Personal Accident Insurance (Optional AD&D) Enrollment Form

Submit your completed form to:
SAMBA, 11301 Old Georgetown Road, Rockville, MD 20852-2800
Fax: (301) 816-0191 | Secure Email: www.sambaplans.com/contact-us

Phone: (800) 638-6589

SAMBA | 72117

1 MEMBER INFORMATION

☐ Male ☐ Female

Last Name | First Name | Middle Initial | Social Security Number

Street Address | City | State | Zip Code | Phone Number

Agency (Initials) | Date of Hire (mm/dd/yyyy) | Date of Birth (mm/dd/yyyy)

Email Address | Marital Status

2 SPOUSE INFORMATION

☐ Male ☐ Female

Last Name | First Name | Middle Initial | Date of Birth (mm/dd/yyyy)

3 DEPENDENT CHILD INFORMATION

Full Name | Date of Birth (mm/dd/yyyy)

1. ______________________ ☐ Male ☐ Female
2. ______________________ ☐ Male ☐ Female
3. ______________________ ☐ Male ☐ Female
4. ______________________ ☐ Male ☐ Female

4 COVERAGE

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) (under age 26) 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 $__________ Biweekly Premium $__________

☐ Member & Family Coverage Amount $__________ Biweekly Premium $__________

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5 MEMBER SIGNATURE

FLORIDA RESIDENTS – Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

NEW YORK RESIDENTS – Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation. This notice ONLY applies to accident and disability income coverage.

I have read and understand the terms and requirements of the fraud warnings included as part of this form. I certify that I am currently a member in good standing of SAMBA. I declare by signing below that all the information I have provided is complete and true and understand that it is the basis of providing insurance under a contract(s) issued by SAMBA Federal Employee Benefit Association.

X ______________________________ Member Signature

______________________________ Date Signed (Month/Day/Year)

IMPORTANT NOTICES

For residents of all states except Alabama, Arkansas, the District of Columbia, Florida, Kentucky, Louisiana, Maine, Maryland, New Jersey, NewYork, North Carolina, Pennsylvania, Puerto Rico, Rhode Island, Utah, Vermont, Virginia and Washington;

WARNING: Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person, or knowing that he is facilitating commission of a fraud, submits incomplete, false, fraudulent, deceptive or misleading facts or information when filing an insurance application or a statement of claim for payment of a loss or benefit commits a fraudulent insurance act, is/may be guilty of a crime and may be prosecuted and punished under state law. Penalties may include fines, civil damages and criminal penalties, including confinement in prison. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant or if the applicant conceals, for the purpose of misleading ,information concerning any fact material thereto.

ALABAMA RESIDENTS – Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

ARKANSAS, DISTRICT OF COLUMBIA, LOUISIANA and RHODE ISLAND RESIDENTS – Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

KENTUCKY RESIDENTS – Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

MAINE AND WASHINGTON RESIDENTS – Any person who knowingly provides false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company commits a crime. Penalties include imprisonment, fines, and denial of insurance benefits.

MARYLAND RESIDENTS – Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NEW JERSEY RESIDENTS – Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NORTH CAROLINA RESIDENTS – Any person who, with the intent to injure, defraud, or deceive an insurer or insurance claimant, knowing that the statement contains false information concerning a fact or matter material to the claim may be guilty of a class H felony.

PENNSYLVANIA and UTAH RESIDENTS – Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any material fact thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

PUERTO RICO RESIDENTS – Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances [be] present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

VERMONT RESIDENTS – Any person who knowingly presents a false or fraudulent claim for payment of a loss or knowingly makes a false statement in an application for insurance may be guilty of a criminal offense under state law.

VIRGINIA RESIDENTS – Any person who, with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

Beneficiary Designation Form

Personal Accident Insurance (Optional AD&D)

SAMBA | 72117

MEMBER INFORMATION

Last Name	First Name	Middle Initial	Member ID/Social Security

Street Address	City	State	ZIP

BENEFICIARY INFORMATION

I request that the beneficiaries under the policy/certificate be changed as indicated below. Unless otherwise provided in this request, if two or more primary beneficiaries are named, the proceeds shall be paid in equal shares to the named primary beneficiaries if surviving the member. If no primary beneficiaries survive, the proceeds shall be paid in equal shares to the named contingent beneficiaries, if any. If no beneficiary survives, payment shall be made according to the terms of the policy. The right of the owner to change the beneficiary hereafter is reserved.

Primary Beneficiary: The person designated to receive insurance proceeds when they become due.

Contingent Beneficiary (also referred to as a secondary beneficiary): An alternate beneficiary designated to receive insurance proceeds if there is no eligible primary beneficiary.

PRIMARY BENEFICIARY(IES) (In equal shares or as designated below)

Full Name	Address	Relationship to Insured	Date of Birth	% of Proceeds
			Total	**100%**

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	Address	Relationship to Insured	Date of Birth	% of Proceeds
			Total	**100%**

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

AUTHORIZATION AND ACKNOWLEDGMENT

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

Member Signature

Date

Mail or Fax Completed Form to:

SAMBA
11301 Old Georgetown Road
Rockville, MD 20852-2800

Phone: (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.

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.

Andrea H Connolly — Senior Vice President

Authorized Signature ______________________ 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.