Prudential

Group Long Term Disability Insurance Enrollment and Record Card

The Prudential Insurance Company of America

1. Policy	2. Dept. #	3. Policyholder Name

4. Employee's Last Name	First	Middle Initial

5. Social Security Number	6. Employee's Birth Date	7. Sex ☐ Male ☐ Female

8. Employment Date	9. Employee's Occupation and/or Title

10. Salary $	☐ Weekly ☐ Monthly ☐ Annually	11. Insurance Effective Date Mo. Day Yr.

12. I authorize my employer to deduct from my salary or wages, if applicable, the necessary premium for the coverage requested above. This signature is also to verify the accuracy of the information on the card.

Signature **Date**

Employer: Retain this card in your files. Do not forward to Prudential.
Be sure to issue certificate of coverage to your new employees.

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For Employer's Use Only

Date of Salary Change	New Salary Amount	Date of Salary Change	New Salary Amount

Employee's Last Name	First	Middle Initial

Declination of Long Term Disability Insurance

This coverage can be declined only if you pay part or all premiums.

I have been offered this Long Term Disability Insurance coverage and decline to purchase it at this time.

I understand that in the event I desire such insurance at a later date, I will be required to furnish evidence of insurability at my own expense, and the company will have the right to refuse my request.

Signature **Date** **Witness' Signature**

Employer: Declinations are to be retained in your files.

The Prudential Insurance Company of America, 751 Broad Street, Newark, NJ 07102. Please refer to your Booklet-Certificate for all plan details, including any exclusions, limitations, and restrictions which may apply.

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