Voluntary Term Life Enrollment Form

Mail or fax 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
FEDERAL EMPLOYEE BENEFIT ASSOCIATION

SAMBA | 72117

1 Member Information

Last Name | First Name | Middle Initial | Social Security Number | ☐ Male ☐ Female

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: ☐ Single ☐ Married ☐ Divorced

2 Spouse Information and Dependent Child Information - Complete if you are requesting coverage for your spouse or dependent child.

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

Dependent Child Information

Full Name	Date of Birth (mm/dd/yyyy)	
1.		☐ Male ☐ Female
2.		☐ Male ☐ Female
3.		☐ Male ☐ Female
4.		☐ Male ☐ Female

3 Coverage Selection - Please refer to attached rate chart for premium cost.

☐ Member*		☐ Spouse*		☐ Child(ren)**
☐ $25,000	☐ $250,000	☐ $25,000	☐ $250,000	☐ $20,000
☐ $50,000	☐ $300,000	☐ $50,000	☐ $300,000	
☐ $75,000	☐ $400,000	☐ $75,000	☐ $400,000	
☐ $100,000	☐ $500,000	☐ $100,000	☐ $500,000	
☐ $125,000	☐ $600,000	☐ $125,000	☐ $600,000	
☐ $150,000	☐ $750,000	☐ $150,000	☐ $750,000	
☐ $200,000		☐ $200,000		

**Member and Spouse coverage is available to a maximum of $750,000. Spouse coverage cannot exceed member's full coverage amount.*
***Dependent Child(ren) - Each child receives $20,000 in coverage. Eligible child coverage begins from live birth until age 26.*

4 Authorization

I have read and understand the terms and requirements of the fraud warnings included as part of this enrollment. I certify that I am currently a member in good standing of the 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.

X

Member Signature | Date Signed (mm/dd/yyyy)

The Prudential Insurance Company of America
751 Broad Street, Newark, New Jersey 07102

Evidence of Insurability Form

Mail or fax 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
FEDERAL EMPLOYEE BENEFIT ASSOCIATION

SAMBA | 72117

1 Member Information

Please print all answers using black ink.

First Name | Last Name | Middle Initial | Social Security Number | ☐ Male ☐ Female

Street Address | City | State | ZIP Code

Phone Number | Email Address

Birth Date (mm/dd/yyyy) | Birth City | Birth State | Height (ft./in.) | Weight (lbs.)

2 Spouse Information – Complete if applying for spouse

First Name | Last Name | Middle Initial | Social Security Number | ☐ Male ☐ Female

Street Address | City | State | ZIP Code

Birth Date (mm/dd/yyyy) | Birth City | Birth State | Height (ft./in.) | Weight (lbs.)

3 Health Questions – Please answer these questions by checking "Yes" or "No"

Member		*Spouse*	
Yes	No	Yes	No
☐	☐	☐	☐

1. **Within the last 12 months,** have you used tobacco, nicotine, cigarettes, electronic cigarettes, cigars, pipe, chewing tobacco, nicotine gum or nicotine patches?

2. **Are you currently** performing all the duties of your job on a full-time basis?
   If no, please explain: _____

3. **Within the last five years,** have you been medically treated or diagnosed with, taken medication for, or experienced known symptoms of any of the following conditions?
   - High blood pressure, chest pain, a heart attack, coronary artery disease, a heart valve disorder, a heart murmur, an irregular heartbeat, cerebrovascular disease, a stroke, circulatory disease, an aneurysm or any disease of the heart or blood vessels
   - A tumor, cancer, leukemia, melanoma, lymphoma or Hodgkin's disease
   - Diabetes, high blood sugar, glucose intolerance or other endocrine disorder
   - Anxiety, depression, or any other mental or psychiatric illness
   - Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), or any other sexually transmitted disease (other than HIV)
   - Asthma, emphysema, cystic fibrosis, sleep apnea, sarcoidosis, tuberculosis or any other disorder of the lungs or respiratory system
   - A seizure, epilepsy, multiple sclerosis, Parkinson's disease, muscular dystrophy, cerebral palsy, paralysis, Alzheimer's disease or any other disorder of the brain or nervous system
   - An ulcer, hepatitis, cirrhosis, pancreatitis, ulcerative colitis, Crohn's disease or any other disorder of the esophagus, liver, stomach or intestines
   - Nephritis, polycystic kidney disease or any other disorder of the bladder, kidney, urinary tract or prostate
   - Arthritis, gout, back trouble, or any disease or disorder of the joints, muscles or bones
   - Lupus, rheumatoid arthritis, chronic fatigue syndrome, fibromyalgia, or any other disease or disorder of the autoimmune system

Continued on the next page

3 Health Conditions – Continued from page 1

Member		*Spouse*	
Yes	**No**	**Yes**	**No**
☐	☐	☐	☐
☐	☐	☐	☐
☐	☐	☐	☐
☐	☐	☐	☐
☐	☐	☐	☐

4. Have you during the last five years?

- Been in a hospital, sanitarium, or other institution for observation, rest, diagnosis, or treatment other than for routine pregnancy
- Used, or are now using, cocaine, barbiturates, amphetamines, marijuana, hallucinatory drugs, heroin, opiates, or narcotics, except as prescribed by a doctor
- Been treated or been advised to have treatment or counseling for alcohol or drug use or been asked to reduce or eliminate their usage
- Been treated or counseled by a psychologist or psychiatrist
- Had life, disability, or health insurance declined, postponed, changed, rated-up, cancelled, or withdrawn

If you answered "Yes" to any questions, please provide full details below.

Member Condition	Status	Last Visit	Recovery Date	Physician Name	Address	Phone

Member Primary Care Physician Information

Physician Name	Street Address	City, State and ZIP	Phone	Last Visit

Spouse Condition	Status	Last Visit	Recovery Date	Physician Name	Address	Phone

Spouse Primary Care Physician Information

Physician Name	Street Address	City, State and ZIP	Phone	Last Visit

Authorization for the Release of Information. This Authorization is intended to comply with the HIPAA Privacy Rule. I/We authorize and instruct any health plan, physician, health care professional, hospital, clinic, laboratory, medical facility, pharmacy benefit manager, retail pharmacy, clearinghouse, data warehouse or other comparable organization that aggregates and maintains pharmacy data, or other health care provider that has provided treatment or services to me/us within the past five years ("My Providers") to disclose my/our entire medical record and any other health information concerning me/us to The Prudential Insurance Company of America (Prudential) and through it, to its reinsurers, authorized agents and MIB, Inc. This includes information on the diagnosis and treatment of Human Immunodeficiency Virus (HIV) infection (In Vermont and Wisconsin, this information is excluded) and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes. I/We also authorize the MIB, Inc. to release any data it may have about me/us for coverage to Prudential. By my/our signature below, I/We acknowledge that any agreements I/We have made to restrict the disclosure of health information do not apply to this Authorization and I/We instruct any of my/our Providers to release and disclose my/our entire medical record without restriction, including without limitation any restrictions on health care items or services for which a health care provider has been paid out of pocket in full. This health information is to be disclosed under this Authorization so that Prudential may: 1) underwrite an application for coverage and make risk determinations; 2) administer coverage; and 3) conduct other legally permissible activities that relate to any coverage I/We have or have applied for with Prudential. This Authorization shall remain in force for 24 months following the date of my/our signature below, and a copy of this Authorization is as valid as the original. I/We understand that I/We have the right to revoke this Authorization in writing, at any time, by sending a signed request for revocation to The Prudential Insurance Company of America, Group Medical Underwriting, P.O. Box 8796, Philadelphia, PA, 19176, Attention: Senior Medical Underwriting Consultant. I/We understand that such a revocation is not effective to the extent that Prudential has taken action in reliance on this Authorization or to the extent that Prudential has a legal right to contest a claim under the insurance contract or to contest the contract itself. I/We understand that any information that is disclosed pursuant to this Authorization may be re-disclosed to other parties and will not be protected by the HIPAA Privacy Rule. (In Montana only, I/We may request a record of any subsequent disclosures of protected health information). I/We understand that if I/We refuse to sign this Authorization to release my/our entire medical record and any other health information concerning me, Prudential may not be able to process an application for coverage. I/We understand that I/We have the right to request and receive a copy of this Authorization.

Statement of Understanding: I/We represent that all statements and answers made within or attached to this Request Form are true and complete to the best of my/our knowledge and belief. I/We understand that my application, including portions containing health information are submitted to the Plan Administrator, acting for the policy holder, and that the administrator shall forward the application to the insurance company. Furthermore, I/We understand that coverage shall be in effect only after all of these conditions have been met: this application has been approved by Prudential; the Certificate has been issued while all persons to be insured thereunder are alive; the answers and statements in this application continue to be true and complete until the Effective Date; and the initial premium contribution has been paid. I/We also understand that coverage will not take effect if the facts have changed. I/We have also read and understand and agree to the additional terms, conditions and requirements as stated in the Authorization for the Release of Information and Important Notice sections. I/We understand that completion of this application in no way implies that I/We will be accepted for insurance coverage.

Please consult Fraud warnings and understand the terms and requirements of these Fraud warnings. I have received the Group Life and Disability Income Medical Underwriting Notice included with this form.

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.

X _____ | _____

Member Signature | Date Signed (mm/dd/yyyy)

By my signature above, I hereby request coverage. I acknowledge that I am a member of the above Association and that I must continue such membership to keep this insurance in force.

X _____ | _____

Spouse or Signature (if applying for Spouse coverage) | Date Signed (mm/dd/yyyy)

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/she 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.

Group Term Life coverage is issued by The Prudential Insurance Company of America, 751 Broad Street, Newark, NJ, 07102. Please refer to the Booklet-Certificate, which is made a part of the Group Contract, for all plan details, including any exclusions, limitations and restrictions which may apply. If there is a discrepancy between this document and the Booklet-Certificate/Group Contract issued by Prudential, the terms of the Group Contract will govern. Contract provisions may vary by state.
California COA #1179, NAIC #68241 Contract series: 83500

Beneficiary Designation Form

Voluntary Group Term Life

SAMBA | 72117

Member Information

Last Name	First Name	Middle Initial	Member ID/Social Security No.

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
Note: The member is the beneficiary for spouse and child(ren) coverage			Total	100%

Authorization and Acknowledgement

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

Member Signature

Date

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

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.

Group Life and Disability Income Medical Underwriting
NOTICE

Thank you for choosing The Prudential Insurance Company of America (Prudential) for your insurance needs. Before we can issue coverage, we must review your application/enrollment form. To do this, we need to collect and evaluate personal information about you. This notice is being provided to inform you of certain information practices Prudential engages in, and your rights, with regard to your personal information. We would like you to know that:

- Personal information may be collected from persons other than yourself or other individuals, if applicable, proposed for coverage;

- This personal information as well as other personal or privileged information subsequently collected by us may in certain circumstances be disclosed to third parties without authorization;

- You have a right of access and correction with respect to personal information we collect about you; and

- Upon request from you, we will provide you with a more detailed notice of our information practices and your rights with respect to such information. Should you wish to receive this notice, please contact:

The Prudential Insurance Company of America
Group Medical Underwriting
P.O. Box 8796
Philadelphia, PA 19176

Information regarding your insurability will be treated as confidential. We may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life, disability, or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file. In addition, upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901. If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400 Braintree, Massachusetts 02184-8734. Information for consumers about MIB may be obtained on its website at www.mib.com.

Please keep this notice for your records.

SAMBA

Term Life Insurance Plan

Schedule of Insurance for Members or Spouses Under Age 70 (Biweekly Premium Cost)

Age	Biweekly Rate/$1,000	COVERAGE $25,000	$50,000	$75,000	$100,000	$125,000	$150,000	$200,000	$250,000	$300,000	$400,000	$500,000	$600,000	$750,000
<30	$0.037	$0.92	$1.85	$2.77	$3.69	$4.62	$5.54	$7.38	$9.23	$11.08	$14.77	$18.46	$22.15	$27.69
30-39	$0.051	$1.27	$2.54	$3.81	$5.08	$6.35	$7.62	$10.15	$12.69	$15.23	$20.31	$25.38	$30.46	$38.08
40-49	$0.070	$1.75	$3.51	$5.26	$7.02	$8.77	$10.52	$14.03	$17.54	$21.05	$28.06	$35.08	$42.09	$52.62
50-54	$0.120	$2.99	$5.98	$8.97	$11.95	$14.94	$17.93	$23.91	$29.88	$35.86	$47.82	$59.77	$71.72	$89.72
55-59	$0.204	$5.11	$10.22	$15.34	$20.45	$25.56	$30.67	$40.89	$51.12	$61.34	$81.78	$102.23	$122.68	$153.42
60-64	$0.312	$7.79	$15.58	$23.37	$31.15	$38.94	$46.73	$62.31	$77.88	$93.46	$124.62	$155.77	$186.92	$233.72
65-69	$0.499	$12.48	$24.97	$37.45	$49.94	$62.42	$74.91	$99.88	$124.85	$149.82	$199.75	$249.69	$299.63	$374.54

Schedule of Insurance for Members or Spouses Age 70 and Over (Biweekly Premium Cost)

Age	Biweekly Rate/$1,000	$25,000		$50,000		$75,000		$100,000		$125,000		$150,000		$200,000	
		Coverage	Cost	Coverage	Cost	Coverage	Cost	Coverage	Cost	Coverage	Cost	Coverage	Cost	Coverage	Cost
70-74	$1.000	$12,500	$12.50	$25,000	$24.99	$37,500	$37.49	$50,000	$49.98	$62,500	$62.48	$75,000	$74.98	$100,000	$99.97
75-79	$2.010	$6,250	$12.56	$12,500	$25.12	$18,750	$37.68	$25,000	$50.24	$31,250	$62.80	$37,500	$75.36	$50,000	$100.48
80-84	$4.002	$6,250	$25.01	$12,500	$50.03	$15,000	$60.03	$15,000	$60.03	$15,000	$60.03	$15,000	$60.03	$15,000	$60.03
85-89	$4.381	$6,250	$27.38	$12,500	$54.77	$15,000	$65.72	$15,000	$65.72	$15,000	$65.72	$15,000	$65.72	$15,000	$65.72
90-94	$4.812	$6,250	$30.08	$12,500	$60.15	$15,000	$72.18	$15,000	$72.18	$15,000	$72.18	$15,000	$72.18	$15,000	$72.18
95+	$5.211	$6,250	$32.57	$12,500	$65.13	$15,000	$78.16	$15,000	$78.16	$15,000	$78.16	$15,000	$78.16	$15,000	$78.16

Age	Biweekly Rate/$1,000	$250,000		$300,000		$400,000		$500,000		$600,000		$750,000	
		Coverage	Cost	Coverage	Cost	Coverage	Cost	Coverage	Cost	Coverage	Cost	Coverage	Cost
70-74	$1.000	$125,000	$124.96	$150,000	$149.95	$200,000	$199.94	$250,000	$249.92	$300,000	$299.91	$375,000	$374.88
75-79	$2.010	$50,000	$100.48	$50,000	$100.48	$50,000	$100.48	$50,000	$100.48	$50,000	$100.48	$50,000	$100.48
80-84	$4.002	$15,000	$60.03	$15,000	$60.03	$15,000	$60.03	$15,000	$60.03	$15,000	$60.03	$15,000	$60.03
85-89	$4.381	$15,000	$65.72	$15,000	$65.72	$15,000	$65.72	$15,000	$65.72	$15,000	$65.72	$15,000	$65.72
90-94	$4.812	$15,000	$72.18	$15,000	$72.18	$15,000	$72.18	$15,000	$72.18	$15,000	$72.18	$15,000	$72.18
95+	$5.211	$15,000	$78.16	$15,000	$78.16	$15,000	$78.16	$15,000	$78.16	$15,000	$78.16	$15,000	$78.16

Age 70, coverage reduces to 50%

Age 75 coverage reduces to 25% – maximum coverage $50,000

Age 80 maximum coverage $15,000

Plans and rates above apply to Members and Spouses. Spouse coverage amount may not exceed member coverage amount.

Costs above include a matching Accidental Death and Dismemberment Benefit on Members who are under age 65.

Dependent Child coverage of $20,000 can be added for a cost of $1 per Biweekly Pay Period (total cost regardless of the number of eligible children).

Member may retain coverage on self and family, even if no longer employed by the federal government.

Rates are subject to change.