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

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

Group No. 67763-9
Account 3

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

*To be used if age 56 and older, or coverage over $150,000. If you have questions contact us at **1-800-638-6589**.*

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

1. MEMBER INFORMATION (Type or print clearly)

Last Name	First Name	Middle Initial	Social Security No.

2. SPOUSE INFORMATION (Complete if you are requesting coverage for your spouse)

Last Name	First Name	Middle Initial	Social Security No.

3. MEMBER AND SPOUSE HEALTH QUESTIONS (Must be answered for coverage that is not Guaranteed Issue.)

Member (EE) Yes	Member (EE) No	Spouse (SP) Yes	Spouse (SP) No	
☐	☐	☐	☐	1. Have you ever been treated for or been diagnosed by a member of the medical profession or health practitioner as having AIDS (Acquired Immunodeficiency Syndrome)?
☐	☐	☐	☐	2. Have you ever had, or been treated for, any of the following: insulin dependent diabetes, heart attack, coronary bypass/angioplasty, heart valve repair/replacement, stroke, metastatic cancer, emphysema or been an organ transplant recipient?
Complete for EE and SP ⇢ (if applying)				3. **Member:** Height ____ ft. ____ in. Weight ____ lbs. **Spouse:** Height ____ ft. ____ in. Weight ____ lbs.
				4. In the past 10 years have you consulted with, been diagnosed or treated by a health practitioner, or taken medication for any of the following:
☐	☐	☐	☐	a. Disease or disorder of the heart, blood vessels (excluding controlled high blood pressure), lung (excluding asthma), liver (excluding hepatitis A), pancreas, or intestine?
☐	☐	☐	☐	b. Non-insulin dependent diabetes, impaired glucose tolerance, or pre-diabetes?
☐	☐	☐	☐	c. Cancer or tumor, rheumatoid arthritis, connective tissue, neurological (excluding headaches), autoimmune or blood disorder?
☐	☐	☐	☐	d. Depression, psychosis, suicide attempt, drug or alcohol abuse or addiction?
☐	☐	☐	☐	e. Polycystic kidney disease or kidney failure?
				5. Have you ever been diagnosed, treated or given medical advice by a physician or other health practitioner for:?
☐	☐	☐	☐	a. Chest pain, heart trouble or circulatory disorder?
☐	☐	☐	☐	b. Anemia or leukemia?
☐	☐	☐	☐	c. Sleep apnea, asthma or other respiratory disorder?
☐	☐	☐	☐	d. Colitis, Crohn's disease, ulcerative colitis or any other intestinal disorder or disease?
☐	☐	☐	☐	e. Stomach disorder?
☐	☐	☐	☐	f. Brain or seizure disorder?
☐	☐	☐	☐	g. Mental or nervous disorder?
☐	☐	☐	☐	h. Arthritis, paralysis or any muscle weakness?
☐	☐	☐	☐	i. Abnormal urine specimen or urinary tract disorder?
☐	☐	☐	☐	j. Prostate or other reproductive organ disorder?
☐	☐	☐	☐	6. Are you pregnant? Due Date _____ Pre-pregnancy weight _____ lbs.
☐	☐	☐	☐	7. Do you currently have any disorder, condition, disease, and/or are you currently taking medication prescribed or provided by a physician or other health practitioner for any disorder, condition, disease not shown above?
☐	☐	☐	☐	8. Have you ever received medical treatment or counseling for the use of alcohol or prescribed or non-prescribed drugs, or been advised by a health practitioner to discontinue the use of such substances?
☐	☐	☐	☐	9. In the past 2 years have you experienced any symptom(s) for which you have not yet consulted a health practitioner, or are any medical, surgical or diagnostic procedures recommended or contemplated?

MEMBER INFORMATION

Last Name	First Name	Middle Initial	Social Security No.

For every "Yes" answer to any question in the previous section, give details below. Please attach a separate sheet if additional space is needed.

Question Number	Applicant	Description of Condition	Date Condition Began	Description of Treatment Received	Fully Recovered?	Health Practitioner Name, Full Address (Street, City, State, ZIP), Phone
	☐ EE ☐ SP				☐ Yes ☐ No	
	☐ EE ☐ SP				☐ Yes ☐ No	
	☐ EE ☐ SP				☐ Yes ☐ No	
	☐ EE ☐ SP				☐ Yes ☐ No	
	☐ EE ☐ SP				☐ Yes ☐ No	
	☐ EE ☐ SP				☐ Yes ☐ No	
	☐ EE ☐ SP				☐ Yes ☐ No	
	☐ EE ☐ SP				☐ Yes ☐ No	

4. BENEFICIARY INFORMATION

PRIMARY BENEFICIARY(IES): IN EQUAL SHARES OR AS DESIGNATED BELOW (Total must equal 100%)

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

as shall then be living, and if no such beneficiary is then living TOTAL 100%

CONTINGENT BENEFICIARY(IES): IN EQUAL SHARES OR AS DESIGNATED BELOW (Total must equal 100%)

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

Note: The member is the beneficiary for spouse and child(ren) coverage TOTAL 100%

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

MEMBER INFORMATION			
Last Name	First Name	Middle Initial	Social Security No.

5. 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 this application is approved by ReliaStar Life Insurance Company.
- I understand my coverage begins on the "effective date" assigned by ReliaStar Life.

Authorization and Acknowledgment – Please read and sign below.

For underwriting and claim purposes, I give my permission to: Any physician, or any other medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsurance company, MIB, Inc., Department of Motor Vehicle Records, employer or any other organization or person to give ReliaStar Life Insurance Company (ReliaStar Life) or its authorized representative (including ChoicePoint or any consumer reporting agency) acting on its behalf ALL INFORMATION on my behalf (except as limited below), including findings on medical care, psychiatric or psychological care or examination, surgery or any non-medical information, including motor vehicle records, as they apply to any person who is to be covered. I give my permission to ReliaStar Life to get consumer or investigative consumer reports about the same persons.

I authorize ReliaStar Life, or its reinsurers, to disclose personal health information about me to MIB, Inc. in the form of a brief coded report for participation in MIB's fraud prevention and detection programs.

I give my permission to ReliaStar Life to get any and all such information for the purposes described in this form. I specifically consent to the redisclosure of such information as set forth in this form. I know that my medical records, including any alcohol or drug abuse information, may be protected by Federal Regulations – 42 CFR Part 2. I may revoke this authorization as it applies to any information protected by 42 CFR Part 2 at any time, but not to the extent action has been taken in reliance on it. I understand all or part of the information obtained by this authorization may be communicated between ReliaStar Life, its affiliates, and may be sent to MIB, Inc. This information may be made available to any ReliaStar Life affiliate, reinsurer, employer, or contractor who processes transactions that concern any coverage I may have requested or have with ReliaStar Life or its affiliates. I understand that my additional written consent will be required before any information described above is given, sold, transferred, or, in any way, relayed to another party not previously specified (unless otherwise provided by law). My additional consent must be provided on a form that states the new use of the information or why another party needs it. I know that I have the right to get a copy of this form. A photocopy of this form will be as valid as the original. As it relates to the incontestability clause, this form will be valid for 30 months from the date shown below or for two years from the date coverage is made effective, whichever is earlier.

I acknowledge that I have been given ReliaStar Life's Consumer Privacy Notice.

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

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 # _____

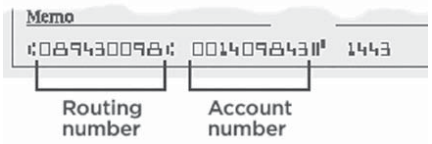
Email _____ Daytime Phone # _____

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.