

You must include a copy of your recent pay stub with the application



Federal Employee  
Benefit Association

## Disability Income Protection Enrollment/Update Form

Complete both sides. Mail or fax to: SAMBA, 11301 Old Georgetown Road, Rockville, MD 20852-2800 • (800) 638-6589 • Fax (301) 816-0191

Section 1 – Member Information										
Last Name			First Name		Middle Initial		Social Security No. — —		Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	
Address										
Street							City		State	Zip
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female										
Date of Birth Month / Day / Year		Email Address			Home Telephone		Work Telephone			
Date of Hire Month / Day / Year		Agency (Initials)	GS Level GS -	Current Annual Salary \$	Occupation/Job Title	Retirement System <input type="checkbox"/> CSRS <input type="checkbox"/> FERS	Height ft. in.		Weight lbs.	

Section 2 – Coverage Requested (You must be a full-time employee working more than 32 hours a week.)		
<input type="checkbox"/> I wish to enroll in the Disability Income Protection Program <input type="checkbox"/> I wish to update my Covered Salary amount in the Disability Income Protection Program <i>You must provide proof of current salary (e.g., pay stub) when enrolling or updating coverage.</i>		
<b>Covered Salary Amount Requested</b> \$	<b>Date of Salary Increase</b> Month / Day / Year	<b>Biweekly Premium</b> \$
<i>Please refer to the "Disability Income Protection Premiums" chart for biweekly premium costs.</i>		

Section 3 – Health Statement
Evidence of Insurability is not required if you apply for an increase in coverage within 12 months of your salary increase and have done so with each salary increase since completing your last Health Statement. If Evidence of Insurability is required a new Pre-Existing Condition Limitation will apply to the increased amount of benefits from the effective date of change, but will not apply to coverage already in force.

**PLEASE ANSWER THE FOLLOWING AND GIVE DETAILS OF ALL "YES" ANSWERS**

1. Have you ever been diagnosed or treated by a member of the medical profession for:
  - Yes  No a. A heart murmur, high blood pressure, or any disease or disorder of the heart, blood or circulatory system?
  - Yes  No b. Asthma, shortness of breath, tuberculosis, or any disease or disorder of the lungs or respiratory system?
  - Yes  No c. Colitis, ulcer, kidney disease, blood or sugar in urine, or any disease or disorder of the digestive, urinary or reproductive system?
  - Yes  No d. Alcoholism, drug abuse, chronic or prolong fatigue, severe headaches, epilepsy, dizziness, stroke, or any disease or disorder of the brain or nervous system including mental or emotional disorders?
  - Yes  No e. Cancer, tumor, diabetes, or any disease or disorder of the glands?
  - Yes  No f. Arthritis, impaired sight or hearing, or any disease or disorder of the skin, bones, or joints, including neck or back disorders, muscular or soft tissue disorders?
  - Yes  No g. Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?
2.  Yes  No a. Are you now pregnant? If yes, please list your due date \_\_\_\_\_  
 Yes  No b. Are there any medical complications?
3.  Yes  No During the past 5 years have you consulted any physician, surgeon, psychologist, psychiatrist, or other medical or dental practitioner for anything other than a routine physical, eye examination, or dental examination for any reason not previously noted on this application or been confined or treated in any hospital, sanatorium or similar institution?

Give details below for those questions for which you answered "YES." (If additional space is required, complete and attach a separate sheet of paper.)

Question No. w/Letter	Condition – Give Details	Occurred Date			Duration	Current Status
		Month	Day	Year		

**SAMBA reserves the right to request additional health information on the basis of responses given to the above.** I declare that, to the best of my knowledge and belief, the statements made in this application are complete and true. I agree that the coverage applied for is subject to the terms of the Program and shall become effective on the date or dates established by SAMBA, provided the evidence of good health is satisfactory.

Member's Signature \_\_\_\_\_ Date \_\_\_\_\_

**Complete the attached Beneficiary Designation Form and SAMBA Payroll Allotment Form 299 or Direct Debit Application.**

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**Section 4 – Dependent Information** (Your dependents are eligible for coverage under the Hospital Confinement Benefit.)

Spouse Information		Social Security Number	Date of Birth
Full Name		— —	/ /

Dependent Children Information		Social Security Number	Sex	Date of Birth
(List additional children w/their information on a separate sheet)				
Full Name		— —	<input type="checkbox"/> Male <input type="checkbox"/> Female	/ /
Full Name		— —	<input type="checkbox"/> Male <input type="checkbox"/> Female	/ /
Full Name		— —	<input type="checkbox"/> Male <input type="checkbox"/> Female	/ /
Full Name		— —	<input type="checkbox"/> Male <input type="checkbox"/> Female	/ /

**Section 5 – Beneficiary Designation for the Disability Income Protection Program**

Please fill out this section so that it fully and accurately describes your request. List the full name, relationship to the insured, and date of birth of the beneficiary(ies). **If you are married, your spouse must be your beneficiary.** For the beneficiary designation to be valid, it must be delivered and recorded in the SAMBA office prior to the death of the member.

**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

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

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

<b>Signature of SAMBA Member (or of Assignee if assigned)</b>	Date
For office use - do not write in this box:	
Received and recorded by SAMBA representative:	Date:

**Complete the attached SAMBA Payroll Allotment Form 299 or Direct Debit Application.**

Visit the SAMBA website at [www.SambaPlans.com](http://www.SambaPlans.com)

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Disability Income Protection Premiums									
Salary to Next Highest \$1,000	Biweekly Cost	Salary to Next Highest \$1,000	Biweekly Cost	Salary to Next Highest \$1,000	Biweekly Cost	Salary to Next Highest \$1,000	Biweekly Cost	Salary to Next Highest \$1,000	Biweekly Cost
\$15,000	\$4.56	\$47,000	\$14.28	\$79,000	\$24.00	\$111,000	\$33.73	\$143,000	\$43.45
\$16,000	\$4.86	\$48,000	\$14.58	\$80,000	\$24.31	\$112,000	\$34.03	\$144,000	\$43.75
\$17,000	\$5.17	\$49,000	\$14.89	\$81,000	\$24.61	\$113,000	\$34.34	\$145,000	\$44.06
\$18,000	\$5.47	\$50,000	\$15.19	\$82,000	\$24.92	\$114,000	\$34.64	\$146,000	\$44.36
\$19,000	\$5.77	\$51,000	\$15.50	\$83,000	\$25.22	\$115,000	\$34.94	\$147,000	\$44.67
\$20,000	\$6.08	\$52,000	\$15.80	\$84,000	\$25.52	\$116,000	\$35.25	\$148,000	\$44.97
\$21,000	\$6.38	\$53,000	\$16.10	\$85,000	\$25.83	\$117,000	\$35.55	\$149,000	\$45.27
\$22,000	\$6.68	\$54,000	\$16.41	\$86,000	\$26.13	\$118,000	\$35.85	\$150,000	\$45.58
\$23,000	\$6.99	\$55,000	\$16.71	\$87,000	\$26.44	\$119,000	\$36.16	\$151,000	\$45.88
\$24,000	\$7.29	\$56,000	\$17.02	\$88,000	\$26.74	\$120,000	\$36.46	\$152,000	\$46.18
\$25,000	\$7.60	\$57,000	\$17.32	\$89,000	\$27.04	\$121,000	\$36.77	\$153,000	\$46.49
\$26,000	\$7.90	\$58,000	\$17.62	\$90,000	\$27.35	\$122,000	\$37.07	\$154,000	\$46.79
\$27,000	\$8.20	\$59,000	\$17.93	\$91,000	\$27.65	\$123,000	\$37.37	\$155,000	\$47.10
\$28,000	\$8.51	\$60,000	\$18.23	\$92,000	\$27.95	\$124,000	\$37.68	\$156,000	\$47.40
\$29,000	\$8.81	\$61,000	\$18.54	\$93,000	\$28.26	\$125,000	\$37.98	\$157,000	\$47.70
\$30,000	\$9.12	\$62,000	\$18.84	\$94,000	\$28.56	\$126,000	\$38.28	\$158,000	\$48.01
\$31,000	\$9.42	\$63,000	\$19.14	\$95,000	\$28.87	\$127,000	\$38.59	\$159,000	\$48.31
\$32,000	\$9.72	\$64,000	\$19.45	\$96,000	\$29.17	\$128,000	\$38.89	\$160,000	\$48.62
\$33,000	\$10.03	\$65,000	\$19.75	\$97,000	\$29.47	\$129,000	\$39.20	\$161,000	\$48.92
\$34,000	\$10.33	\$66,000	\$20.05	\$98,000	\$29.78	\$130,000	\$39.50	\$162,000	\$49.22
\$35,000	\$10.64	\$67,000	\$20.36	\$99,000	\$30.08	\$131,000	\$39.80	\$163,000	\$49.53
\$36,000	\$10.94	\$68,000	\$20.66	\$100,000	\$30.38	\$132,000	\$40.11	\$164,000	\$49.83
\$37,000	\$11.24	\$69,000	\$20.97	\$101,000	\$30.69	\$133,000	\$40.41	\$165,000	\$50.14
\$38,000	\$11.55	\$70,000	\$21.27	\$102,000	\$30.99	\$134,000	\$40.72	\$166,000	\$50.44
\$39,000	\$11.85	\$71,000	\$21.57	\$103,000	\$31.30	\$135,000	\$41.02	\$167,000	\$50.74
\$40,000	\$12.15	\$72,000	\$21.88	\$104,000	\$31.60	\$136,000	\$41.32	\$168,000	\$51.05
\$41,000	\$12.46	\$73,000	\$22.18	\$105,000	\$31.90	\$137,000	\$41.63	\$169,000	\$51.35
\$42,000	\$12.76	\$74,000	\$22.48	\$106,000	\$32.21	\$138,000	\$41.93	\$170,000	\$51.65
\$43,000	\$13.07	\$75,000	\$22.79	\$107,000	\$32.51	\$139,000	\$42.24	\$171,000	\$51.96
\$44,000	\$13.37	\$76,000	\$23.09	\$108,000	\$32.82	\$140,000	\$42.54	\$172,000	\$52.26
\$45,000	\$13.67	\$77,000	\$23.40	\$109,000	\$33.12	\$141,000	\$42.84	\$173,000	\$52.57
\$46,000	\$13.98	\$78,000	\$23.70	\$110,000	\$33.42	\$142,000	\$43.15	\$174,000	\$52.87