

## IMPORTANT INFORMATION ABOUT BENEFICIARY DESIGNATIONS

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Use this form to designate or make changes to the beneficiary(ies) of your Group Insurance death proceeds. The information on this form will replace any prior beneficiary designation. You may name anyone or any entity as your beneficiary and you may change your beneficiary at any time by completing a new Group Insurance Beneficiary Designation/Change form. Common designations include individuals, estates, corporation/organizations and trusts. **Payment will be made to the named beneficiary. If there is no named beneficiary, or the named beneficiary predeceased the insured, settlement will be made in accordance with the terms of your Group Contract.**

### DEFINITIONS

You may find the following definitions helpful in completing this form:

**Primary Beneficiary(ies)** – the person(s) or entity you choose to receive your life insurance proceeds. Payment will be made in equal shares unless otherwise specified. In the event that a designated primary beneficiary predeceases the insured, the proceeds will be paid to the remaining primary beneficiaries in equal shares or all to the sole remaining primary beneficiary.

**Contingent Beneficiary(ies)** – the person(s) or entity you choose to receive your life insurance proceeds if the primary beneficiary(ies) die (or the entity dissolves) before you die. Payment will be made in equal shares unless otherwise specified. In the event that a designated contingent beneficiary predeceases the insured, the proceeds will be paid to the remaining contingent beneficiaries in equal shares or all to the sole remaining contingent beneficiary.

### INSTRUCTIONS FOR DESIGNATING A PRIMARY OR CONTINGENT BENEFICIARY

#### 1. EMPLOYEE INFORMATION

- All information in this section is required.
- Unless otherwise indicated in Section 1, the information supplied on the form will apply to ALL coverages offered under the employer's group plan.
- Unless otherwise indicated in Section 2, the information supplied on the form will apply to all the Group Life coverage(s) issued by The Prudential Insurance Company of America to the group contract holder.

#### 2. BENEFICIARY DESIGNATION

- You may name more than one primary and more than one contingent beneficiary. This form allows you to name up to four primary and four contingent beneficiaries. If you need additional space, please attach a separate sheet of paper.
- Please indicate the percentage share designated to each primary beneficiary. **The total for all primary beneficiaries must equal 100%.** If no percentages are specified, the proceeds will be split evenly among those named. Payment will be made to the named beneficiary. If there is no named beneficiary, or the named beneficiary predeceased the insured, settlement will be made in accordance with the terms of your Group Contract. **If designating percentages for contingent beneficiaries, the percentage for all contingent beneficiaries must also equal 100%.**
- You can name an individual, corporation/organization, trust, or an estate as a beneficiary. The following examples may be helpful in designating beneficiaries:

**Individual:** "Mary A. Doe"

- Each name should be listed as first name, middle initial, last name ("Mary A. Doe," not "Mrs. M. Doe")
- Include the address, telephone number, social security number, relationship and Date of Birth for each individual listed.
- Indicate the percentage to be assigned to each individual.

**Estate:** "Estate of the Insured"

- Select "Other" as the Beneficiary Description and write "Estate" in the blank space provided.
- Indicate the percentage to be assigned to the Estate of the Insured.

**Corporation/Organization:** "ABC Charitable Organization"

- Select "Corporation/Organization" as the Beneficiary Description.
- Write the legal name of the corporation or organization in the space for the Beneficiary's First Name.
- Include the address, city and state, telephone number and tax ID number of operation for each organization or corporation listed.
- Indicate the percentage to be assigned to the corporation or organization.

**Trust:** "The John Doe Trust. A Trust with a trust agreement dated 1/1/99 whose Trustee is Jane Smith."

- Select "Trust" as the Beneficiary Description.
- Indicate the percentage to be assigned to the trust.
- Complete Section 3, Trust Designation.

#### 3. TRUST DESIGNATION

- Complete this section if you have named a trust as a primary or contingent beneficiary in Section 2. Fill in the name and address for each trustee.
- Fill in the title and date of the Trust Agreement in the space provided.

#### 4. AUTHORIZATION/SIGNATURE

- The employee must read, sign and date the authorization.
- Submit the completed form to your Benefits Administrator or Human Resources (as directed by your employer) and keep a copy for your records.



# Group Insurance Beneficiary Designation/Change

DATE: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

## 1. EMPLOYEE INFORMATION (please print)

Last Name	First Name	MI	Employee ID# (if applicable)	Marital Status (check one) <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Single <input type="checkbox"/> Divorced	Sex assigned at birth (check one) <input type="checkbox"/> Male <input type="checkbox"/> Female	Has this insurance been assigned? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Address	City	State	ZIP Code	Daytime Phone	Home Phone	Date of Birth	Date of Hire	Date of Retirement (if applicable)
Name of Employer/Group Policyholder	Group Policy No.	Unless otherwise indicated below, this Beneficiary Designation/Change form applies to ALL coverages offered under my employer's group plan. This form applies only to <input type="checkbox"/> Basic Life <input type="checkbox"/> Basic AD&D <input type="checkbox"/> Optional Term Life <input type="checkbox"/> Optional AD&D <input type="checkbox"/> GUL <input type="checkbox"/> GVUL coverage(s).						

## 2. BENEFICIARY DESIGNATION: I hereby revoke any previous designations of primary beneficiary(ies) and contingent beneficiary(ies), if any, and in the event of my death, designate the following:

### A. Primary Beneficiaries

Beneficiary Description (check one)	First Name	MI	Last Name	Address (include city, state, ZIP)	Relationship	Date of Birth	SSN/Tax ID Number	Phone	% Share
<input type="checkbox"/> Individual <input type="checkbox"/> Other <input type="checkbox"/> Trust <input type="checkbox"/> Corporation/Organization									
<input type="checkbox"/> Individual <input type="checkbox"/> Other <input type="checkbox"/> Trust <input type="checkbox"/> Corporation/Organization									
<input type="checkbox"/> Individual <input type="checkbox"/> Other <input type="checkbox"/> Trust <input type="checkbox"/> Corporation/Organization									
<input type="checkbox"/> Individual <input type="checkbox"/> Other <input type="checkbox"/> Trust <input type="checkbox"/> Corporation/Organization									
<b>TOTAL: (Must equal 100%)</b>									

### B. Contingent Beneficiaries

Beneficiary Description (check one)	First Name	MI	Last Name	Address (include city, state, ZIP)	Relationship	Date of Birth	SSN/Tax ID Number	Phone	% Share
<input type="checkbox"/> Individual <input type="checkbox"/> Other <input type="checkbox"/> Trust <input type="checkbox"/> Corporation/Organization									
<input type="checkbox"/> Individual <input type="checkbox"/> Other <input type="checkbox"/> Trust <input type="checkbox"/> Corporation/Organization									
<input type="checkbox"/> Individual <input type="checkbox"/> Other <input type="checkbox"/> Trust <input type="checkbox"/> Corporation/Organization									
<input type="checkbox"/> Individual <input type="checkbox"/> Other <input type="checkbox"/> Trust <input type="checkbox"/> Corporation/Organization									
<b>TOTAL: (Must equal 100%)</b>									

## 3. TRUST DESIGNATION - COMPLETE IF A TRUST HAS BEEN NAMED AS A BENEFICIARY IN SECTION 2

Trustee's Name (First, MI, Last)	Address (include city, state, ZIP)

And successor(s) in trust, as Trustee(s) under \_\_\_\_\_ dated \_\_\_\_\_ as amended and executed by me and said Trustee.  
Title of Agreement Date of Agreement



## Group Insurance Beneficiary Designation/Change

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**4. AUTHORIZATION/SIGNATURE** I authorize my plan administrator to record and consider the individuals/institutions that I have named on this form as beneficiaries for benefits under the applicable employee benefit plans. If designating a trust as a beneficiary, I understand Prudential assumes no obligation as to the validity or sufficiency of any executed Trust Agreement and does not pass on its legality. In making payment to any Trustee(s), Prudential has the right to assume that the Trustee(s) is acting in a fiduciary capacity until notice to the contrary is received by Prudential at its Group Life Claim office. I agree that if Prudential makes any payment(s) to the Trustee(s) before notice is received, Prudential will not make payment(s) again.

Employee's Signature  X  Date Signed \_\_\_\_\_

The employee must sign and date this form. The signature date must be the date the employee actually signed the form.

## Fraud Warnings

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**For residents of all states and jurisdictions except Alabama, Alaska, Arizona, Arkansas, California, Colorado, Delaware, the District of Columbia, Florida, Idaho, Indiana, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Minnesota, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Puerto Rico, Rhode Island, Tennessee, Texas, Utah, Vermont, Virginia, Washington and West Virginia; WARNING:**—Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person, or knowing that he or 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.

**ALASKA RESIDENTS** — A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

**ARIZONA RESIDENTS** — For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

**ARKANSAS, DISTRICT OF COLUMBIA, LOUISIANA, MASSACHUSETTS, RHODE ISLAND and WEST VIRGINIA 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.

**CALIFORNIA RESIDENTS** — For your protection, California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

**COLORADO RESIDENTS** — It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

**DELAWARE RESIDENTS** — Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

**IDAHO RESIDENTS** — Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement containing any false, incomplete, or misleading information is guilty of a felony.

## Fraud Warnings

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**INDIANA RESIDENTS** — A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

**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, TENNESSEE, VIRGINIA, and WASHINGTON RESIDENTS** — It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. 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.

**MINNESOTA RESIDENTS** — A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

**NEW HAMPSHIRE RESIDENTS** — Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638.20.

**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.

**NEW MEXICO 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 CIVIL FINES AND CRIMINAL 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.

**OHIO RESIDENTS** — Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

**OKLAHOMA RESIDENTS** — WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete, or misleading information is guilty of a felony.

**OREGON RESIDENTS** — Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurance company, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

**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.

**TEXAS RESIDENTS** — For your protection, Texas law requires the following to appear on this form. Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

## Fraud Warnings

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**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.

**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.**

Group Life coverage(s) are issued by The Prudential Insurance Company of America, a New Jersey company, 751 Broad Street, Newark, NJ 07102. Group Variable Universal Life Insurance is distributed by Prudential Investment Management Services LLC, 655 Broad Street, 19TH Floor, Newark, NJ 07102, a registered broker/dealer and a Prudential Financial company. 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. Contract provisions may vary by state. Contract series: 83500 (Term Life), 89579 (Group Variable Universal Life), 96945 (Group Universal Life).

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