Prudential Financial

Group Short and 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	11. Insurance Eff. Date
$ _____ ❑ Weekly ❑ Monthly ❑ Annually	_____/_____/_____ Month Day Year

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 contained on their 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.

Cat# 77M253E Ed. 12-96

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 Short and Long Term Disability Insurance

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

I have been offered this ❑ STD ❑ LTD 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.

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