



Enrollment and/or Request for Change Form
SAMBA TERM LIFE AND PERSONAL ACCIDENT INSURANCE PLANS

Control # 9400

Return completed form to: SAMBA, 11301 Old Georgetown Road, Rockville, MD 20852-2800 • (800) 638-6589 • Fax (301) 816-0191

Select One: [] New Enrollment* [] Change to Current Coverage
*To initially enroll for coverage, the employee must be under age 70 and on active pay and duty status working at least 20 hours per week.
Employment Status: [] Active [] Retired

MEMBER INFORMATION
Last Name First Name Middle Initial Social Security No. Marital Status [] Single [] Married [] Divorced [] Widowed
Address Street City State Zip Sex [] Male [] Female
Date of Birth Date of Hire Agency (Initials) Daytime Telephone Email Address

TERM LIFE INSURANCE PLAN COVERAGE SELECTIONS
[] Member Coverage Amount \$ Premium \$
[] Spouse Coverage Amount \$ Premium \$
[] Dependent Child (cost is \$2.17 monthly for all eligible children) Premium \$ \$

Note: Health Statement Questionnaire required:
Short Form may be used up through age 55 for coverage not to exceed \$150,000.
Long Form is required for coverage exceeding \$150,000 or if the applicant requesting coverage is age 56 and older.

TERM LIFE INSURANCE PLAN RATES & COVERAGES (Effective 7/1/09)

Schedule of Insurance for Member or Spouse Under Age 70 (Monthly Premium)
Table with columns: Age, \$25,000, \$50,000, \$75,000, \$100,000, \$125,000, \$150,000, \$200,000, \$250,000, \$300,000, \$400,000, \$500,000, \$600,000

Note: Amount of coverage permitted under the SAMBA Term Life Insurance Plan for member or spouse is limited to \$600,000 each.
Dependent child (under age 26) coverage of \$20,000 can be added for a cost of \$2.17 monthly for all eligible children.
(No Health Statement Questionnaire is needed to enroll your child.)

I certify that I am actively at work and performing all the duties of my regular occupation.
[Signature]
Signature of Member – Use Payroll Name Date



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Member Information			
Last Name	First Name	Middle Initial	Social Security No.

PERSONAL ACCIDENT INSURANCE PLAN RATES & COVERAGES											TOTAL COST
You do not need to be enrolled in any other SAMBA plan to enroll in the Personal Accident Insurance Plan.											
Enrollment Option	Schedule of Insurance (Monthly Premium)										\$ _____
	\$10,000	\$25,000	\$50,000	\$100,000	\$150,000	\$200,000	\$250,000	\$300,000	\$400,000	\$500,000	
Member Only	\$0.30	\$0.76	\$1.52	\$3.03	\$4.55	\$6.07	\$7.58	\$9.10	\$12.13	\$15.17	
Member & Family*	0.50	1.24	2.48	4.97	7.45	9.93	12.42	14.90	19.87	24.83	
Coverage Selections: <input type="checkbox"/> Member Amount \$ _____ <input type="checkbox"/> Member & Family Amount \$ _____											
<small>*Coverage levels under Member & Family are: Member – amount listed; Spouse only – 60% of member coverage; Spouse and Child(ren) – 50% of member coverage for spouse, 15% of member coverage for child(ren); Child(ren) only – 20% of member coverage (coverage limited to \$50,000 per child).</small>											
If coverage selected is Member & Family, indicate dependents' names and dates of birth in <i>Dependent Information</i> below. No Health Statement Questionnaire is required to enroll for Personal Accident Insurance.											
Note: Maximum coverage amount available for members age 70 to age 74 is \$50,000. Maximum coverage amount for members age 75 and over is \$10,000.											

Please provide the name and date of birth for your spouse and/or each eligible dependent child to be covered under the Plan(s) selected on the reverse side.

Dependent Information	
SAMBA Term Life Insurance Plan	Sex Date of Birth
Spouse	<input type="checkbox"/> Male <input type="checkbox"/> Female
Child	<input type="checkbox"/> Male <input type="checkbox"/> Female
Child	<input type="checkbox"/> Male <input type="checkbox"/> Female
Child	<input type="checkbox"/> Male <input type="checkbox"/> Female
Child	<input type="checkbox"/> Male <input type="checkbox"/> Female

Personal Accident Insurance Plan	Sex Date of Birth
Spouse	<input type="checkbox"/> Male <input type="checkbox"/> Female
Child	<input type="checkbox"/> Male <input type="checkbox"/> Female
Child	<input type="checkbox"/> Male <input type="checkbox"/> Female
Child	<input type="checkbox"/> Male <input type="checkbox"/> Female
Child	<input type="checkbox"/> Male <input type="checkbox"/> Female



Beneficiary Designation/Change Form

Control # 9400

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Member Information			
Last Name	First Name	Middle Initial	Social Security No.

Please indicate your designated beneficiary(ies) name(s) and relationship(s) on the lines below. If more than one primary beneficiary is designated, settlement will be made in equal shares to the designated beneficiaries (or beneficiary) who are then still living, unless their shares are specified. If there is no named beneficiary, or no beneficiary survives the insured, settlement will be made in accordance with the terms of your Group Contract.

SAMBA Term Life Insurance Plan

PRIMARY BENEFICIARY(IES): IN EQUAL SHARES OR AS DESIGNATED BELOW

Full Name and Address	% of Proceeds	Relationship to Insured	Date of Birth

as shall then be living, and if no such beneficiary is then living **TOTAL 100%**

CONTINGENT BENEFICIARY(IES): IN EQUAL SHARES OR AS DESIGNATED BELOW

Full Name and Address	% of Proceeds	Relationship to Insured	Date of Birth

TOTAL 100%

Personal Accident Insurance Plan

PRIMARY BENEFICIARY(IES): IN EQUAL SHARES OR AS DESIGNATED BELOW

Full Name and Address	% of Proceeds	Relationship to Insured	Date of Birth

as shall then be living, and if no such beneficiary is then living **TOTAL 100%**

CONTINGENT BENEFICIARY(IES): IN EQUAL SHARES OR AS DESIGNATED BELOW

Full Name and Address	% of Proceeds	Relationship to Insured	Date of Birth

TOTAL 100%

Please refer to the Certificate for all plan details, including any exclusions, limitations and restrictions which may apply. SAMBA Term Life Insurance Plan, SAMBA Term Life Insurance Plan Accidental Death Benefit, SAMBA Dependent Term Life Insurance Plan, and Personal Accident Insurance Plan coverages are issued by The Prudential Insurance Company of America, 751 Broad Street, a Prudential Financial company, Newark, New Jersey 07102, 1-800-524-0542. If there is a discrepancy between this document and the Group Contract issued by Prudential, the terms of the Group Contract will govern. Contract provisions may vary by state. Contract Series: 83500. Prudential Financial is a service mark of The Prudential Insurance Company of America, Newark, NJ, USA and its affiliates.

Signature of SAMBA Member (or of Assignee if assigned)		Date
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For office use - do not write in this box:

Received and recorded by SAMBA representative: _____ Date: _____



If you have questions contact us at
1.800.638.6589

Mail or fax the completed form to:
SAMBA
11301 Old Georgetown Road
Rockville, MD 20852-2800
Fax 301.816.0191

Long Form Health Statement Questionnaire
Request for Coverage Form
(You must also complete the Enrollment/Change Form)

Group Contract No: 09400

Please print clearly

1 MEMBER INFORMATION					
Last Name		First Name		Middle Initial	Social Security No.
Address					
Street			City	State	Zip
Date of Birth Month Day Year		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Height Ft. In.	Weight Lbs.	Daytime Telephone _____ Evening Telephone _____

2 SPOUSE INFORMATION (Complete if you are requesting coverage for your spouse)					
Last Name		First Name		Middle Initial	Social Security No.
Date of Birth Month Day Year					
Date of Birth Month Day Year		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Height Ft. In.	Weight Lbs.	Daytime Telephone _____ Evening Telephone _____

3 HEALTH QUESTIONS (Please answer these questions by checking "Yes" or "No")

Member		Spouse (if applicable)		
Yes	No	Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1. Are you currently performing all the duties of your job for the number of hours required? If no, please explain: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2. Within the last five years, have you been evaluated for, medically treated for, diagnosed with, taken medications for, or experienced symptoms of any of the following conditions:
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	a. Disease or disorder of the heart, blood or circulatory system
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	b. High blood pressure
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	c. Cancer or tumors
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	d. Lung, respiratory or breathing disorders
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	e. Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	f. Liver or kidney disorders
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	g. Gastrointestinal, stomach or intestine disorders, including ulcers or gallstones
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	h. Mental or nervous illness or disorder, alcoholism or drug addiction
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	i. Chronic pain or fatigue syndromes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	j. Neurological disorders such as Multiple Sclerosis or Parkinson's Disease
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	k. Musculoskeletal disorders including arthritis, fractures, or carpal tunnel syndrome
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	l. HIV, Acquired Immune Deficiency Syndrome (AIDS) or AIDS-related Complex (ARC) or any other immune deficiency disorder (such as Lupus)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3. Within the last five years, have you been in a hospital or other institution for observation, rest, diagnosis or treatment?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4. Within the last five years, have you been attended by a doctor or licensed practitioner for anything other than a routine physical?

MEMBER INFORMATION			
Last Name	First Name	Middle Initial	Social Security No.

3 HEALTH QUESTIONS (continued from page 1)

Member	Spouse (if applicable)		
Yes No	Yes No	Yes No	
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	5. Do you have any known symptoms, physical or mental impairments not mentioned in the previous questions?
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	6. Are you taking any medication or being treated for any condition, including pregnancy, or disease not mentioned in the previous questions?

If you answered "Yes" to any of questions 2-6, please provide full details below.
 (If more space is needed, please attach an additional sheet.)

Member	Spouse	Question Number	Date of Illness	Date of Full Recovery	Details of nature of illness, number of attacks, duration, severity, treatments and medications prescribed and taken	Names, complete addresses and phone numbers of physicians
<input type="checkbox"/>	<input type="checkbox"/>					
<input type="checkbox"/>	<input type="checkbox"/>					
<input type="checkbox"/>	<input type="checkbox"/>					
<input type="checkbox"/>	<input type="checkbox"/>					
<input type="checkbox"/>	<input type="checkbox"/>					

Primary Care Physician Information

Name	Date last seen	Telephone
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Address

4 COVERAGE (Choose the coverage and amounts for which you are applying)

- SAMBA Term Life and Accidental Death Insurance Plan – Member**
 Coverage Amounts (please check one):
 \$ 25,000 \$ 50,000 \$ 75,000 \$100,000 \$125,000 \$150,000
 \$200,000 \$250,000 \$300,000 \$400,000 \$500,000 \$600,000

- SAMBA Term Life Plan – Spouse**
 Coverage Amounts (please check one):
 \$ 25,000 \$ 50,000 \$ 75,000 \$100,000 \$125,000 \$150,000
 \$200,000 \$250,000 \$300,000 \$400,000 \$500,000 \$600,000

- Optional Coverage(s) Requested**
 Dependent Child Coverage \$20,000

MEMBER INFORMATION			
Last Name	First Name	Middle Initial	Social Security No.

AUTHORIZATION FOR THE RELEASE OF INFORMATION. This authorization is intended to comply with the HIPAA Privacy Rule. I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, medical facility, or other health care provider that has provided payment, treatment, or services to me or on my behalf within the past 5 years ("My Providers") to disclose the entire medical record and any other health information concerning me and/or any dependent proposed for coverage in the application to The Prudential Insurance Company of America ("Prudential") and through it, to its reinsurers, authorized agents, and the Medical Information Bureau, Inc.. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection (in Vermont, this information is excluded) and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol and/or drugs, but excludes psychotherapy notes. I also authorize the Medical Information Bureau, Inc. to release any data it may have about me and/or any dependent proposed for coverage to Prudential. By my signature below, I acknowledge that any agreements I or my dependents have made to restrict my health information do not apply to this Authorization and I instruct My Providers to release and disclose the entire medical record for me and/or my dependent without restriction. This health information is to be disclosed under this Authorization so that Prudential may: 1) underwrite an application for coverage and make risk determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with Prudential. This Authorization shall remain in force for 24 months following the date of my signature below, and a copy of this Authorization is as valid as the original. I understand that I have the right to revoke this Authorization in writing, at any time, by sending a signed request for revocation to The Prudential Insurance Company of America, Group Medical Underwriting, P. O. Box 8796, Philadelphia, PA 19176, Attention: Senior Medical Underwriting Consultant. I understand that a revocation is not effective to the extent that Prudential has relied on this Authorization or to the extent that Prudential has a legal right to contest a claim under insurance coverage or to contest the coverage itself. I understand that any information that is disclosed pursuant to the Authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information. (In Montana only: I may request a record of any subsequent disclosures of protected health information.) I understand that if I refuse to sign this Authorization to release the entire medical record for me and/or my dependent, Prudential may not be able to process an application for coverage, or if coverage has been issued, may not be able to make any benefit payments. I understand that I have the right to request and receive a copy of this Authorization.

Statement of Understanding: I (We) represent that all statements and answers made within or attached to the Request Form are true and complete to the best of my (our) knowledge and belief. I (We) understand that coverage shall be in effect only after all of these conditions have been met: this application has been approved by Prudential; the Contract has been issued while all persons to be insured thereunder are alive, and; the answers and statements in this application continue to be true and complete until the Effective Date. I (We) also understand that coverage will not take effect if the facts have changed. I (We) have also read and understand and agree to the additional terms, conditions and requirements as stated in the Authorization for the Release of Information and Important Notice sections. I (We) understand that completion of this application in no way implies that I (we) will be accepted for insurance coverage.

Accelerated Death Benefits: Receipt of accelerated death benefits may affect eligibility for public assistance programs and may be taxable. There is no administrative fee to accelerate death benefits. The accelerated amount is not discounted.

Beneficiary Designation: If you name more than one beneficiary, settlement will be made in equal shares to the designated beneficiaries (or beneficiary) that survive you, unless otherwise provided in the designation. If no named beneficiary survives you, settlement will be made to your estate. The beneficiary named herein will be the beneficiary for your total amount of insurance coverage issued.

Florida Residents: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

✓

Member's Signature

Date

✓

Spouse's Signature (if applying for Spouse Coverage)

Date

Important Notice: For residents of all states except Florida, New Jersey, New York, Pennsylvania, Utah, Vermont, Virginia, and Washington: Warning: Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person, or knowing that he is facilitating commission of a fraud, submits incomplete, false, fraudulent, deceptive or misleading facts or information when filing an insurance application or a statement of claim for payment of a loss or benefit commits a fraudulent insurance act, is or may be guilty of a crime and may be prosecuted and punished under state law. Penalties may include fines, civil damages and criminal penalties, including confinement in prison. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant or if the applicant conceals, for the purpose of misleading, information concerning any fact material thereto.

New Jersey Residents: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

New York Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation. This notice ONLY applies to accident coverage.

Pennsylvania and Utah Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Vermont Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or knowingly makes a false statement in an application for insurance may be guilty of a criminal offense under state law.

Virginia Residents: Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person, or knowing that he is facilitating commission of a fraud, submits incomplete, false, fraudulent, deceptive or misleading facts or information when filing a statement of claim for payment of a loss or benefit may have violated state law, is guilty of a crime and may be prosecuted and punished under state law. Penalties may include fines, civil damages and criminal penalties, including confinement in prison. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant or if the applicant conceals, for the purpose of misleading information concerning any fact material thereto.

Washington Residents: Any person who knowingly provides false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company commits a crime. Penalties include imprisonment, fines, and denial of insurance benefits.

Please keep this notice for your records.



Federal Employee
Benefit Association

11301 Old Georgetown Road • Rockville, Maryland 20852-2800 • (301) 984-1440 • Fax (301) 816-0191

DIRECT DEBIT APPLICATION

SAMBA offers our members the convenience of having their premium payments automatically deducted from their checking or savings account on a monthly basis through our **Direct Debit Program**.

Complete the application below and mail or fax it to:

SAMBA Group Plans Department
11301 Old Georgetown Road
Rockville, MD 20852-2800
Fax (301) 816-0191

APPLICATION FOR DIRECT DEBIT PROGRAM

Please print or type

Member Name _____ ID # _____

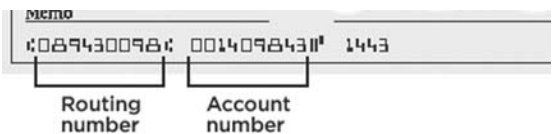
Email _____ Daytime Phone # _____

Bank Account Information

Banking Institution: _____

Account Holder's Name: _____

Bank Routing Number: _____
(9-digit number found on the bottom left of your check. See example.)



Please fill in **ONLY ONE** (checking or savings) account number in the field below.

Checking Account #: _____ *(Account number on the bottom center of check. See example.)*
 Savings Account #: _____ *(Account number from bank statement or passbook.)*

Authorization Agreement: I authorize SAMBA to automatically deduct payment from the account specified, for the premium I owe each month for the Group Plan(s) I have with SAMBA (excludes premium collection for the SAMBA Health Benefit Plan). I understand that SAMBA has the right to change the amount of my automatic deduction to reflect a change in my premium or a change in my participation in the Direct Debit Program, and I will be notified of such change in writing. I also understand payment will be deducted on the 2nd of each month or the first business day thereafter if the 2nd is a holiday or weekend. I further understand that SAMBA will subject me to a return check fee of \$10 if insufficient funds are available at the time of the Direct Debit. I may suspend payment by notifying SAMBA in writing at any time prior to ten (10) business days before an amount is scheduled to be deducted from my bank account.

I have read and agree to the terms of the above Authorization Agreement.

✓ Signed _____ Date _____

Contact SAMBA's Group Plans Department at (301) 984-1440 or (800) 638-6589 with any questions.