



GROUP LIFE & DISABILITY ENROLLMENT/CHANGE CARD

The Prudential Insurance Company of America

Please refer to the description of your plan for coverage options and amounts available to you.

Employee's Last Name	First Name	MI	Name of Employer	Group Policy No.	Claim Branch
Employee's Address				Employee's Annual Salary \$	
Social Security No. - -	Date of Birth / /	Date Employed / /	<input type="checkbox"/> Married <input type="checkbox"/> Single	<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	<input type="checkbox"/> Male <input type="checkbox"/> Female

Please mark the appropriate box according to your plan.

Type of Coverage	<input type="checkbox"/> Basic Term Life (Non Contrib.)	<input type="checkbox"/> Optional Term Life	<input type="checkbox"/> Dependent Term Life	<input type="checkbox"/> Accidental Death & Dismemberment (Non Contrib.)	<input type="checkbox"/> Optional Accidental Death & Dismemberment	<input type="checkbox"/> Short Term Disability	<input type="checkbox"/> Long Term Disability
Enter Amount							
Effective Date							

EMPLOYEE'S DEPENDENT INFORMATION

Dependent's Last Name	First Name	MI	Date of Birth	Relationship to Employee
			/ /	
			/ /	
			/ /	

My Dependent coverage is for: Spouse Only Spouse & Children

MY BENEFICIARY'S NAME (PLEASE PRINT) Example: Mary A. Doe, not Mrs. J. Doe

First Name	Middle Initial	Last Name	Relationship To Employee
First Name	Middle Initial	Last Name	Relationship To Employee
First Name	Middle Initial	Last Name	Relationship To Employee

If more than one beneficiary is designated, settlement will be made in equal shares to the designated beneficiaries (or beneficiary) who are then still living unless their shares are specified. If no designated beneficiary survives the insured, settlement will be made to the estate of the insured, unless otherwise provided in the Group Policy.

EMPLOYEE'S SIGNATURE

- I am enrolling for coverage and I authorize my employer to deduct from my earnings until further notice my contributions for insurance under a contract issued by The Prudential Insurance Company of America. I understand that if I desire to increase the amount of my insurance or add dependent coverage hereafter, I may be required to furnish evidence of insurability for myself and/or my dependents. I declare the statement above is true and understand it is the basis for determining the monthly contribution for coverage.
- I do not wish to enroll for any of the above optional coverages. I certify that I have been given the opportunity by my above named employer to enroll for coverage. I understand that if I desire to enroll hereafter, I may be required to furnish evidence of insurability for myself and/or my dependents.

Employee Signature _____ Date (Month/Day/Year) _____ / _____ / _____

Spouse Signature _____ Date (Month/Day/Year) _____ / _____ / _____

(When enrolling for Spouse Dependent Term Life coverage, the spouse must sign above to acknowledge consent for the coverage.)

IMPORTANT NOTICE

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 a statement of claim for payment of a loss or benefit commits a fraudulent insurance act, 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.

FOR EMPLOYER'S USE ONLY										
CHANGES OF BENEFICIARY										
DATE OF CHANGE	NEW BENEFICIARY DESIGNATED						RELATIONSHIP			
ADDITIONAL INFORMATION:										
CHANGED AMOUNT OF INSURANCE										
COVERAGE	CHANGE 1		CHANGE 2		CHANGE 3		CHANGE 4		CHANGE 5	
	Eff. Date	Amount	Eff. Date	Amount	Eff. Date	Amount	Eff. Date	Amount	Eff. Date	Amount
BASIC TERM LIFE										
OPT. TERM LIFE										
BASIC AD&D										
OPT. AD&D										
STD										
LTD										
DEPENDENT TERM LIFE										

Short Term Disability, Long Term Disability, Basic Term Life, Dependent Term Life, Optional Term Life, and Basic and Optional Accidental Death & Dismemberment coverages are issued by The Prudential Insurance Company of America, 751 Broad Street, Newark, NJ 07102. Prudential is a service mark of The Prudential Insurance Company, USA and its affiliates. The Accidental Death & Dismemberment phone number is: 800-524-0542 and the Disability phone number is: 800-290-5903. Please refer to the Booklet-Certificate for all plan details, including any exclusions, limitations, and restrictions which may apply. Contract series: 83500.

The Prudential Insurance Company of America is a Prudential Financial company.