



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: <input type="checkbox"/> New Enrollment <input type="checkbox"/> Change to Current Coverage	Employment Status: <input type="checkbox"/> Active <input type="checkbox"/> 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 <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	
Address					Sex
Street		City		State	Zip
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		<input type="checkbox"/> Male <input type="checkbox"/> Female	
Child		<input type="checkbox"/> Male <input type="checkbox"/> Female	
Child		<input type="checkbox"/> Male <input type="checkbox"/> Female	
Child		<input type="checkbox"/> Male <input type="checkbox"/> 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.?) <input type="checkbox"/> Yes <input type="checkbox"/> No				
Application For	Total Amount Desired	Current Amount	Amount to be Underwritten	Premium
<input type="checkbox"/> Member	\$	\$	\$	\$
<input type="checkbox"/> Spouse	\$	\$	\$	\$
<input type="checkbox"/> 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 of Member	Date
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SAMBA TERM LIFE INSURANCE Group Term Life Application

Short Form Health Statement Questionnaire & Beneficiary Information

Group No. 67763-9

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

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

PART A: MEMBER INFORMATION (Type or print clearly)

Last Name	First Name	Middle Initial	Social Security No.

PART B: SPOUSE INFORMATION (Complete if you are requesting coverage for your spouse)

Last Name	First Name	Middle Initial	Social Security No.

PART C: HEALTH QUESTIONS (Please answer these questions by checking "Yes" or "No")

Member		Spouse (Complete only if requesting spouse coverage)		
Yes	No	Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1. Have you had or been treated for heart trouble, stroke, diabetes, or cancer?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2. Have you ever had or been treated for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), disorders of the immune system or tested positive for antibodies to the HIV virus?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3. Have you ever sought help or received counseling or treatment for anxiety/depression, alcohol or drug abuse, or are you currently using illegal drugs?

BENEFICIARY INFORMATION (Type or print clearly)

PRIMARY BENEFICIARY:

Full Name and Address	100% of Proceeds	Relationship to Member	Date of Birth

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

CONTINGENT BENEFICIARY:

Full Name and Address	100% of Proceeds	Relationship to Member	Date of Birth

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

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 the application is approved by ReliaStar Life Insurance Company.
- I understand my coverage begins on the "effective date" assigned by ReliaStar Life.

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

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




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 <input type="checkbox"/> New Allotment \$ _____ <input type="checkbox"/> Increase Allotment to Total of \$ _____ <input type="checkbox"/> Decrease Allotment to Total of \$ _____ <input type="checkbox"/> Cancel Allotment for all Plans <input type="checkbox"/> 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.  Authorized Signature _____		VICE PRESIDENT _____ Title	
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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.