

# 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](http://www.sambaplans.com/contact-us)  
 Phone: (800) 638-6589



SAMBA | 72117

## 1 Member Information

				Male
Last Name	First Name	Middle Initial	Social Security Number	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.

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

### Dependent Child Information

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

## 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](http://www.sambaplans.com/contact-us)

Phone: (800) 638-6589



SAMBA | 72117

### 1 Member Information

*Please print all answers using black ink.*

				Male	Female
First Name	Last Name	Middle Initial	Social Security Number		
Street Address		City	State	ZIP Code	
Phone Number	Email Address				
Birth Date (mm/dd/yyyy)	Birth City	Birth State	Height	ft./in.	lbs.
					Weight

### 2 Spouse Information – Complete if applying for spouse

				Male	Female
First Name	Last Name	Middle Initial	Social Security Number		
Street Address		City	State	ZIP Code	
Birth Date (mm/dd/yyyy)	Birth City	Birth State	Height	ft./in.	lbs.
					Weight

### 3 Health Questions – Please answer these questions by checking “Yes” or “No”

Member		Spouse	
Yes	No	Yes	No

- Within the last 12 months**, have you used tobacco, nicotine, cigarettes, electronic cigarettes, cigars, pipe, chewing tobacco, nicotine gum or nicotine patches?
- Are you currently** performing all the duties of your job on a full-time basis?  
If no, please explain: \_\_\_\_\_
- 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**

<i>Member</i>		<i>Spouse</i>	
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	Recovery		Physician Name	Address	Phone
		Last Visit	Date			

**Member Primary Care Physician Information**

Physician Name	Street Address	City, State and ZIP	Phone	Last Visit
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Spouse Condition	Status	Recovery		Physician Name	Address	Phone
		Last Visit	Date			

**Spouse Primary Care Physician Information**

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



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 # \_\_\_\_\_

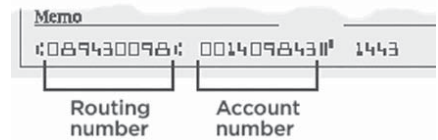
Email \_\_\_\_\_ Daytime Phone # \_\_\_\_\_

#### 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.

# 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](http://www.mib.com).

**Please keep this notice for your records.**





## Term Life Insurance Plan

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

Age	COVERAGE													
	Monthly Rate/\$1,000	\$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	\$0.080	\$2.00	\$4.00	\$6.00	\$8.00	\$10.00	\$12.00	\$16.00	\$20.00	\$24.00	\$32.00	\$40.00	\$48.00	\$60.00
30-39	\$0.110	\$2.75	\$5.50	\$8.25	\$11.00	\$13.75	\$16.50	\$22.00	\$27.50	\$33.00	\$44.00	\$55.00	\$66.00	\$82.50
40-49	\$0.152	\$3.80	\$7.60	\$11.40	\$15.20	\$19.00	\$22.80	\$30.40	\$38.00	\$45.60	\$60.80	\$76.00	\$91.20	\$114.00
50-54	\$0.259	\$6.48	\$12.95	\$19.43	\$25.90	\$32.38	\$38.85	\$51.80	\$64.75	\$77.70	\$103.60	\$129.50	\$155.40	\$194.40
55-59	\$0.443	\$11.08	\$22.15	\$33.23	\$44.30	\$55.38	\$66.45	\$88.60	\$110.75	\$132.90	\$177.20	\$221.50	\$265.80	\$332.40
60-64	\$0.675	\$16.88	\$33.75	\$50.63	\$67.50	\$84.38	\$101.25	\$135.00	\$168.75	\$202.50	\$270.00	\$337.50	\$405.00	\$506.40
65-69	\$1.082	\$27.05	\$54.10	\$81.15	\$108.20	\$135.25	\$162.30	\$216.40	\$270.50	\$324.60	\$432.80	\$541.00	\$649.20	\$811.50

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

Age	Monthly 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	\$2.166	\$12,500	\$27.08	\$25,000	\$54.15	\$37,500	\$81.23	\$50,000	\$108.30	\$62,500	\$135.38	\$75,000	\$162.45	\$100,000	\$216.60
75-79	\$4.354	\$6,250	\$27.21	\$12,500	\$54.43	\$18,750	\$81.64	\$25,000	\$108.85	\$31,250	\$136.06	\$37,500	\$163.28	\$50,000	\$217.70
80-84	\$8.671	\$6,250	\$54.19	\$12,500	\$108.39	\$15,000	\$130.07	\$15,000	\$130.07	\$15,000	\$130.07	\$15,000	\$130.07	\$15,000	\$130.07
85-89	\$9.493	\$6,250	\$59.33	\$12,500	\$118.66	\$15,000	\$142.40	\$15,000	\$142.40	\$15,000	\$142.40	\$15,000	\$142.40	\$15,000	\$142.40
90-94	\$10.426	\$6,250	\$65.16	\$12,500	\$130.33	\$15,000	\$156.39	\$15,000	\$156.39	\$15,000	\$156.39	\$15,000	\$156.39	\$15,000	\$156.39
95+	\$11.290	\$6,250	\$70.56	\$12,500	\$141.13	\$15,000	\$169.35	\$15,000	\$169.35	\$15,000	\$169.35	\$15,000	\$169.35	\$15,000	\$169.35

Age	Monthly 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	\$2.166	\$125,000	\$270.75	\$150,000	\$324.90	\$200,000	\$433.20	\$250,000	\$541.50	\$300,000	\$649.80	\$375,000	\$812.25	<i>Age 70, coverage reduces to 50%</i>
75-79	\$4.354	\$50,000	\$217.70	\$50,000	\$217.70	\$50,000	\$217.70	\$50,000	\$217.70	\$50,000	\$217.70	\$50,000	\$217.70	<i>Age 75 coverage reduces to 25% – maximum coverage \$50,000</i>
80-84	\$8.671	\$15,000	\$130.07	\$15,000	\$130.07	\$15,000	\$130.07	\$15,000	\$130.07	\$15,000	\$130.07	\$15,000	\$130.07	
85-89	\$9.493	\$15,000	\$142.40	\$15,000	\$142.40	\$15,000	\$142.40	\$15,000	\$142.40	\$15,000	\$142.40	\$15,000	\$142.40	
90-94	\$10.426	\$15,000	\$156.39	\$15,000	\$156.39	\$15,000	\$156.39	\$15,000	\$156.39	\$15,000	\$156.39	\$15,000	\$156.39	<i>Age 80 maximum coverage \$15,000</i>
95+	\$11.290	\$15,000	\$169.35	\$15,000	\$169.35	\$15,000	\$169.35	\$15,000	\$169.35	\$15,000	\$169.35	\$15,000	\$169.35	

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 \$2.17 per month (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.