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

SAMBA PAYROLL ALLOTMENT FORM 299 01-13

SAMBA
FEDERAL EMPLOYEE BENEFIT ASSOCIATION

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.

RESET

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.

Authorized Signature

VICE PRESIDENT
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***