SAMBA GROUP TERM LIFE INSURANCE
Simplified Issue Application

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 ❑ Change to Current Coverage

Employment Status: ❑ Active ❑ Retired

*This **Simplified Issue Application** may be used up to age 56 for member or spouse coverage not to exceed $150,000 each. An application for coverage exceeding $150,000, or if the applicant requesting coverage is age 56 or older, requires completion of the **Medically Underwritten Application**.*

Note: If you have been previously declined for group life insurance by ReliaStar Life, then you are not eligible to apply for Simplified Issue coverage from SAMBA.

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 56 (Biweekly Premium)

Age	$25,000	$50,000	$75,000	$100,000	$125,000	$150,000
Under 30	$0.92	$1.85	$2.77	$3.69	$4.62	$5.54
30-39	$1.27	$2.54	$3.81	$5.08	$6.35	$7.62
40-49	$1.75	$3.51	$5.26	$7.02	$8.77	$10.52
50-54	$2.99	$5.98	$8.97	$11.95	$14.94	$17.93
55	$5.11	$10.22	$15.34	$20.45	$25.56	$30.67

$1 biweekly provides $20,000 coverage for all eligible children under age 26.

COVERAGE APPLYING FOR

Application For	Total Amount of Coverage						Biweekly Premium
❑ Member	❑ $25,000	❑ $50,000	❑ $75,000	❑ $100,000	❑ $125,000	❑ $150,000	$
❑ Spouse	❑ $25,000	❑ $50,000	❑ $75,000	❑ $100,000	❑ $125,000	❑ $150,000	$
❑ Child(ren)	❑ $20,000						$

Health Statement Questionnaire & Beneficiary Information

Group No. 67763-9
Account 3

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

Question	Member		Spouse	
1. Have you had or been treated for heart trouble, stroke, diabetes, or cancer?	❑ Yes	❑ No	❑ Yes	❑ No
2. Have you ever had or been treated for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), disorders of the immune system or tested positive for antibodies to the HIV virus?	❑ Yes	❑ No	❑ Yes	❑ No
3. Have you ever sought help or received counseling or treatment for anxiety/depression, alcohol or drug abuse, or are you currently using illegal drugs?	❑ Yes	❑ No	❑ Yes	❑ No
4. In the past 5 years, have you been hospitalized or admitted to a medical care facility?	❑ Yes	❑ No	❑ Yes	❑ No

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 have 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.

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

SAMBA PAYROLL ALLOTMENT FORM 299 01-13

Mail or Fax Completed Form to:

SAMBA
11301 Old Georgetown Road
Rockville, MD 20852-2800

(301) 984-1440 • (800) 638-6589
Fax (301) 816-0191

PRIVACY ACT STATEMENT

The information collected on this form is authorized by 5 U.S.C. 5527, which authorizes disbursing officers to permit employees to make allotments of their pay under regulations issued by the Office of Personnel Management. The information will be used primarily to identify you in your agency's payroll system (by employee number) and to process the payment of the allotment. Other possible disclosures of the information would be to a court or a federal, state or local taxing authority.

Executive Order 9397 permits use of the Social Security Number (SSN) as the means of identifying individuals in personnel record systems. Furnishing your SSN or any other information on this form is voluntary. However, failure to provide your employee identification number (or SSN when it is used by your agency as the employee identification number) or any of the other requested data may result in your agency not being able to process your request.

PART 1 – To be Completed by Employee

1. Employee's Name *(As Stated on Pay Check)*

2. Employee Identification Number

3. Employee's Home Address (Number, Street, City, State & Zip Code)

4. Employee Agency (Include Bureau, Division, Branch, or Other Designation)

5. Payroll Office Location (City, State)

6. Action Requested

☐ New Allotment . . . . $______________________

☐ Increase Allotment to Total of . . . . $______________________

☐ Decrease Allotment to Total of . . . . $______________________

☐ Cancel Allotment for all Plans

☐ Cancel Allotment only for Plans Listed Below:

7. Employee's Telephone Number

8. Employee's Account Number in the Financial Organization

0970192980

9. Recipient of Allotment *(Name & Mailing Address)*

M & T Bank
POST OFFICE BOX 64629
BALTIMORE, MD 21264-4629

TRN 052000113

10. **Authorization and Certification by Employee**

You are hereby authorized, under 5 CFR 550.311 to take the action requested above with respect to deductions from salary or wages due me in the amount specified in Item 6, which are for remittance to the individual/organization, as designated in Item 9, which is SAMBA's banking institution. This authorization shall also apply to any and all changes in my SAMBA allotment when certified by SAMBA as necessary and in accordance with the SAMBA plans in which I am enrolled. I understand that this allotment will continue until SAMBA receives and processes my written notice of cancellation.

I agree that the agency shall be held harmless for any erroneous allotment deduction made pursuant to this authorization. Any disputes regarding this allotment shall be a matter between me and the individual/organization designated in Item 9 to receive the remittance.

✓

Signature Date Signed

PART 2 – To be completed by Organization/Individual Receiving the Allotment

(Complete this part for a new allotment. It may be completed for changes to, or cancellations of, an existing allotment determined by agency policy.)

11. **Acknowledgment and Certification by Recipient of Allotment**

We, the above-designated financial organization, hereby agree to act as agent of the above-named Government employee.

VICE PRESIDENT

Authorized Signature Title

As requested above, the amount allotted will be deducted from your salaries or wages and will be remitted by the disbursing office, as soon as practicable, to the designated financial organization.

Visit our website at ***www.SambaPlans.com***