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SAMBA
FEDERAL EMPLOYEE BENEFIT ASSOCIATION

PERSONAL ACCIDENT INSURANCE
Enrollment Form

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

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 (complete if requesting family coverage)

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

COVERAGE AMOUNTS AND BIWEEKLY PREMIUMS

Enrollment Option	$10,000	$25,000	$50,000	$100,000	$150,000	$200,000	$250,000	$300,000	$400,000	$500,000
Member Only	$0.14	$0.35	$0.70	$1.40	$2.10	$2.80	$3.50	$4.20	$5.60	$ 7.00
Member & Family	$0.23	$0.57	$1.15	$2.29	$3.44	$4.58	$5.73	$6.88	$9.17	$11.46

Coverage levels for Member & Family are: **Member** = coverage amount; **Spouse only** = 60% of member's coverage; **Spouse and Child(ren)** = 50% of member's coverage for spouse and 15% of member's coverage for child(ren)*****; **Child(ren) only*** = 20% of member's coverage.
*****Child(ren) coverage limited to $50,000 per child.

Note: Maximum coverage amount available for members age 70 through age 74 is $50,000. Maximum coverage amount for members age 75 and over is $10,000.

COVERAGE SELECTION

❑ Member Only Coverage Amount $_____ Premium $_____

❑ Member & Family Coverage Amount $_____ Premium $_____

BENEFICIARY INFORMATION (type or print clearly)

Please indicate your designated beneficiary(ies) name(s) and relationship(s) on the lines below. If more than one primary beneficiary is designated, settlement will be made in equal shares to the designated beneficiaries (or beneficiary) who are then still living, unless their shares are specified. If there is no named beneficiary, or no beneficiary survives the insured, settlement will be made in accordance with the terms of your Group Contract.

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

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

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 Insured	Birth Date

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

Please refer to the Certificate for all plan details, including any exclusions, limitations and restrictions which may apply. **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.**

I wish to enroll in the SAMBA Personal Accident Insurance Plan.

✓ Signature Required

Signature of Member Date

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

PAIB_1212

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.

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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***