



EMPLOYEE BENEVOLENT FUND ENROLLMENT FORM

Send to: **SAMBA**
 11301 Old Georgetown Road
 Rockville, MD 20852-2800
 (301) 984-1440 or 800-638-6589
 Fax (301) 816-0191
 www.SambaPlans.com

Please check the appropriate box:

- Open Enrollment Period
- Enrollment within 60 days of Date of Hire
- Change of Beneficiary
- Name and/or address change

Desired coverage amount:

- \$17,500 @ \$1.50 biweekly
- \$35,000 @ \$3.00 biweekly

Employing Agency:

U.S. Secret Service

Employee Information (Please Print or Type):

Full Name of Employee: _____

Mailing Address: _____

STREET CITY STATE ZIP

SSN: _____ - _____ - _____ Sex: Male Female Date of Birth: _____ - _____ - _____

Date of Hire: _____ - _____ - _____ Email: _____

Daytime Phone Number (_____) _____ - _____ Home/Cell Phone Number (_____) _____ - _____

PRIMARY BENEFICIARY(IES): (In equal shares or as designated below.) Primary beneficiary(ies) must be a natural person(s). Minors and trusts cannot be designated as primary beneficiary(ies).

Full Name and Address (Example: Mary A. Doe, not Mrs. John J. Doe)	% of Proceeds	Relationship to Employee	Date of Birth
TOTAL	100%		

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 (Example: Mary A. Doe, not Mrs. John J. Doe)	% of Proceeds	Relationship to Employee	Date of Birth
TOTAL	100%		

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.

Signature of Employee _____ Date _____

Signature of Spouse (Required only in Community Property States; AZ, CA, ID, LA, NV, NM, TX, WA, WI) _____ Date _____



Mail or Fax Completed Form to:

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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 <input type="checkbox"/> New Allotment \$ _____ <input type="checkbox"/> Increase Allotment to Total of \$ _____ <input type="checkbox"/> Decrease Allotment to Total of \$ _____ <input type="checkbox"/> Cancel Allotment for all Plans <input type="checkbox"/> 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. _____ Authorized Signature	_____ VICE PRESIDENT _____ Title
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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.