# SAMBA GROUP TERM LIFE INSURANCE
## Simplified Issue Application

Group No. 67763-9
Account 3

Submit completed application to: **SAMBA, 11301 Old Georgetown Road, Rockville, MD 20852-2800**
**Fax: (301) 816-0191 • Secure email: www.sambaplans.com/contact-us/**

**Select One:** ❑ New Applicant ❑ Change to Current Coverage

**Employment Status:** ❑ Active ❑ Retired

*This **Simplified Issue Application** may be used up to age 56 for member or spouse coverage not to exceed $150,000 each. An application for coverage exceeding $150,000, or if the applicant requesting coverage is age 56 or older, requires completion of the **Medically Underwritten Application**.*

***Note: If you have been previously declined for group life insurance by ReliaStar Life, then you are not eligible to apply for Simplified Issue coverage from SAMBA.***

## MEMBER INFORMATION

| Last Name | First Name | Middle Initial | Social Security No. | Date of Birth (Month / Day / Year) | Sex |
|---|---|---|---|---|---|
| | | | | / / | ❑ Male ❑ Female |

| Address: Street | City | State | Zip |
|---|---|---|---|
| | | | |

| Agency (Initials) | Home/Cell Phone | Work Phone | Email Address |
|---|---|---|---|
| | | | |

## DEPENDENT INFORMATION Complete if you are requesting coverage for your spouse and/or dependent child(ren)

| Relationship | Last Name | First Name | Middle Initial | Social Security No. | Date of Birth | Sex |
|---|---|---|---|---|---|---|
| Spouse | | | | | / / | ❑ Male ❑ Female |
| Child | | | | | / / | ❑ Male ❑ Female |
| Child | | | | | / / | ❑ Male ❑ Female |
| Child | | | | | / / | ❑ Male ❑ Female |

## GROUP TERM LIFE INSURANCE RATES & COVERAGES Rates effective 10/1/12 and are subject to change

Schedule of Insurance for Member or Spouse Under Age 56 (Monthly Premium)

| Age | $25,000 | $50,000 | $75,000 | $100,000 | $125,000 | $150,000 |
|---|---|---|---|---|---|---|
| <30 | $2.00 | $4.00 | $6.00 | $8.00 | $10.00 | $12.00 |
| 30-39 | $2.75 | $5.50 | $8.25 | $11.00 | $13.75 | $16.50 |
| 40-49 | $3.80 | $7.60 | $11.40 | $15.20 | $19.00 | $22.80 |
| 50-54 | $6.48 | $12.95 | $19.43 | $25.90 | $32.38 | $38.85 |
| 55 | $11.08 | $22.15 | $33.23 | $44.30 | $55.38 | $66.45 |

**$2.17 monthly provides $20,000 coverage for all eligible children under age 26.**

## COVERAGE APPLYING FOR

| Application For | Total Amount of Coverage | | | | | | Monthly Premium |
|---|---|---|---|---|---|---|---|
| ❑ Member | ❑ $25,000 | ❑ $50,000 | ❑ $75,000 | ❑ $100,000 | ❑ $125,000 | ❑ $150,000 | $ |
| ❑ Spouse | ❑ $25,000 | ❑ $50,000 | ❑ $75,000 | ❑ $100,000 | ❑ $125,000 | ❑ $150,000 | $ |
| ❑ Child(ren) | ❑ $20,000 | | | | | | $ |

# Health Statement Questionnaire & Beneficiary Information

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## HEALTH QUESTIONS Please answer these questions by checking "Yes" or "No"

| Question | Member | Spouse |
|---|---|---|
| 1. Have you had or been treated for heart trouble, stroke, diabetes, or cancer? | ❑ Yes ❑ No | ❑ Yes ❑ No |
| 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? | ❑ Yes ❑ No | ❑ Yes ❑ No |
| 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? | ❑ Yes ❑ No | ❑ Yes ❑ No |
| 4. In the past 5 years, have you been hospitalized or admitted to a medical care facility? | ❑ Yes ❑ No | ❑ Yes ❑ No |

## MEMBER BENEFICIARY INFORMATION Note: The member is the beneficiary for spouse and child(ren) coverage

**PRIMARY BENEFICIARY(IES):** List the percent each will receive. The total must equal 100%

| Full Name and Address | Percentage | Relationship to Member | Date of Birth |
|---|---|---|---|
| | % | | / / |
| | % | | / / |
| | % | | / / |

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

**CONTINGENT BENEFICIARY(IES):** List the percent each will receive. The total must equal 100%

| Full Name and Address | Percentage | Relationship to Member | Date of Birth |
|---|---|---|---|
| | % | | / / |
| | % | | / / |
| | % | | / / |

### READ THIS INFORMATION CAREFULLY, THEN SIGN AND DATE BELOW

- To the best of my knowledge and belief, the information I have 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 and the first premium is paid in my lifetime.
- I understand my coverage begins on the "effective date" assigned by ReliaStar Life Insurance Company.

**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.**

| Print Member's Name | Member Signature | Date Signed |
|---|---|---|
| Print Spouse's Name (if applying for spouse coverage) | Spouse Signature (if applying for spouse coverage) | Date Signed |

11301 Old Georgetown Road
Rockville, Maryland 20852-2800

(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 # ________________

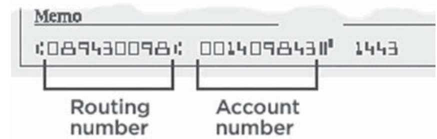
Email ______________________________ Daytime Phone # ________________

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 ______________________________ Date ________________

Contact SAMBA's Group Plans Department at (301) 984-1440 or (800) 638-6589 with any questions.