



Enrollment and/or Request for Change Form

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

Control # 9400

Member General 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		Entered on Duty Date (EOD) Month / Day / Year		Agency (Initials)		GS Level		GS Effective Date Month / Day / Year				Daytime Telephone _____										
						GS -						Email Address _____										
PLAN										RATES & COVERAGES		BIWEEKLY COST										
Group Term Life with Accidental Death and Dismemberment Insurance Plan	The amount of insurance for which you are eligible and the cost are based upon your current GS level.																					
	Your GS Level		Available Coverage		Biweekly Cost		Your GS Level		Available Coverage		Biweekly Cost											
<input type="checkbox"/> GS-5 & Below			\$80,000		\$6.00		<input type="checkbox"/> GS-13 thru GS-14		\$175,000		\$17.00											
<input type="checkbox"/> GS-6 thru GS-9			\$100,000		\$8.00		<input type="checkbox"/> GS-15		\$200,000		\$20.00											
<input type="checkbox"/> GS-10 thru GS-12			\$140,000		\$13.00		<input type="checkbox"/> SES & SL		\$250,000		\$23.00											
												\$ _____										
Dependent Group Term Life Insurance Plan	The amount of insurance for which you are eligible and the cost are based upon your current GS level.																					
You must be enrolled in the Group Term Life Plan to enroll your dependents in this plan.	Your GS Level		Spouse no Children			Spouse w/Children*			Biweekly Cost													
<input type="checkbox"/> GS-9 & Below			\$25,000			\$20,000			\$3.00													
<input type="checkbox"/> GS-10 thru GS-15			\$35,000			\$30,000			\$4.00													
<input type="checkbox"/> SES & SL			\$50,000			\$45,000			\$5.00													
List names and dates of birth of your eligible dependents on reverse side.												\$ _____										
Supplemental Group Term Life Insurance Plan	The amount of insurance for which you are eligible and the cost are based upon your current GS level.																					
You must be enrolled in the Group Term Life Plan. If enrolling your spouse in this plan, he/she must be enrolled in the Dependent Group Term Life Insurance Plan.	Available Coverage		Biweekly Cost by Age Group																			
			18-24		25-29		30-34		35-39		40-44		45-49		50-54		55-59		60-64		65-69	
	\$30,000		\$0.90		\$1.14		\$1.35		\$1.65		\$2.25		\$5.25		\$9.00		\$15.00		\$22.50		\$40.50	
	60,000		1.80		2.28		2.70		3.30		4.50		10.50		18.00		30.00		45.00		81.00	
	90,000		2.70		3.42		4.05		4.95		6.75		15.75		27.00		45.00		67.50		121.50	
	120,000		3.60		4.56		5.40		6.60		9.00		21.00		36.00		60.00		90.00		162.00	
	150,000		4.50		5.70		6.75		8.25		11.25		26.25		45.00		75.00		112.50		202.50	
	180,000		5.40		6.84		8.10		9.90		13.50		31.50		54.00		90.00		135.00		243.00	
	210,000		6.30		7.98		9.45		11.55		15.75		36.75		63.00		105.00		157.50		283.50	
	240,000		7.20		9.12		10.80		13.20		18.00		42.00		72.00		120.00		180.00		324.00	
	270,000		8.10		10.26		12.15		14.85		20.25		47.25		81.00		135.00		202.50		364.50	
	300,000		9.00		11.40		13.50		16.50		22.50		52.50		90.00		150.00		225.00		405.00	
	Coverage Selected: <input type="checkbox"/> Self Amount \$ _____ <input type="checkbox"/> Spouse Amount \$ _____																					
If coverage selection is for a dependent please indicate dependent's name and date of birth on reverse side.												\$ _____										
Personal Accident Insurance Plan	The amount of insurance for which you are eligible and the cost are based upon your current GS level.																					
You do not need to be enrolled in any other SAMBA plan to enroll in the Personal Accident Insurance Plan.	Available Coverage		Biweekly Cost																			
			\$10,000		\$25,000		\$50,000		\$100,000		\$150,000		\$200,000		\$250,000		\$300,000		\$400,000		\$500,000	
	Member Only		\$0.14		\$0.35		\$0.70		\$1.40		\$2.10		\$2.80		\$3.50		\$4.20		\$5.60		\$7.00	
	Member & Family*		0.23		0.57		1.15		2.29		3.44		4.58		5.73		6.88		9.17		11.46	
	Coverage Selected: <input type="checkbox"/> Self Amount \$ _____ <input type="checkbox"/> Member & Family Amount \$ _____																					
*Coverage levels under Member & Family are: Member – amount listed; Spouse only – 60% of member coverage; Child(ren) only – 20% of member coverage; Spouse and Child(ren) – 50% of member coverage for spouse, 15% of member coverage for child(ren). Note: Coverage limited to \$50,000 per child.																						
If coverage selection is for a dependent please indicate dependent's name and date of birth on reverse side.												\$ _____										
I certify that I am actively at work and performing all the duties of my regular occupation.											TOTAL COST \$ _____											

I certify that I am actively at work and performing all the duties of my regular occupation.

TOTAL COST \$ _____



Signature of Member – Use Payroll Name

Date

Complete the attached Beneficiary Designation Form – SAMBA Payroll Allotment Form 299 – and Health Statement (if required)



Enrollment and/or Request for Change Form Dependent Information

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

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

Dependent Group 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	/ /

Supplemental Group Term Life Insurance Plan		Sex	Date of Birth
Spouse		<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

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Member General 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.

Group Term Life with Accidental Death and Dismemberment Insurance Plan			
PRIMARY BENEFICIARY(IES): IN EQUAL SHARES OR AS DESIGNATED BELOW			
Full Name and Address	% of Proceeds	Relationship to Insured	Birth Date / /
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	Birth Date / /

Supplemental Group Term Life Insurance Plan			
PRIMARY BENEFICIARY(IES): IN EQUAL SHARES OR AS DESIGNATED BELOW			
Full Name and Address	% of Proceeds	Relationship to Insured	Birth Date / /
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	Birth Date / /

Personal Accident Insurance Plan			
PRIMARY BENEFICIARY(IES): IN EQUAL SHARES OR AS DESIGNATED BELOW			
Full Name and Address	% of Proceeds	Relationship to Insured	Birth Date / /
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	Birth Date / /

Please refer to the Certificate for all plan details, including any exclusions, limitations and restrictions which may apply. Group Term Life, Accidental Death & Dismemberment, Supplemental Group Term Life, Dependent Group Term Life and Personal Accident Insurance 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
For office use - do not write in this box:	
Received and recorded by SAMBA representative: _____ Date: _____	