SAMBA
FEDERAL EMPLOYEE BENEFIT ASSOCIATION

SAMBA GROUP TERM LIFE INSURANCE
Medically Underwritten Application

Reset

Group No. 67763-9
Account 3

Submit completed application to: **SAMBA, 11301 Old Georgetown Road, Rockville, MD 20852-2800**
Fax: (301) 816-0191 • Secure email: www.sambaplans.com/contact-us/

Select One:	❑ New Applicant	**Employment Status:**	❑ Active
	❑ Change to Current Coverage		❑ Retired

*This **Medically Underwritten Application** is to be used if your age is between 56 and 69 or the coverage amount requested is greater than $150,000. If you are under age 56 and requesting coverage of $150,000 or less, please use the **Simplified Issue Application**.*

MEMBER INFORMATION

Last Name	First Name	Middle Initial	Social Security No.	Date of Birth (Month / Day / Year)	Sex
				/ /	❑ Male ❑ Female

Address

Street | City | State | Zip

Agency (Initials)	Home/Cell Phone	Work Phone	Email Address

DEPENDENT INFORMATION Complete if you are requesting coverage for your spouse and/or dependent child(ren)

Relationship	Last Name	First Name	Middle Initial	Social Security No.	Date of Birth	Sex
Spouse					/ /	❑ Male ❑ Female
Child					/ /	❑ Male ❑ Female
Child					/ /	❑ Male ❑ Female
Child					/ /	❑ Male ❑ Female

GROUP TERM LIFE INSURANCE RATES & COVERAGES Rates effective 10/1/12 and are subject to change

Schedule of Insurance for Member or Spouse Under Age 70 (Monthly Premium)

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
Under 30	$2.00	$4.00	$6.00	$8.00	$10.00	$12.00	$16.00	$20.00	$24.00	$32.00	$40.00	$48.00
30-39	$2.75	$5.50	$8.25	$11.00	$13.75	$16.50	$22.00	$27.50	$33.00	$44.00	$55.00	$66.00
40-49	$3.80	$7.60	$11.40	$15.20	$19.00	$22.80	$30.40	$38.00	$45.60	$60.80	$76.00	$91.20
50-54	$6.48	$12.95	$19.43	$25.90	$32.38	$38.85	$51.80	$64.75	$77.70	$103.60	$129.50	$155.40
55-59	$11.08	$22.15	$33.23	$44.30	$55.38	$66.45	$88.60	$110.75	$132.90	$177.20	$221.50	$265.80
60-64	$16.88	$33.75	$50.63	$67.50	$84.38	$101.25	$135.00	$168.75	$202.50	$270.00	$337.50	$405.00
65-69	$27.05	$54.10	$81.15	$108.20	$135.25	$162.30	$216.40	$270.50	$324.60	$432.80	$541.00	$649.20

Note: Amount of coverage permitted under the SAMBA Group Term Life Insurance for member or spouse is limited to $600,000 each.

$2.17 monthly provides $20,000 coverage for all eligible children under age 26.

COVERAGE APPLYING FOR

Application For	Total Amount Desired	Current Amount	Amount to be Underwritten	Premium
❑ Member	$	$	$	$
❑ Spouse	$	$	$	$
❑ Child(ren)	$20,000			$

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Medically Underwritten Health Statement Questionnaire

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MEMBER AND SPOUSE HEALTH QUESTIONS

Please answer these questions by checking "Yes" or "No"

	Member	Spouse
1. Have you ever been treated for or been diagnosed by a member of the medical profession or health practitioner as having AIDS (Acquired Immunodeficiency Syndrome)?	❑ Yes ❑ No	❑ Yes ❑ No
2. Have you ever had, or been treated for, any of the following: insulin dependent diabetes, heart attack, coronary bypass/angioplasty, heart valve repair/replacement, stroke, metastatic cancer, emphysema or been an organ transplant recipient?	❑ Yes ❑ No	❑ Yes ❑ No
3. **Member:** Height ____ ft. ____ in. Weight ____ lbs. **Spouse:** Height ____ ft. ____ in. Weight ____ lbs.	Complete for Member and Spouse (if applying)	
4. In the past 10 years have you consulted with, been diagnosed or treated by a health practitioner, or taken medication for any of the following:		
a. Disease or disorder of the heart, blood vessels (excluding controlled high blood pressure), lung (excluding asthma), liver (excluding hepatitis A), pancreas, or intestine?	❑ Yes ❑ No	❑ Yes ❑ No
b. Non-insulin dependent diabetes, impaired glucose tolerance, or pre-diabetes?	❑ Yes ❑ No	❑ Yes ❑ No
c. Cancer or tumor, rheumatoid arthritis, connective tissue, neurological (excluding headaches), autoimmune or blood disorder?	❑ Yes ❑ No	❑ Yes ❑ No
d. Depression, psychosis, suicide attempt, drug or alcohol abuse or addiction?	❑ Yes ❑ No	❑ Yes ❑ No
e. Polycystic kidney disease or kidney failure?	❑ Yes ❑ No	❑ Yes ❑ No
5. Have you ever been diagnosed, treated or given medical advice by a physician or other health practitioner for:		
a. Chest pain, heart trouble or circulatory disorder?	❑ Yes ❑ No	❑ Yes ❑ No
b. Anemia or leukemia?	❑ Yes ❑ No	❑ Yes ❑ No
c. Sleep apnea, asthma or other respiratory disorder?	❑ Yes ❑ No	❑ Yes ❑ No
d. Colitis, Crohn's disease, ulcerative colitis or any other intestinal disorder or disease?	❑ Yes ❑ No	❑ Yes ❑ No
e. Stomach disorder?	❑ Yes ❑ No	❑ Yes ❑ No
f. Brain or seizure disorder?	❑ Yes ❑ No	❑ Yes ❑ No
g. Mental or nervous disorder?	❑ Yes ❑ No	❑ Yes ❑ No
h. Arthritis, paralysis or any muscle weakness?	❑ Yes ❑ No	❑ Yes ❑ No
i. Abnormal urine specimen or urinary tract disorder?	❑ Yes ❑ No	❑ Yes ❑ No
j. Prostate or other reproductive organ disorder?	❑ Yes ❑ No	❑ Yes ❑ No
6. Are you pregnant? Due Date _____ Pre-pregnancy weight _____ lbs.	❑ Yes ❑ No	❑ Yes ❑ No
7. Do you currently have any disorder, condition, disease, and/or are you currently taking medication prescribed or provided by a physician or other health practitioner for any disorder, condition, disease not shown above?	❑ Yes ❑ No	❑ Yes ❑ No
8. Have you ever received medical treatment or counseling for the use of alcohol or prescribed or non-prescribed drugs, or been advised by a health practitioner to discontinue the use of such substances?	❑ Yes ❑ No	❑ Yes ❑ No
9. In the past 2 years have you experienced any symptom(s) for which you have not yet consulted a health practitioner, or are any medical, surgical or diagnostic procedures recommended or contemplated?	❑ Yes ❑ No	❑ Yes ❑ No

For every "Yes" answer to any question, please give details below. Attach a separate sheet if additional space is needed.

Question Number	Applicant	Description of Condition	Date Condition Began	Description of Treatment Received	Fully Recovered?	Health Practitioner Name, Full Address (Street, City, State, ZIP), Phone
	❑ Member ❑ Spouse				❑ Yes ❑ No	
	❑ Member ❑ Spouse				❑ Yes ❑ No	
	❑ Member ❑ Spouse				❑ Yes ❑ No	
	❑ Member ❑ Spouse				❑ Yes ❑ No	

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Beneficiary Information and Authorization

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MEMBER BENEFICIARY INFORMATION

Note: The member is the beneficiary for spouse and child(ren) coverage

PRIMARY BENEFICIARY(IES): List the percent each will receive. The total must equal 100%

Full Name and Address	Percentage	Relationship to Member	Date of Birth
	%		/ /
	%		/ /
	%		/ /

as shall then be living, and if no such beneficiary is then living

CONTINGENT BENEFICIARY(IES): List the percent each will receive. The total must equal 100%

Full Name and Address	Percentage	Relationship to Member	Date of Birth
	%		/ /
	%		/ /

Read this information carefully, then sign and date below

- To the best of my knowledge and belief, the information I've provided is complete and correct.
- I understand and agree that no coverage shall take effect unless this application is approved by ReliaStar Life Insurance Company and the first premium is paid in my lifetime.
- I understand my coverage begins on the "effective date" assigned by ReliaStar Life Insurance Company.

Authorization and Acknowledgment – Please read and sign below. For underwriting and claim purposes, I give my permission to: Any physician, or any other member of the medical profession, hospital, clinic, other medical or medically related facility, pharmacy, pharmacy benefit manager, insurance or reinsurance company, MIB, Inc. (MIB), Department of Motor Vehicle Records, employer or any other organization or person to give ReliaStar Life Insurance Company (ReliaStar Life) or its authorized representative (including ChoicePoint or any consumer reporting agency) acting on its behalf ALL INFORMATION on my behalf (except as limited below), including findings on medical care, psychiatric or psychological care or examination, surgery, pharmacy prescriptions or prescription records or any non-medical information, including motor vehicle records, as they apply to any person who is to be covered. I give my permission to ReliaStar Life, or its reinsurers, to make a brief report of personal health information to MIB about these persons. I give my permission to ReliaStar Life to get consumer or investigative consumer reports about the same persons.

I give my permission to ReliaStar Life to get any and all such information for the purposes described in this form. I specifically consent to the redisclosure of such information as set forth in this form. I know that my medical records, including any alcohol or drug abuse information, may be protected by Federal Regulations – 42 CFR Part 2. I may revoke this authorization as it applies to any information protected by 42 CFR Part 2 at any time, but not to the extent action has been taken in reliance on it.

I understand all or part of the information obtained by this authorization may be communicated between ReliaStar Life, its affiliates, and may be sent to MIB. This information may be made available to any ReliaStar Life affiliate, reinsurer, employer, or contractor who processes transactions that concern any coverage I may have requested or have with ReliaStar Life or its affiliates.

I understand that my additional written consent will be required before any information described above is given, sold, transferred, or, in any way, relayed to another party not previously specified (unless otherwise provided by law). My additional consent must be provided on a form that states the new use of the information or why another party needs it. I know that I have the right to get a copy of this form. A photocopy of this form will be as valid as the original. This form will be valid for 24 months from the date shown below. I acknowledge that I have been given ReliaStar Life's Consumer Privacy Notice.

Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Print Member's Name	Member Signature	Date Signed
	Signature Required	
Print Spouse's Name (if applying for spouse coverage)	**Spouse Signature (if applying for spouse coverage)**	**Date Signed**
	Signature Required	

ReliaStar Life Insurance Company and ReliaStar Life Insurance Company of New York
Consumer Privacy Notice and Insurance Information Practices Notice

We are pleased to provide you with information regarding your application or claim. This information is provided to you in accordance with legislation enacted in your state. You may also receive other privacy notices from us or from our affiliated companies. **Please keep this notice and a copy of the completed application or claim form for your records.**

Our Underwriting Procedures

For certain types of coverage, we underwrite your request to determine if you are eligible for the coverage you requested. We review all of the information in the application, and, if necessary, confirm or add to this information in the ways described in this notice. In the event of an adverse underwriting decision, we will provide you with the specific reason for the decision in writing.

Privacy and Information Practices

Collecting Information

Your application or claim form is our main source of information. But we may:

- Ask you to have a physical exam, an EKG and/or a blood profile, etc.
- Ask physicians, hospitals, or other health care providers to confirm or add to the information you have given us. The types of information we may ask for are described on the authorization form you will be asked to sign. If you want a copy of this form, it will be given to you for your records.
- Obtain information from MIB, Inc., formerly known as the Medical Information Bureau. See "Notice Regarding MIB, Inc." below.
- Seek information from other companies you have applied to for insurance.
- Ask you for additional information through use of a written request.

Notice Regarding Consumer Reports

Insurance companies commonly ask an outside source to verify and add to the information given in an application. Consumer reports are used to help us decide if you are eligible for the insurance you have applied for. The report deals with your mode of living, character, general reputation, and such personal items as your health, job, and finances. It may include information on the following: your marital status, past and present employment record, job duties, driving record, avocation, health history, use of alcohol and drugs, and hazardous sports activities. The agency may get information in these ways: from public records, and by contacting you, members of your family, business associates and employers, financial sources, friends, or others you know. This information will not be used to determine your sexual orientation. You can request that the agency interview you in connection with the preparation of the report. If the report affects your application as requested, we will notify you and provide you with the name and address of the reporting firm.

We use the report only to be sure that each application is evaluated on a fair basis. We will not reveal any of the information we obtain to your friends or associates. We may reveal the information we obtain to other companies or entities affiliated with us. The information may be kept by the consumer reporting agency; it may also later be given to others who have a legitimate need for these reports. It will be given only to the extent permitted by these laws: the Federal Fair Credit Reporting Act as amended by the Consumer Credit Reporting Reform Act of 1996; your state's Fair Credit Reporting Act, if any; or your state's Insurance Information and Privacy Protection Act, if any. If you wish, we will send you the name, address and phone number of any agency we ask to prepare a consumer report about you. The agency will give you a copy of the report if you ask for one and give proper identification.

Information Use

We will use the information only for business purposes arising from the relationship you have with us.

Information Maintenance and Disclosure

We treat the information we have about you as confidential. The authorization form that you have been asked to complete will permit us to send the information to our affiliates and to MIB, our reinsurers, employees, contractors, or other organizations that process transactions concerning coverage you have with us or our affiliates, and to other life insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted. In certain circumstances, the information we have about you may be disclosed to third parties without your specific permission.

Access to Information

If you request it in writing, we will send you a copy of the relevant information we obtain about you in connection with your request for coverage or an adverse underwriting decision. Medical information, however, will only be disclosed through the attending licensed physician unless state law provides otherwise. If you feel that any of the information in our file is not correct or is incomplete, we will review it. If we agree with you, we will make the corrections. If we do not agree with you, you may file a short statement of dispute with us. Your statement will be included any time we disclose this information to anyone. We will not send you information we collect in expectation of or in connection with any claim or civil or criminal proceeding.

Notice Regarding MIB, Inc.

We or our reinsurers may make brief reports to MIB. The reports will include the factors that affect the insurability of any person for whom coverage is being requested. MIB is a nonprofit organization of life insurance companies. It operates an information exchange for its members. If you apply to some other member company for life or health coverage, or send in a claim for benefits, MIB may supply that company with any information in its file. If you ask, MIB will arrange to disclose to you the information it has about you in its file. If you question the accuracy of the information in MIB's file, you may contact MIB and ask them to correct it as provided in the Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734. MIB's phone number is 866-692-6901 (TTY 866 346-3642). We may also release information in our files to other life insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted.

11301 Old Georgetown Road
Rockville, Maryland 20852-2800

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(301) 984-1440 • (800) 638-6589
www.SambaPlans.com

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 recurring **Direct Debit Program**.

Please 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 RECURRING DIRECT DEBIT PROGRAM

Please print or type

Member Name _____ ID # _____

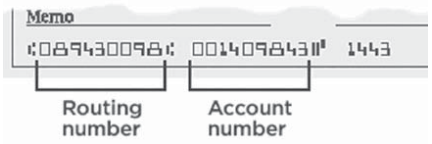
Email _____ Daytime Phone # _____

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 Recurring 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 _____ Signature Required _____ Date _____

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