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

RESET

SAMBA
FEDERAL EMPLOYEE BENEFIT ASSOCIATION

LONG TERM DISABILITY Enrollment/Update Form

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

Section 1 – Employee 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 (Month / Day / Year)	Email Address	Home Telephone	Daytime Telephone
/ /			

Date of Hire (Month / Day / Year)	Agency (Initials)	GS Level	Current Annual Salary	Occupation/Job Title	Retirement System	Height	Weight
/ /		GS -	$		❑ CSRS ❑ FERS	ft. in.	lbs.

Section 2 – Coverage Requested (You must be under age 62 and a full-time employee working more than 32 hours a week. You are not eligible for the coverage if your Regular Place of Work is your home or other residence)

❑ **I want to enroll in the Long Term Disability plan**

❑ **I want to update my Covered Salary amount in the Long Term Disability plan**

You must provide proof of current salary (e.g., pay stub) when enrolling or updating coverage.

Covered Salary Amount Requested	Date of Last Salary Increase (Month / Day / Year)	Monthly Premium
$	/ /	$

Please refer to the "Long Term Disability Premiums" chart for monthly premium costs.

Section 3 – Health Statement

Evidence of Insurability is not required if you apply for an increase in coverage within 90 days 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. Human Immunodeficiency Virus (HIV), 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 any reason not previously noted on this application; have you 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 (Month / Day / Year)	Duration	Current Status
		/ /		
		/ /		
		/ /		

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.

✓ Signature Required

Employee's Signature Date

Complete the attached Beneficiary Designation Form and Direct Debit Application.

You must include a copy of your recent pay stub with the 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 (List additional children w/their information on a separate sheet)		Social Security Number	Sex	Date of Birth
Full Name			❑ Male ❑ Female	/ /
Full Name			❑ Male ❑ Female	/ /
Full Name			❑ Male ❑ Female	/ /
Full Name			❑ Male ❑ Female	/ /

Section 5 – Beneficiary Designation for the Long Term Disability Plan

Please fill out this section so that it fully and accurately describes your request. List the full name, relationship to the employee, 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 employee.

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

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

Signature of Employee (or of Assignee if assigned)	Signature Required	Date

Complete the attached Direct Debit Application.

SAMBA

Long Term Disability Premiums

Salary to Next Highest $1,000	Monthly Cost	Salary to Next Highest $1,000	Monthly Cost	Salary to Next Highest $1,000	Monthly Cost	Salary to Next Highest $1,000	Monthly Cost	Salary to Next Highest $1,000	Monthly Cost
$21,000	$13.83	$57,000	$37.53	$93,000	$61.23	$129,000	$84.93	165,000	$108.63
$22,000	$14.48	$58,000	$38.18	$94,000	$61.88	$130,000	$85.58	166,000	$109.28
$23,000	$15.14	$59,000	$38.84	$95,000	$62.54	$131,000	$86.24	167,000	$109.94
$24,000	$15.80	$60,000	$39.50	$96,000	$63.20	$132,000	$86.90	168,000	$110.60
$25,000	$16.46	$61,000	$40.16	$97,000	$63.86	$133,000	$87.56	169,000	$111.26
$26,000	$17.12	$62,000	$40.82	$98,000	$64.52	$134,000	$88.22	170,000	$111.92
$27,000	$17.78	$63,000	$41.48	$99,000	$65.18	$135,000	$88.88	171,000	$112.58
$28,000	$18.43	$64,000	$42.13	$100,000	$65.83	$136,000	$89.53	172,000	$113.23
$29,000	$19.09	$65,000	$42.79	$101,000	$66.49	$137,000	$90.19	173,000	$113.89
$30,000	$19.75	$66,000	$43.45	$102,000	$67.15	$138,000	$90.85	174,000	$114.55
$31,000	$20.41	$67,000	$44.11	$103,000	$67.81	$139,000	$91.51	175,000	$115.21
$32,000	$21.07	$68,000	$44.77	$104,000	$68.47	$140,000	$92.17	176,000	$115.87
$33,000	$21.73	$69,000	$45.43	$105,000	$69.13	$141,000	$92.83	177,000	$116.53
$34,000	$22.38	$70,000	$46.08	$106,000	$69.78	$142,000	$93.48	178,000	$117.18
$35,000	$23.04	$71,000	$46.74	$107,000	$70.44	$143,000	$94.14	179,000	$117.84
$36,000	$23.70	$72,000	$47.40	$108,000	$71.10	$144,000	$94.80	180,000	$118.50
$37,000	$24.36	$73,000	$48.06	$109,000	$71.76	$145,000	$95.46	181,000	$119.16
$38,000	$25.02	$74,000	$48.72	$110,000	$72.42	$146,000	$96.12	182,000	$119.82
$39,000	$25.68	$75,000	$49.38	$111,000	$73.08	$147,000	$96.78	183,000	$120.47
$40,000	$26.33	$76,000	$50.03	$112,000	$73.73	$148,000	$97.43	184,000	$121.13
$41,000	$26.99	$77,000	$50.69	$113,000	$74.39	$149,000	$98.09	185,000	$121.79
$42,000	$27.65	$78,000	$51.35	$114,000	$75.05	$150,000	$98.75	186,000	$122.45
$43,000	$28.31	$79,000	$52.01	$115,000	$75.71	$151,000	$99.41	187,000	$123.11
$44,000	$28.97	$80,000	$52.67	$116,000	$76.37	$152,000	$100.07	188,000	$123.77
$45,000	$29.63	$81,000	$53.33	$117,000	$77.03	$153,000	$100.73	189,000	$124.42
$46,000	$30.28	$82,000	$53.98	$118,000	$77.68	$154,000	$101.38	190,000	$125.08
$47,000	$30.94	$83,000	$54.64	$119,000	$78.34	$155,000	$102.04	191,000	$125.74
$48,000	$31.60	$84,000	$55.30	$120,000	$79.00	$156,000	$102.70	192,000	$126.40
$49,000	$32.26	$85,000	$55.96	$121,000	$79.66	$157,000	$103.36	193,000	$127.06
$50,000	$32.92	$86,000	$56.62	$122,000	$80.32	$158,000	$104.02	194,000	$127.72
$51,000	$33.58	$87,000	$57.28	$123,000	$80.98	$159,000	$104.68	195,000	$128.37
$52,000	$34.23	$88,000	$57.93	$124,000	$81.63	$160,000	$105.33	196,000	$129.03
$53,000	$34.89	$89,000	$58.59	$125,000	$82.29	$161,000	$105.99	197,000	$129.69
$54,000	$35.55	$90,000	$59.25	$126,000	$82.95	$162,000	$106.65	198,000	$130.35
$55,000	$36.21	$91,000	$59.91	$127,000	$83.61	$163,000	$107.31	199,000	$131.01
$56,000	$36.87	$92,000	$60.57	$128,000	$84.27	$164,000	$107.97	200,000	$131.67

Reset Form Print

11301 Old Georgetown Road
Rockville, Maryland 20852-2800

SAMBA
FEDERAL EMPLOYEE BENEFIT ASSOCIATION

(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 # _____

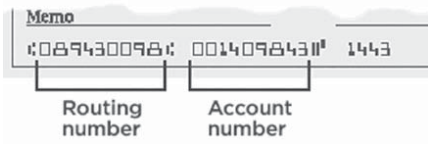
Email _____ Daytime Phone # _____

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.