RESET

SAMBA
FEDERAL EMPLOYEE BENEFIT ASSOCIATION

SAMBA TERM LIFE INSURANCE
Group Term Life Application

Group No. 67763-9
Account 3

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

Select One: ❑ New Enrollment ❑ Change to Current Coverage

Employment Status: ❑ Active ❑ Retired

To enroll or increase coverage, the enrollee must be under age 70

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 (type or print clearly)

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

TERM LIFE INSURANCE RATES & COVERAGES (Effective 10/1/12)

Schedule of Insurance for Member or Spouse Under Age 70 (Monthly Premium)

Age	$25,000	$50,000	$75,000	$100,000	$125,000	$150,000	$200,000	$250,000	$300,000	$400,000	$500,000	$600,000
<30	$2.00	$4.00	$6.00	$8.00	$10.00	$12.00	$16.00	$20.00	$24.00	$32.00	$40.00	$48.00
30-39	$2.75	$5.50	$8.25	$11.00	$13.75	$16.50	$22.00	$27.50	$33.00	$44.00	$55.00	$66.00
40-49	$3.80	$7.60	$11.40	$15.20	$19.00	$22.80	$30.40	$38.00	$45.60	$60.80	$76.00	$91.20
50-54	$6.48	$12.95	$19.43	$25.90	$32.38	$38.85	$51.80	$64.75	$77.70	$103.60	$129.50	$155.40
55-59	$11.08	$22.15	$33.23	$44.30	$55.38	$66.45	$88.60	$110.75	$132.90	$177.20	$221.50	$265.80
60-64	$16.88	$33.75	$50.63	$67.50	$84.38	$101.25	$135.00	$168.75	$202.50	$270.00	$337.50	$405.00
65-69	$27.05	$54.10	$81.15	$108.20	$135.25	$162.30	$216.40	$270.50	$324.60	$432.80	$541.00	$649.20

Note: Amount of coverage permitted under the SAMBA Term Life Insurance for member or spouse is limited to $600,000 each.

Child(ren) under age 26, coverage of $20,000 can be added for a cost of $2.17 monthly for all eligible children.

TERM LIFE INSURANCE COVERAGE SELECTIONS

Are you completing this form due to a Family Status Change (Marriage, Divorce, Birth, Adoption, etc.?) ❑ Yes ❑ No

Application For	Total Amount Desired	Current Amount	Amount to be Underwritten	Premium
❑ Member	$	$	$	$
❑ Spouse	$	$	$	$
❑ Child(ren)	$	$	$	$

Note: Health Statement Questionnaire required: **Short Form** may be used up through age 55 for coverage not to exceed $150,000. Coverage exceeding $150,000 or if the applicant requesting coverage is age 56 and older, requires completion of the **Long Form**.

(No Health Statement Questionnaire is needed to enroll your child.)

✓ **Signature Required**

Signature of Member _____ Date _____

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

SAMBA TERM LIFE INSURANCE
Group Term Life Application
Short Form Health Statement Questionnaire & Beneficiary Information

Group No. 67763-9

SAMBA • 11301 Old Georgetown Road • Rockville, MD 20852-2800 • Fax 301-816-0191 • Phone 1-800-638-6589

Note: ***Short Form*** *may be used up through age 55 for coverage not to exceed $150,000. Coverage exceeding $150,000 or the applicant requesting coverage is age 56 and older, requires completion of the* ***Long Form****.*

PART A: MEMBER INFORMATION (Type or print clearly)

Last Name	First Name	Middle Initial	Social Security No.

PART B: SPOUSE INFORMATION (Complete if you are requesting coverage for your spouse)

Last Name	First Name	Middle Initial	Social Security No.

PART C: HEALTH QUESTIONS (Please answer these questions by checking "Yes" or "No")

Member		Spouse (Complete only if requesting spouse coverage)		
Yes	No	Yes	No	
❑	❑	❑	❑	1. Have you had or been treated for heart trouble, stroke, diabetes, or cancer?
❑	❑	❑	❑	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?
❑	❑	❑	❑	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?

BENEFICIARY INFORMATION (Type or print clearly)

PRIMARY BENEFICIARY:

Full Name and Address	100% of Proceeds	Relationship to Member	Date of Birth

as shall then be living, and if no such beneficiary is then living

CONTINGENT BENEFICIARY:

Full Name and Address	100% of Proceeds	Relationship to Member	Date of Birth

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

Read this information carefully, then sign and date below

- To the best of my knowledge and belief, the information I've provided is complete and correct.
- I understand and agree that no coverage shall take effect unless the application is approved by ReliaStar Life Insurance Company.
- I understand my coverage begins on the "effective date" assigned by ReliaStar Life.

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.

Member Signature ✓ **Signature Required**	Date Signed
Spouse Signature (if applying for spouse coverage) ✓ **Signature Required**	Date Signed

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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 # _____

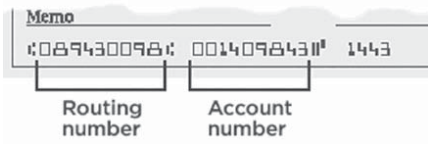
Email _____ Daytime Phone # _____

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.