RESET

SAMBA
FEDERAL EMPLOYEE BENEFIT ASSOCIATION

DENTAL AND VISION PLAN ENROLLMENT FORM

FOR DEPENDENT CHILDREN
Incapable of Self Support (unmarried, over age 26)

11301 Old Georgetown Road, Rockville, MD 20852-2800 • (301) 984-1440 • (800) 638-6589 • Fax (301) 816-0191

You must be enrolled in the SAMBA Dental and Vision Plan for your child to be eligible for coverage

Self Only Premium: $19.38 Biweekly
$42.00 Monthly

To apply for coverage:

1. Complete this Enrollment Form (type or print clearly).
2. Complete the Direct Debit Application to have your premium conveniently deducted from your checking or savings account on a monthly basis. (**Note:** Employees of ATFE, CBP, CIS, DEA, FBI, ICE, and USSS may complete the SAMBA Payroll Allotment Form 299 instead of the Direct Debit Application.)
3. Be sure that all forms are signed and dated.
4. Mail or fax the completed forms to SAMBA at the address or number listed above.

Section I. MEMBER INFORMATION

Member's Last Name	First Name	Middle Initial

Member's Mailing Address (No. & Street)	(City)	(State)	(Zip Code)

Member's ID or Social Security Number	Daytime Phone Number	Member's e-mail address

What is your current government employment status	List Your Employing Agency or Retirement System
☐ Active ☐ Retired ☐ OWCP	

Section II. DEPENDENT INFORMATION

Dependent's Last Name	First Name	Middle Initial

Dependent's Mailing Address (No. & Street)	(City)	(State)	(Zip Code)

Dependent's Social Security Number	Date of Birth	Sex	Child's Relationship to Member
		☐ Male ☐ Female	☐ Natural ☐ Stepchild ☐ Adopted ☐ Foster

Your dependent will be enrolled in the same Plan Option (DMO or PPO) that you are enrolled

I, the member, understand that for my child to be eligible and remain eligible for coverage under the SAMBA Dental and Vision Plan, I must also be enrolled in the Dental and Vision Plan. In addition, my child must be unmarried, incapable of self-support, and considered as one of my dependents under a FEHBP plan. I understand that coverage for my child will cease as of the day my dependent ceases to qualify for this coverage. In addition, I understand that it is my responsibility to notify SAMBA immediately when such dependent ceases to meet any of the qualifications listed above, and I shall remain liable to the Plan to refund any payments made in error due to my failure to make such notification to SAMBA and any premium paid will not be refunded. Refer to Summary Plan Description for detailed information.

Signature of Member	Date
✓	

The SAMBA Dental and Vision Plan is a non-FEDVIP

Reset Form Print

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Rockville, Maryland 20852-2800

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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 # _____

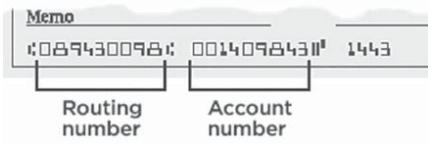
Email _____ Daytime Phone # _____

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.