

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)
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3 DEPENDENT CHILD INFORMATION

Full Name	Date of Birth (mm/dd/yyyy)		
1. _____	_____	<input type="checkbox"/> Male	<input type="checkbox"/> Female
2. _____	_____	<input type="checkbox"/> Male	<input type="checkbox"/> Female
3. _____	_____	<input type="checkbox"/> Male	<input type="checkbox"/> Female
4. _____	_____	<input type="checkbox"/> Male	<input type="checkbox"/> Female

4 COVERAGE

COVERAGE AMOUNTS AND MONTHLY 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	\$0.30	\$0.76	\$1.52	\$3.03	\$4.55	\$6.07	\$ 7.58	\$ 9.10	\$12.13	\$15.17
Member & Family	\$0.50	\$1.24	\$2.48	\$4.97	\$7.45	\$9.93	\$12.42	\$14.90	\$19.87	\$24.83

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

<input type="checkbox"/> Member Only	Coverage Amount \$ _____	Monthly Premium \$ _____
<input type="checkbox"/> Member & Family	Coverage Amount \$ _____	Monthly 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, New York, 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

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 # _____

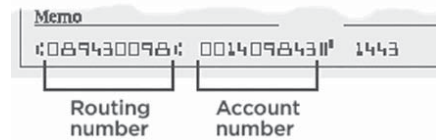
Email _____ Daytime Phone # _____

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.