Prudential

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.

GL.2003.090 Ed. 2/2018 (Plan A Preferred)

Please return this form to:

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: ☐ Male ☐ Female

Street Address	Apartment #	City	State	ZIP

Date of Birth	Social Security Number	Daytime Phone Number	Home Phone Number

Email Address	Marital Status ☐ Married ☐ Single ☐ Divorced ☐ 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 ☐ **$** _____ Elect lower amount ☐ **$** _____	**Employee:** Retain current face amount ☐ **$** _____ Elect lower amount ☐ **$** _____
Spouse (Dependent Term Life Insurance): Retain current face amount ☐ **$** _____ Elect lower amount ☐ **$** _____	**Spouse:** Retain current face amount ☐ **$** _____ Elect lower amount ☐ **$** _____
Children (Dependent Term Life Insurance): Retain current face amount ☐ **$** _____ Elect lower amount ☐ **$** _____	**Children:** Retain current face amount ☐ **$** _____ Elect lower amount ☐ **$** _____
NOTE: round down to the nearest $1,000	**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: ☐ Trust ☐ Estate ☐ 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: ☐ Trust ☐ Estate ☐ 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? ☐ Yes ☐ No	Is spouse confined for medical care or treatment at home or elsewhere? ☐ Yes ☐ 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? ☐ Yes ☐ 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.

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.**

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 Date Signed	Assignee's Signature (if applicable) Date Signed

9. For Prudential Use Only

Effective Date of Coverage: ☐☐/☐☐/☐☐☐☐ (mm/dd/yyyy)

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

IMPORTANT NOTICE REQUIRED BY CERTAIN STATE REGULATORS:

For residents of all states except Alabama, the District of Columbia, Florida, Kentucky, Maryland, New Jersey, New York, Pennsylvania, 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 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.

DISTRICT OF COLUMBIA 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.

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.

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.

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 knowingly and with intent to injure, defraud, or deceive any insurance company or other person, or knowing that he is facilitating commission of a fraud, submits incomplete, false, fraudulent, deceptive or misleading facts or information when filing a statement of claim for payment of a loss or benefit may have violated state law, is 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.

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.

Prudential

GROUP INSURANCE

The Prudential Insurance Company of America

Employer:

Group Contract No.(s): **Branch No.:**

O O

Short Form Health Statement For Portability Only

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

Employee

First Name | MI | Last Name

Number and Street | P.O. Box / Apt. Number

City | State | ZIP Code

Social Security Number | Employee ID Number | Telephone

Email Address

Name of Person for Whom Insurance is Being Requested

Relationship to Employee: ☐ Self ☐ Spouse or Domestic Partner

First Name | MI | Last Name | Social Security Number

Coverage that requires Evidence of Insurability: **Employee** ☐ Life **Spouse or Domestic Partner** ☐ Life

Gender: ☐ Female ☐ Male

Height: ft. in.

Weight: lbs.

Date of Birth: (mm-dd-yyyy)

Please answer these questions by checking "Yes" or "No". Note: In this section, "you" refers to the person for whom the insurance is being requested.

Yes ☐ No ☐ **Do you currently** have any disorder, condition, or disease or are you currently taking prescription medication for any disorder, condition, or disease (other than: acid reflux; allergies; cold; cough; herniated disc; high cholesterol; nonrheumatoid arthritis; overactive or underactive thyroid; or pregnancy)?

Yes ☐ No ☐ **In the last five years** have you been diagnosed with, treated for, had any symptoms of, or been in a hospital or other facility for any of the following?

- Chest pain, heart disease or disorder, high blood pressure;
- Cancer, tumors;
- Respiratory disease or disorder of the lungs;
- Multiple sclerosis, epilepsy, seizure, stroke;
- Kidney, liver or pancreas disease or disorder;
- AIDS, AIDS-related complex;
- Diabetes;
- Mental or nervous disorder;
- Alcoholism, drug addiction;
- Chronic pain, rheumatoid arthritis, lupus; or
- Colitis, Crohn's disease, gastric bypass.

Prudential reserves the right to request additional health information on the basis of the responses given to the above questions.

LSFAG001

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 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 Contract No.(s): 0 0

Branch No.:

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.

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.

376050

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.

Please keep this notice for your records.

Prudential

GROUP INSURANCE

The Prudential Insurance Company of America

Employer:

Group Contract No.(s): **Branch No.:**

O O

Short Form Health Statement For Portability Only

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

Employee

First Name | MI | Last Name

Number and Street | P.O. Box / Apt. Number

City | State | ZIP Code

Social Security Number | Employee ID Number | Telephone

Email Address

Name of Person for Whom Insurance is Being Requested

Relationship to Employee: ☐ Self ☐ Spouse or Domestic Partner

First Name | MI | Last Name | Social Security Number

Coverage that requires Evidence of Insurability: **Employee** ☐ Life **Spouse or Domestic Partner** ☐ Life

Gender: ☐ Female ☐ Male

Height: ft. in.

Weight: lbs.

Date of Birth: (mm-dd-yyyy)

Please answer these questions by checking "Yes" or "No". Note: In this section, "you" refers to the person for whom the insurance is being requested.

Yes ☐ No ☐ **Do you currently** have any disorder, condition, or disease or are you currently taking prescription medication for any disorder, condition, or disease (other than: acid reflux; allergies; cold; cough; herniated disc; high cholesterol; nonrheumatoid arthritis; overactive or underactive thyroid; or pregnancy)?

Yes ☐ No ☐ **In the last five years** have you been diagnosed with, treated for, had any symptoms of, or been in a hospital or other facility for any of the following?

- Chest pain, heart disease or disorder, high blood pressure;
- Cancer, tumors;
- Respiratory disease or disorder of the lungs;
- Multiple sclerosis, epilepsy, seizure, stroke;
- Kidney, liver or pancreas disease or disorder;
- AIDS, AIDS-related complex;
- Diabetes;
- Mental or nervous disorder;
- Alcoholism, drug addiction;
- Chronic pain, rheumatoid arthritis, lupus; or
- Colitis, Crohn's disease, gastric bypass.

Prudential reserves the right to request additional health information on the basis of the responses given to the above questions.

LSFAG001

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 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): 0 0

Branch No.:

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.

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.

376050

Group Life and Disability Income Medical Underwriting NOTICE

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- 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.

Please keep this notice for your records.