You must include a copy of your recent pay stub with the application

RESET

SAMBA
FEDERAL EMPLOYEE BENEFIT ASSOCIATION

LONG TERM DISABILITY Enrollment/Update Form

Mail or fax completed forms to: SAMBA, 11301 Old Georgetown Road, Rockville, MD 20852-2800 • (800) 638-6589 • Fax (301) 816-0191

Section 1 – Employee Information

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)	Email Address	Home Telephone	Daytime Telephone
/ /			

Date of Hire (Month / Day / Year)	Agency (Initials)	GS Level	Current Annual Salary	Occupation/Job Title	Retirement System	Height	Weight
/ /		GS -	$		❑ CSRS ❑ FERS	ft. in.	lbs.

Section 2 – Coverage Requested (You must be under age 62 and a full-time employee working more than 32 hours a week. You are not eligible for the coverage if your Regular Place of Work is your home or other residence.)

❑ **I want to enroll in the Long Term Disability plan**

❑ **I want to update my Covered Salary amount in the Long Term Disability plan**

You must provide proof of current salary (e.g., pay stub) when enrolling or updating coverage.

Covered Salary Amount Requested	Date of Last Salary Increase (Month / Day / Year)	Biweekly Premium
$	/ /	$

Please refer to the "Long Term Disability Premiums" chart for biweekly premium costs.

Section 3 – Health Statement

Evidence of Insurability is not required if you apply for an increase in coverage within 90 days of your salary increase and have done so with each salary increase since completing your last Health Statement. If Evidence of Insurability is required, a new Pre-Existing Condition Limitation will apply to the increased amount of benefits from the effective date of change, but will not apply to coverage already in force.

PLEASE ANSWER THE FOLLOWING AND GIVE DETAILS OF ALL "YES" ANSWERS

1. Have you ever been diagnosed or treated by a member of the medical profession for:

❑ Yes ❑ No a. A heart murmur, high blood pressure, or any disease or disorder of the heart, blood or circulatory system?

❑ Yes ❑ No b. Asthma, shortness of breath, tuberculosis, or any disease or disorder of the lungs or respiratory system?

❑ Yes ❑ No c. Colitis, ulcer, kidney disease, blood or sugar in urine, or any disease or disorder of the digestive, urinary or reproductive system?

❑ Yes ❑ No d. Alcoholism, drug abuse, chronic or prolong fatigue, severe headaches, epilepsy, dizziness, stroke, or any disease or disorder of the brain or nervous system including mental or emotional disorders?

❑ Yes ❑ No e. Cancer, tumor, diabetes, or any disease or disorder of the glands?

❑ Yes ❑ No f. Arthritis, impaired sight or hearing, or any disease or disorder of the skin, bones, or joints, including neck or back disorders, muscular or soft tissue disorders?

❑ Yes ❑ No g. Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), or AIDS Related Complex (ARC)?

2. ❑ Yes ❑ No a. Are you now pregnant? If yes, please list your due date _____

❑ Yes ❑ No b. Are there any medical complications?

3. ❑ Yes ❑ No During the past 5 years have you consulted any physician, surgeon, psychologist, psychiatrist, or other medical or dental practitioner for any reason not previously noted on this application; have you been confined or treated in any hospital, sanatorium or similar institution?

Give details below for those questions for which you answered "YES." (If additional space is required, complete and attach a separate sheet of paper.)

Question No. w/Letter	Condition – Give Details	Occurred Date (Month / Day / Year)	Duration	Current Status
		/ /		
		/ /		
		/ /		

SAMBA reserves the right to request additional health information on the basis of responses given to the above. I declare that, to the best of my knowledge and belief, the statements made in this application are complete and true. I agree that the coverage applied for is subject to the terms of the Program and shall become effective on the date or dates established by SAMBA, provided the evidence of good health is satisfactory.

✓ Signature Required

Employee's Signature Date

Complete the attached Beneficiary Designation Form and SAMBA Payroll Allotment Form 299

You must include a copy of your recent pay stub with the application

SAMBA
FEDERAL EMPLOYEE BENEFIT ASSOCIATION

LONG TERM DISABILITY Enrollment/Update Form

Section 4 – Dependent Information (Your dependents are eligible for coverage under the Hospital Confinement Benefit)

Spouse Information		Social Security Number	Date of Birth
Full Name			/ /

Dependent Children Information (List additional children w/their information on a separate sheet)		Social Security Number	Sex	Date of Birth
Full Name			❑ Male ❑ Female	/ /
Full Name			❑ Male ❑ Female	/ /
Full Name			❑ Male ❑ Female	/ /
Full Name			❑ Male ❑ Female	/ /

Section 5 – Beneficiary Designation for the Long Term Disability Plan

Please fill out this section so that it fully and accurately describes your request. List the full name, relationship to the employee, and date of birth of the beneficiary(ies). **If you are married, your spouse must be your beneficiary.** For the beneficiary designation to be valid, it must be delivered and recorded in the SAMBA office prior to the death of the employee.

PRIMARY BENEFICIARY(IES): IN EQUAL SHARES OR AS DESIGNATED BELOW

Full Name and Address	% of Proceeds	Relationship to Employee	Date of Birth
			/ /
			/ /
			/ /

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

CONTINGENT BENEFICIARY(IES): IN EQUAL SHARES OR AS DESIGNATED BELOW

Full Name and Address	% of Proceeds	Relationship to Employee	Date of Birth
			/ /
			/ /
			/ /

Signature of Employee (or of Assignee if assigned)	Signature Required	Date

Complete the attached SAMBA Payroll Allotment Form 299

SAMBA

Long Term Disability Premiums

Salary to Next Highest $1,000	Biweekly Cost	Salary to Next Highest $1,000	Biweekly Cost	Salary to Next Highest $1,000	Biweekly Cost	Salary to Next Highest $1,000	Biweekly Cost	Salary to Next Highest $1,000	Biweekly Cost
$21,000	$6.38	$57,000	$17.32	$93,000	$28.26	$129,000	$39.20	$165,000	$50.14
$22,000	$6.68	$58,000	$17.62	$94,000	$28.56	$130,000	$39.50	$166,000	$50.44
$23,000	$6.99	$59,000	$17.93	$95,000	$28.87	$131,000	$39.80	$167,000	$50.74
$24,000	$7.29	$60,000	$18.23	$96,000	$29.17	$132,000	$40.11	$168,000	$51.05
$25,000	$7.60	$61,000	$18.54	$97,000	$29.47	$133,000	$40.41	$169,000	$51.35
$26,000	$7.90	$62,000	$18.84	$98,000	$29.78	$134,000	$40.72	$170,000	$51.65
$27,000	$8.20	$63,000	$19.14	$99,000	$30.08	$135,000	$41.02	$171,000	$51.96
$28,000	$8.51	$64,000	$19.45	$100,000	$30.38	$136,000	$41.32	$172,000	$52.26
$29,000	$8.81	$65,000	$19.75	$101,000	$30.69	$137,000	$41.63	$173,000	$52.57
$30,000	$9.12	$66,000	$20.05	$102,000	$30.99	$138,000	$41.93	$174,000	$52.87
$31,000	$9.42	$67,000	$20.36	$103,000	$31.30	$139,000	$42.24	$175,000	$53.17
$32,000	$9.72	$68,000	$20.66	$104,000	$31.60	$140,000	$42.54	$176,000	$53.48
$33,000	$10.03	$69,000	$20.97	$105,000	$31.90	$141,000	$42.84	$177,000	$53.78
$34,000	$10.33	$70,000	$21.27	$106,000	$32.21	$142,000	$43.15	$178,000	$54.08
$35,000	$10.64	$71,000	$21.57	$107,000	$32.51	$143,000	$43.45	$179,000	$54.39
$36,000	$10.94	$72,000	$21.88	$108,000	$32.82	$144,000	$43.75	$180,000	$54.69
$37,000	$11.24	$73,000	$22.18	$109,000	$33.12	$145,000	$44.06	$181,000	$55.00
$38,000	$11.55	$74,000	$22.48	$110,000	$33.42	$146,000	$44.36	$182,000	$55.30
$39,000	$11.85	$75,000	$22.79	$111,000	$33.73	$147,000	$44.67	$183,000	$55.60
$40,000	$12.15	$76,000	$23.09	$112,000	$34.03	$148,000	$44.97	$184,000	$55.91
$41,000	$12.46	$77,000	$23.40	$113,000	$34.34	$149,000	$45.27	$185,000	$56.21
$42,000	$12.76	$78,000	$23.70	$114,000	$34.64	$150,000	$45.58	$186,000	$56.52
$43,000	$13.07	$79,000	$24.00	$115,000	$34.94	$151,000	$45.88	$187,000	$56.82
$44,000	$13.37	$80,000	$24.31	$116,000	$35.25	$152,000	$46.18	$188,000	$57.12
$45,000	$13.67	$81,000	$24.61	$117,000	$35.55	$153,000	$46.49	$189,000	$57.43
$46,000	$13.98	$82,000	$24.92	$118,000	$35.85	$154,000	$46.79	$190,000	$57.73
$47,000	$14.28	$83,000	$25.22	$119,000	$36.16	$155,000	$47.10	$191,000	$58.03
$48,000	$14.58	$84,000	$25.52	$120,000	$36.46	$156,000	$47.40	$192,000	$58.34
$49,000	$14.89	$85,000	$25.83	$121,000	$36.77	$157,000	$47.70	$193,000	$58.64
$50,000	$15.19	$86,000	$26.13	$122,000	$37.07	$158,000	$48.01	$194,000	$58.95
$51,000	$15.50	$87,000	$26.44	$123,000	$37.37	$159,000	$48.31	$195,000	$59.25
$52,000	$15.80	$88,000	$26.74	$124,000	$37.68	$160,000	$48.62	$196,000	$59.55
$53,000	$16.10	$89,000	$27.04	$125,000	$37.98	$161,000	$48.92	$197,000	$59.86
$54,000	$16.41	$90,000	$27.35	$126,000	$38.28	$162,000	$49.22	$198,000	$60.16
$55,000	$16.71	$91,000	$27.65	$127,000	$38.59	$163,000	$49.53	$199,000	$60.47
$56,000	$17.02	$92,000	$27.95	$128,000	$38.89	$164,000	$49.83	$200,000	$60.77

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 Required

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.