
Marital/Partner Status: 🖸 Single 🖸 Marrie	ed 🖸 Partner 🕻	Divorced	🖸 Widow		
Please indicate what insurance you're interested in:					
Long Term Care       Traditional         Insurance:       Annuity with Long Term Care         Unknown/Unsure       Other:	e Rider	Life	Insurance: Term Universal Whole With Long Term Care Rider		
		Des	ired Amount of Life Insurance? \$		
<ul> <li>Tobacco use in any form in last 12 months?</li> <li>Have you recently stopped using tobacco?</li> <li>Adverse motor vehicle report?</li> <li>Any family history of heart or vascular disease, or cancer?</li> <li>Any family history of Alzheimer or dementia?</li> <li>Are you adopted?</li> <li>High blood pressure or elevated cholesterol?</li> <li>Ever been hospitalized?</li> <li>Any history of the following? (check all that apply</li> </ul>	Yes       No         Yes       No	If yes, wh If yes, ple If yes, list If yes, list If yes, cur	e form and frequency: en: ase detail: family member, age if living or age at death and cause: family member, age if living or age at death and cause: rent reading: BP /Chol ase detail:		
Cancer history       If yes, date diagnosed?         Diabetes history       If yes, date diagnosed?         Do you use insulin?       Yes         Alcohol or drug abuse history       If yes, date diagnosed?         Heart history / condition       Heart attack – date?         Sleep apnea       If yes, date diagnosed?		Last A1C reading? Daily number of units: Last date of in-treatment? By pass – how many vessels and date? On CPAP?			
<ul> <li>Does you have foreign travel plans? Yes No If yes, when, where, and for what duration?:</li> <li>Does you participate in aviation or hazardous activities? Yes No If yes, when, where, and for what duration?:</li> <li>Have you had a routine medical check-up within the past year? Yes No If yes, No If yes, Normal Other</li> <li>List other illnesses or impairments:</li> <li>List any prescribed medications taken (including dosage and frequency):</li> </ul>					
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.