



Group Term Life Insurance Portability Election Form

If you have been actively employed prior to leaving your employer, and you are not retiring or disabled, you may apply for Group Term Life Insurance coverage under Prudential's portability option. This option may be available to you and your covered dependents (if you continue your coverage). Portable coverage terminates according to the terms of the group portability contract, however coverage will not be continued beyond age 80.

When to Apply

You must enroll for the Portability Option within 31* calendar days of your coverage termination date.

*or the time frame indicated in the Employer Contract.

How to Apply

1. Your employer completes Sections 2 and 3 of the Portability Election Form.
2. You need to complete Sections 1, 4, 5, 6, 7, and 8 of the Portability Election Form. Please designate a beneficiary in Section 5 since this form replaces your previous beneficiary form. You are automatically the beneficiary for any dependent coverages. If your spouse elects portability as a result of a divorce, he/she should designate their own beneficiary.
3. To apply for preferred premium rates, you and your spouse must each complete the attached Short Form Health Statement Questionnaire. If you do not complete this form, or if it is not approved by Prudential, your rate (and your spouse, if applicable) will be higher than if you had completed the statement and Prudential approved your statement.
4. Return the completed form(s) to this address:

**The Prudential Insurance Company of America
Group Life Record Keeping
P.O. Box 13676
Philadelphia, PA 19176**
5. Portability may be available for dependent spouse and children (without an employee porting) if due to divorce (spouse only) or the death (spouse and child) of the employee.

Confirmation of Coverage

After you have completed all of the above steps, Prudential will send you a billing statement within six weeks, which will confirm that your coverage is in effect. All payments must be made promptly to prevent lapse or termination of your Group Term Life Insurance coverage. Electronic Funds Transfer (EFT) is available as an option to pay premiums once payment of your initial billing statement is received. You can contact Prudential at the toll free number indicated below for further details or to request an EFT authorization form.

If You Have Questions

If you have questions, you may contact Prudential Group Life Recordkeeping at **800-778-3827**.

The description above is intended to be a summary of the portability provision and does not include all plan provisions, exclusions, and limitations. Details of your portability provision can be found in your booklet-certificate, which is made a part of the Group Contract. 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. Prudential Group Term Life Insurance (Contract Series 83500) is issued by The Prudential Insurance Company of America, 751 Broad Street, Newark, New Jersey, 07102.

Prudential Financial and the Rock logo are registered service marks of The Prudential Insurance Company of America and its affiliates.

The Prudential Insurance Company of America
Group Life Record Keeping
P.O. Box 13676
Philadelphia, PA 19176

Group Term Life Insurance Coverage Portability Election Form

1. Employee/Applicant Data (to be completed by employee/applicant)

Last Name		First Name		MI	Sex assigned at birth: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Street Address		Apartment #		City	State	ZIP
Date of Birth	Social Security Number		Daytime Phone Number		Home Phone Number	
Email Address		Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widower				

2. Group Term Life Insurance Coverage Amount(s) (to be completed by employer)

Complete all blocks. If your current Optional Term plan does not include some of the options below (e.g. Accidental Death and Dismemberment (AD&D) or Dependent Term Life), or the employee is not enrolled in the option or the option is not eligible for portability based on your contract, please indicate 'not applicable' (NA).

Coverage Termination Date	Reason and Date of Termination of Employment
Salary and Date of Last Day Actively at Work	Group Contract Number
Current Optional Term Life Coverage Amount – Employee \$	Current Optional AD&D Coverage Amount – Employee \$
Current Dependent Term Life Coverage Amount – Spouse \$	Current Optional AD&D Coverage Amount – Spouse \$
Current Dependent Term Life Coverage Amount – Children \$	Current Optional AD&D Coverage Amount – Children \$

I certify that, to the best of my knowledge and belief, the information provided in Section 2 is correct and the employee who is named on this form is eligible for portability according to the terms specified in the Prudential group contract.

Signature of Employer Representative (employer certification for portability eligibility)

X **Date Signed** **Representative Phone Number**

3. Assignment Data (to be completed by employer)

Has this insurance been assigned? ☐ Yes ☐ No **If NO, sign the certification at the bottom of this section. If YES, complete this section with assignee or trustee information and attach copy of the assignment form.**

Last Name of Assignee or Trustee		First Name		MI
Street Address		Apartment #		City State ZIP
Daytime Phone Number	Home Phone Number		Social Security Number or Tax Identification Number	

I certify that, to the best of my knowledge and belief, the assignment information provided above is correct.

Signature of Employer Representative (employer certification of assignment information)

X **Date Signed** **Representative Phone Number**

4. Group Term Life Insurance Coverage Amount(s) (to be completed by employee/applicant)

Please note: If you are eligible for AD&D coverage, any amounts elected must be equal to or less than the group term life amount. All insurance amounts will be rounded down to the nearest \$1,000. Coverage amounts will be reduced by any accelerated benefits paid under the Accelerated Benefit Option.

Optional Term Life and Dependent Term Life Coverage	Optional AD&D Coverage
Employee (Optional Term Life Insurance): Retain current face amount <input type="checkbox"/> \$ _____ Elect lower amount <input type="checkbox"/> \$ _____ Spouse (Dependent Term Life Insurance): Retain current face amount <input type="checkbox"/> \$ _____ Elect lower amount <input type="checkbox"/> \$ _____ Children (Dependent Term Life Insurance): Retain current face amount <input type="checkbox"/> \$ _____ Elect lower amount <input type="checkbox"/> \$ _____ NOTE: round down to the nearest \$1,000	Employee: Retain current face amount <input type="checkbox"/> \$ _____ Elect lower amount <input type="checkbox"/> \$ _____ Spouse: Retain current face amount <input type="checkbox"/> \$ _____ Elect lower amount <input type="checkbox"/> \$ _____ Children: Retain current face amount <input type="checkbox"/> \$ _____ Elect lower amount <input type="checkbox"/> \$ _____ NOTE: round down to the nearest \$1,000

*Participants are eligible if they have been actively employed prior to leaving their employer, and they are not retiring or disabled.

5. Employee/Applicant Beneficiary Designations (to be completed by employee/applicant or assignee, if assigned)										
A. PRIMARY BENEFICIARIES: Please designate at least one primary beneficiary. Use a separate sheet if you want to name additional beneficiaries. If there is no named beneficiary, or no named beneficiary survives the insured, settlement will be made in accordance with the terms of the Group Contract. If designating a Trust, Estate, or Corporation, please complete the corresponding fields.										
Last Name			First Name			MI		Telephone Number		
Social Security Number			Date of Birth			Relationship		Percentage		
Street Address			Apartment #		City		State		ZIP	
Last Name			First Name			MI		Telephone Number		
Social Security Number			Date of Birth			Relationship		Percentage		
Street Address			Apartment #		City		State		ZIP	
Check one, if applicable: <input type="checkbox"/> Trust <input type="checkbox"/> Estate <input type="checkbox"/> Corporation						Name:				
Tax ID Number/Tax Exempt ID Number			Creation/Incorporation/Formation Date			Telephone Number		Percentage		
Street Address			Apartment #		City		State		ZIP	
B. CONTINGENT BENEFICIARIES: Death benefits will be paid to the contingent beneficiaries if the primary beneficiary(ies) is not alive. Use a separate sheet if you want to name additional beneficiaries. If designating a Trust, Estate, or Corporation, please complete the corresponding fields.										
Last Name			First Name			MI		Telephone Number		
Social Security Number			Date of Birth			Relationship		Percentage		
Street Address			Apartment #		City		State		ZIP	
Last Name			First Name			MI		Telephone Number		
Social Security Number			Date of Birth			Relationship		Percentage		
Street Address			Apartment #		City		State		ZIP	
Check one, if applicable: <input type="checkbox"/> Trust <input type="checkbox"/> Estate <input type="checkbox"/> Corporation						Name:				
Tax ID Number/Tax Exempt ID Number			Creation/Incorporation/Formation Date			Telephone Number		Percentage		
Street Address			Apartment #		City		State		ZIP	
6. Dependent Term Life Insurance Coverage - Spouse (to be completed by employee)										
This section should only be completed if you previously had dependent coverage with Prudential for your spouse and you wish to continue this dependent coverage.										
Note: With the exception of death and divorce, you must elect portability in order for your spouse to have portable coverage. The employee is the beneficiary for Dependent Term Life Insurance.										
Is spousal coverage being ported due to the death of the employee or divorce? <input type="checkbox"/> Yes <input type="checkbox"/> No						Is spouse confined for medical care or treatment at home or elsewhere? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Spouse's Last Name			First Name			MI		Social Security Number		Date of Birth
7. Dependent Term Life Insurance Coverage - Children (to be completed by employee)										
This section should only be completed if you previously had dependent coverage with Prudential for your children and you wish to continue this dependent coverage.										
Note: You must elect portability in order for your children to take portable coverage. The employee is the beneficiary for Dependent Term Life Insurance.										
Is any child confined for medical care or treatment at home or elsewhere? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide name of child _____										
Youngest Child's Last Name			First Name			MI		Social Security Number		Date of Birth

*Participants are eligible if they have been actively employed prior to leaving their employer, and they are not retiring or disabled.

8. Employee/Applicant/Assignee Signature(s) (to be completed by employee/applicant/assignee)

I hereby request coverage under the Group Term Life Insurance Portability Plan. I understand that I will be billed on a quarterly basis and that a \$3 billing fee per quarter will apply. I understand that, if I elect to convert my coverage to an individual policy, I waive my right to apply for coverage under the Portability Plan. I understand that my Group Term Life Insurance coverage will be subject to the rules of the group contract governing the Portability Plan. I also understand that I may apply for coverage under the Portability Plan subject to the following:

- This selection is made within 31 days of the date that I am no longer eligible for coverage through my former employer.
- Your coverage amount will reduce in accordance with the terms of the group contract.
- Generally, Group Term Life Insurance for my dependents is only available with my election of portable Group Term Life Insurance.
- Portability is not available if age 80 and over at the time of election.
- Group Term Life Insurance for my dependents ends when they no longer qualify as eligible dependents.
- Group Term Life Insurance and coverage under all applicable riders will end if I fail to make any payment needed to keep my coverage in force within 31 days from the date due.
- Rates may change as the insured enters a higher age category, or if plan experience requires a change for all insured. Rates will not be changed on an individual basis.

I represent that supplied above is true and correct. I have thoroughly reviewed, understand and accurately responded to all questions on this form.

X _____	X _____
Employee's/Applicant's Signature	Assignee's Signature (if applicable)
Date Signed	Date Signed

9. For Prudential Use Only

Effective Date of Coverage:

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 (mm/dd/yyyy)

IMPORTANT NOTICE REQUIRED BY CERTAIN STATE REGULATORS:

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, 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 and TEXAS RESIDENTS – For your protection, California and 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.

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.

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.

IMPORTANT NOTICE REQUIRED BY CERTAIN STATE REGULATORS:

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.

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.**

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(Submit a separate form for each person whose coverage requires Evidence of Insurability.)

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- Diabetes;
- Mental or nervous disorder;
- Alcoholism, drug addiction;
- Chronic pain, rheumatoid arthritis, lupus; or
- Colitis, Crohn's disease, gastric bypass.

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Group Contract No.(s):

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Branch No.:

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Fraud Warnings

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, 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.

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Group Contract No.(s):

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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.



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I have read and understand the terms and requirements of the fraud warnings included as part of this form.

I declare that, to the best of my knowledge and belief, the statements made in this application are complete and true. I agree that the coverage applied for is subject to the terms of the plan and shall become effective on the date or dates established by the plan, provided the evidence of good health is satisfactory.

Print Your First Name

Last Name

--

Your Social Security Number

 Your Signature (unless a minor)

--

Date Signed (mm-dd-yyyy)

 If Person for whom insurance is being requested is a minor,
 Signature of Parent, Guardian, or Person Liable for Support

Relationship

--

Date Signed (mm-dd-yyyy)

Please keep a copy of this form for your records.

Group Life Insurance coverage is issued by The Prudential Insurance Company of America, a New Jersey company, 751 Broad Street, Newark, NJ 07102.

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Prudential, the Prudential logo, and the Rock symbol are service marks of Prudential Financial, Inc. and its related entities, registered in many jurisdictions worldwide.



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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. Prudential or its reinsurers may, however, make a brief report thereon to MIB, LLC, which operates an information exchange on behalf of insurance companies that are members of MIB Group Inc. If you apply to another MIB Member company for life 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 in its file.

Upon receipt of a request from you MIB will arrange disclosure of any information it may have in your file. Please contact MIB at *866-692-6901 or go to its website at www.mib.com to request disclosure online. If you question the accuracy of 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, MA 02184-8734.

Prudential or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

Please keep this notice for your records.

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(Submit a separate form for each person whose coverage requires Evidence of Insurability.)

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[illegible]

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- Diabetes;
- Mental or nervous disorder;
- Alcoholism, drug addiction;
- Chronic pain, rheumatoid arthritis, lupus; or
- Colitis, Crohn's disease, gastric bypass.

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Fraud Warnings

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, 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 and TEXAS RESIDENTS – For your protection, California and 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.

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.

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.



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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.

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.



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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.

I declare that, to the best of my knowledge and belief, the statements made in this application are complete and true. I agree that the coverage applied for is subject to the terms of the plan and shall become effective on the date or dates established by the plan, provided the evidence of good health is satisfactory.

Print Your First Name

Last Name

--

Your Social Security Number

 Your Signature (unless a minor)

--

Date Signed (mm-dd-yyyy)

 If Person for whom insurance is being requested is a minor,
Signature of Parent, Guardian, or Person Liable for Support

Relationship

--

Date Signed (mm-dd-yyyy)

Please keep a copy of this form for your records.

Group Life Insurance coverage is issued by The Prudential Insurance Company of America, a New Jersey company, 751 Broad Street, Newark, NJ 07102.

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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. Prudential or its reinsurers may, however, make a brief report thereon to MIB, LLC, which operates an information exchange on behalf of insurance companies that are members of MIB Group Inc. If you apply to another MIB Member company for life 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 in its file.

Upon receipt of a request from you MIB will arrange disclosure of any information it may have in your file. Please contact MIB at *866-692-6901 or go to its website at www.mib.com to request disclosure online. If you question the accuracy of 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, MA 02184-8734.

Prudential or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

Please keep this notice for your records.