RESET

SAMBA
FEDERAL EMPLOYEE BENEFIT ASSOCIATION

SAMBA TERM LIFE INSURANCE
Group Term Life Application

Group No. 67763-9
Account 3

SAMBA, 11301 Old Georgetown Road, Rockville, MD 20852-2800 • (800) 638-6589 • Fax (301) 816-0191

Select One: ❑ New Enrollment ❑ Change to Current Coverage

Employment Status: ❑ Active ❑ Retired

To enroll or increase coverage, the enrollee must be under age 70

MEMBER INFORMATION (type or print clearly)

Last Name	First Name	Middle Initial	Social Security No.	Marital Status
				❑ Single ❑ Married ❑ Divorced ❑ Widowed

Address: Street	City	State	Zip	Sex
				❑ Male ❑ Female

Date of Birth (Month / Day / Year)	Date of Hire (Month / Day / Year)	Agency (Initials)	Daytime Telephone	Email Address
/ /	/ /			

DEPENDENT INFORMATION (type or print clearly)

Relationship	Name	Sex	Date of Birth
Spouse		❑ Male ❑ Female	
Child		❑ Male ❑ Female	
Child		❑ Male ❑ Female	
Child		❑ Male ❑ Female	

TERM LIFE INSURANCE RATES & COVERAGES (Effective 10/1/12)

Schedule of Insurance for Member or Spouse Under Age 70 (Biweekly Premium)

Age	$25,000	$50,000	$75,000	$100,000	$125,000	$150,000	$200,000	$250,000	$300,000	$400,000	$500,000	$600,000
<30	$ .92	$1.85	$2.77	$3.69	$4.62	$5.54	$7.38	$9.23	$11.08	$14.77	$18.46	$22.15
30-39	$1.27	$2.54	$3.81	$5.08	$6.35	$7.62	$10.15	$12.69	$15.23	$20.31	$25.38	$30.46
40-49	$1.75	$3.51	$5.26	$7.02	$8.77	$10.52	$14.03	$17.44	$21.05	$28.06	$35.08	$42.09
50-54	$2.99	$5.98	$8.97	$11.95	$14.94	$17.93	$23.91	$29.88	$35.86	$47.82	$59.77	$71.72
55-59	$5.11	$10.22	$15.34	$20.45	$25.56	$30.67	$40.89	$51.12	$61.34	$81.78	$102.23	$122.68
60-64	$7.79	$15.58	$23.37	$31.15	$38.94	$46.73	$62.31	$77.88	$93.46	$124.62	$155.77	$186.92
65-69	$12.48	$24.97	$37.45	$49.94	$62.42	$74.91	$99.88	$124.85	$149.82	$199.75	$249.69	$299.63

Note: Amount of coverage permitted under the SAMBA Term Life Insurance for member or spouse is limited to $600,000 each.

Child(ren) under age 26, coverage of $20,000 can be added for a cost of $1 biweekly for all eligible children.

TERM LIFE INSURANCE COVERAGE SELECTIONS

Are you completing this form due to a Family Status Change (Marriage, Divorce, Birth, Adoption, etc.?) ❑ Yes ❑ No

Application For	Total Amount Desired	Current Amount	Amount to be Underwritten	Premium
❑ Member	$	$	$	$
❑ Spouse	$	$	$	$
❑ Child(ren)	$	$	$	$

Note: Health Statement Questionnaire required: **Short Form** may be used up through age 55 for coverage not to exceed $150,000. Coverage exceeding $150,000 or if the applicant requesting coverage is age 56 and older, requires completion of the **Long Form**.

(No Health Statement Questionnaire is needed to enroll your child.)

✓ **Signature Required**

Signature of Member Date

Underwritten by ReliaStar Life Insurance Company • Box 20 • Minneapolis, MN 55440

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SAMBA TERM LIFE INSURANCE
Group Term Life Application
Long Form Health Statement Questionnaire & Beneficiary Information

Group No. 67763-9
Account 3

Mail or fax the completed forms to:

SAMBA • 11301 Old Georgetown Road • Rockville, MD 20852-2800 • Fax 301-816-0191 • Phone 1-800-638-6589

*To be used if age 56 and older, or coverage over $150,000. If you have questions contact us at **1-800-638-6589**.*

(You must also complete the Application and payment type forms)

1. MEMBER INFORMATION (Type or print clearly)

Last Name	First Name	Middle Initial	Social Security No.

2. SPOUSE INFORMATION (Complete if you are requesting coverage for your spouse)

Last Name	First Name	Middle Initial	Social Security No.

3. MEMBER AND SPOUSE HEALTH QUESTIONS (Must be answered for coverage that is not Guaranteed Issue.)

Member (EE) Yes	Member (EE) No	Spouse (SP) Yes	Spouse (SP) No	
☐	☐	☐	☐	1. Have you ever been treated for or been diagnosed by a member of the medical profession or health practitioner as having AIDS (Acquired Immunodeficiency Syndrome)?
☐	☐	☐	☐	2. Have you ever had, or been treated for, any of the following: insulin dependent diabetes, heart attack, coronary bypass/angioplasty, heart valve repair/replacement, stroke, metastatic cancer, emphysema or been an organ transplant recipient?
Complete for EE and SP ⇢ (if applying)				3. **Member:** Height ____ ft. ____ in. Weight ____ lbs. **Spouse:** Height ____ ft. ____ in. Weight ____ lbs.
				4. In the past 10 years have you consulted with, been diagnosed or treated by a health practitioner, or taken medication for any of the following:
☐	☐	☐	☐	a. Disease or disorder of the heart, blood vessels (excluding controlled high blood pressure), lung (excluding asthma), liver (excluding hepatitis A), pancreas, or intestine?
☐	☐	☐	☐	b. Non-insulin dependent diabetes, impaired glucose tolerance, or pre-diabetes?
☐	☐	☐	☐	c. Cancer or tumor, rheumatoid arthritis, connective tissue, neurological (excluding headaches), autoimmune or blood disorder?
☐	☐	☐	☐	d. Depression, psychosis, suicide attempt, drug or alcohol abuse or addiction?
☐	☐	☐	☐	e. Polycystic kidney disease or kidney failure?
				5. Have you ever been diagnosed, treated or given medical advice by a physician or other health practitioner for:?
☐	☐	☐	☐	a. Chest pain, heart trouble or circulatory disorder?
☐	☐	☐	☐	b. Anemia or leukemia?
☐	☐	☐	☐	c. Sleep apnea, asthma or other respiratory disorder?
☐	☐	☐	☐	d. Colitis, Crohn's disease, ulcerative colitis or any other intestinal disorder or disease?
☐	☐	☐	☐	e. Stomach disorder?
☐	☐	☐	☐	f. Brain or seizure disorder?
☐	☐	☐	☐	g. Mental or nervous disorder?
☐	☐	☐	☐	h. Arthritis, paralysis or any muscle weakness?
☐	☐	☐	☐	i. Abnormal urine specimen or urinary tract disorder?
☐	☐	☐	☐	j. Prostate or other reproductive organ disorder?
☐	☐	☐	☐	6. Are you pregnant? Due Date _____ Pre-pregnancy weight _____ lbs.
☐	☐	☐	☐	7. Do you currently have any disorder, condition, disease, and/or are you currently taking medication prescribed or provided by a physician or other health practitioner for any disorder, condition, disease not shown above?
☐	☐	☐	☐	8. Have you ever received medical treatment or counseling for the use of alcohol or prescribed or non-prescribed drugs, or been advised by a health practitioner to discontinue the use of such substances?
☐	☐	☐	☐	9. In the past 2 years have you experienced any symptom(s) for which you have not yet consulted a health practitioner, or are any medical, surgical or diagnostic procedures recommended or contemplated?

Underwritten by ReliaStar Life Insurance Company • Box 20 • Minneapolis, MN 55440

MEMBER INFORMATION

Last Name	First Name	Middle Initial	Social Security No.

For every "Yes" answer to any question in the previous section, give details below. Please attach a separate sheet if additional space is needed.

Question Number	Applicant	Description of Condition	Date Condition Began	Description of Treatment Received	Fully Recovered?	Health Practitioner Name, Full Address (Street, City, State, ZIP), Phone
	☐ EE ☐ SP				☐ Yes ☐ No	
	☐ EE ☐ SP				☐ Yes ☐ No	
	☐ EE ☐ SP				☐ Yes ☐ No	
	☐ EE ☐ SP				☐ Yes ☐ No	
	☐ EE ☐ SP				☐ Yes ☐ No	
	☐ EE ☐ SP				☐ Yes ☐ No	
	☐ EE ☐ SP				☐ Yes ☐ No	
	☐ EE ☐ SP				☐ Yes ☐ No	

4. BENEFICIARY INFORMATION

PRIMARY BENEFICIARY(IES): IN EQUAL SHARES OR AS DESIGNATED BELOW (Total must equal 100%)

Full Name and Address	% of Proceeds	Relationship to Member	Date of Birth

as shall then be living, and if no such beneficiary is then living TOTAL 100%

CONTINGENT BENEFICIARY(IES): IN EQUAL SHARES OR AS DESIGNATED BELOW (Total must equal 100%)

Full Name and Address	% of Proceeds	Relationship to Member	Date of Birth

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

You must complete all forms – Application, Health Statement Questionnaire and payment type

MEMBER INFORMATION			
Last Name	First Name	Middle Initial	Social Security No.

5. Read this information carefully, then sign and date below

- To the best of my knowledge and belief, the information I've 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.
- I understand my coverage begins on the "effective date" assigned by ReliaStar Life.

Authorization and Acknowledgment – Please read and sign below.

For underwriting and claim purposes, I give my permission to: Any physician, or any other medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsurance company, MIB, Inc., Department of Motor Vehicle Records, employer or any other organization or person to give ReliaStar Life Insurance Company (ReliaStar Life) or its authorized representative (including ChoicePoint or any consumer reporting agency) acting on its behalf ALL INFORMATION on my behalf (except as limited below), including findings on medical care, psychiatric or psychological care or examination, surgery or any non-medical information, including motor vehicle records, as they apply to any person who is to be covered. I give my permission to ReliaStar Life to get consumer or investigative consumer reports about the same persons.

I authorize ReliaStar Life, or its reinsurers, to disclose personal health information about me to MIB, Inc. in the form of a brief coded report for participation in MIB's fraud prevention and detection programs.

I give my permission to ReliaStar Life to get any and all such information for the purposes described in this form. I specifically consent to the redisclosure of such information as set forth in this form. I know that my medical records, including any alcohol or drug abuse information, may be protected by Federal Regulations – 42 CFR Part 2. I may revoke this authorization as it applies to any information protected by 42 CFR Part 2 at any time, but not to the extent action has been taken in reliance on it. I understand all or part of the information obtained by this authorization may be communicated between ReliaStar Life, its affiliates, and may be sent to MIB, Inc. This information may be made available to any ReliaStar Life affiliate, reinsurer, employer, or contractor who processes transactions that concern any coverage I may have requested or have with ReliaStar Life or its affiliates. I understand that my additional written consent will be required before any information described above is given, sold, transferred, or, in any way, relayed to another party not previously specified (unless otherwise provided by law). My additional consent must be provided on a form that states the new use of the information or why another party needs it. I know that I have the right to get a copy of this form. A photocopy of this form will be as valid as the original. As it relates to the incontestability clause, this form will be valid for 30 months from the date shown below or for two years from the date coverage is made effective, whichever is earlier.

I acknowledge that I have been given ReliaStar Life's Consumer Privacy Notice.

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.

Member Signature	Date Signed
✓ Signature Required	
Spouse Signature (if applying for spouse coverage)	**Date Signed**
✓ Signature Required	

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

(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 Required**

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.

Authorized Signature

VICE PRESIDENT
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.