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SAMBA
FEDERAL EMPLOYEE BENEFIT ASSOCIATION

PERSONAL ACCIDENT INSURANCE
Enrollment Form

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

MEMBER INFORMATION (type or print clearly)

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)	Date of Hire (Month / Day / Year)	Agency (Initials)	Daytime Telephone	Email Address
/ /	/ /			

DEPENDENT INFORMATION (complete if requesting family coverage)

Relationship	Name	Sex	Date of Birth
Spouse		❑ Male ❑ Female	
Child		❑ Male ❑ Female	
Child		❑ Male ❑ Female	

COVERAGE AMOUNTS AND MONTHLY PREMIUMS

Enrollment Option	$10,000	$25,000	$50,000	$100,000	$150,000	$200,000	$250,000	$300,000	$400,000	$500,000
Member Only	$0.30	$0.76	$1.52	$3.03	$4.55	$6.07	$ 7.58	$ 9.10	$12.13	$15.17
Member & Family	$0.50	$1.24	$2.48	$4.97	$7.45	$9.93	$12.42	$14.90	$19.87	$24.83

Coverage levels for Member & Family are: **Member** = coverage amount; **Spouse only** = 60% of member's coverage; **Spouse and Child(ren)** = 50% of member's coverage for spouse and 15% of member's coverage for child(ren)*; **Child(ren) only*** = 20% of member's coverage.
*Child(ren) coverage limited to $50,000 per child.

Note: Maximum coverage amount available for members age 70 through age 74 is $50,000. Maximum coverage amount for members age 75 and over is $10,000.

COVERAGE SELECTION

❑ Member Only Coverage Amount $_____ Premium $_____

❑ Member & Family Coverage Amount $_____ Premium $_____

BENEFICIARY INFORMATION (type or print clearly)

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.

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

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

Please refer to the Certificate for all plan details, including any exclusions, limitations and restrictions which may apply. **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.**

I wish to enroll in the SAMBA Personal Accident Insurance Plan.

✓ Signature Required

Signature of Member Date

Underwritten by ReliaStar Life Insurance Company, Box 20, Minneapolis, MN 55440

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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 # _____

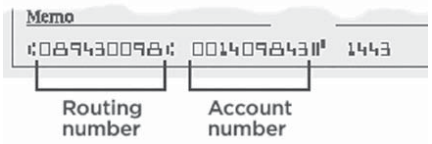
Email _____ Daytime Phone # _____

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.