SAMBA TERM LIFE INSURANCE
Group Term Life Application

SAMBA
FEDERAL EMPLOYEE BENEFIT ASSOCIATION

Group No. 67763-9

Mail or fax completed forms to: 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 (Biweekly 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	$ .92	$1.85	$2.77	$3.69	$4.62	$5.54	$7.38	$9.23	$11.08	$14.77	$18.46	$22.15
30-39	$1.27	$2.54	$3.81	$5.08	$6.35	$7.62	$10.15	$12.69	$15.23	$20.31	$25.38	$30.46
40-49	$1.75	$3.51	$5.26	$7.02	$8.77	$10.52	$14.03	$17.44	$21.05	$28.06	$35.08	$42.09
50-54	$2.99	$5.98	$8.97	$11.95	$14.94	$17.93	$23.91	$29.88	$35.86	$47.82	$59.77	$71.72
55-59	$5.11	$10.22	$15.34	$20.45	$25.56	$30.67	$40.89	$51.12	$61.34	$81.78	$102.23	$122.68
60-64	$7.79	$15.58	$23.37	$31.15	$38.94	$46.73	$62.31	$77.88	$93.46	$124.62	$155.77	$186.92
65-69	$12.48	$24.97	$37.45	$49.94	$62.42	$74.91	$99.88	$124.85	$149.82	$199.75	$249.69	$299.63

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

Dependent child (under age 26) coverage of $20,000 can be added for a cost of $1 biweekly for all eligible children.

TERM LIFE INSURANCE COVERAGE SELECTIONS

TOTAL COST

❑ Member Coverage Amount $_____ Premium $_____

❑ Spouse Coverage Amount $_____ Premium $_____

❑ Dependent Child (cost is $1 biweekly for all eligible children) Premium $_____

$_____

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 of Member Date

You must complete all forms – Application, Health Statement Questionnaire and payment type

SAMBA_GTLIFE_SF

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

Mail or fax the completed forms to:

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****.*

(You must also complete the Application and payment type forms)

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 postive 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 incude 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 ✓	Date Signed
Spouse Signature (if applying for spouse coverage) ✓	Date Signed

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***