



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 form with fields for Last Name, First Name, Middle Initial, Social Security No., Marital Status, Address, Date of Birth, Date of Hire, Agency (Initials), GS Level, GS Effective Date, Daytime Telephone, Email Address, Sex, and Marital Status options.

Table for PLAN RATES & COVERAGES. Columns include PLAN, RATES & COVERAGES, and BIWEEKLY COST. Rows include Group Term Life with Accidental Death and Dismemberment Insurance Plan with various GS level options and coverage amounts.

Table for Dependent Group Term Life Insurance Plan. Columns include Your GS Level, Spouse no Children, Spouse w/Children*, and Biweekly Cost. Includes a note: 'List names and dates of birth of your eligible dependents on the Dependent Information Form.'

Table for Supplemental Group Term Life Insurance Plan. Columns include Available Coverage and Biweekly Cost by Age Group (18-24 to 65-69). Includes a note: 'If coverage selected is for spouse, indicate spouse's name and date of birth on Dependent Information Form.'

Table for Personal Accident Insurance Plan. Columns include Available Coverage and Biweekly Cost for Member Only and Member & Family*. Includes a note: 'If coverage selected is Member & Family, indicate dependents' names and dates of birth on Dependent Information Form.'

Signature line: 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 or Direct Debit Application - 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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Control # 9400

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: _____