

# SUPPLEMENTAL LIFE ENROLLMENT FORM

Policyholder's Name: Union Benefits Trust

Group Policy Number: LG-01049

New enrollment    Change    Terminate member coverage (includes spouse/children coverage)

Please mark the appropriate boxes if you are making a change (check all that apply)

Increase My Coverage    Add Spouse Coverage    Add Children Coverage    Change Smoker Status    Change Spouse Smoker Status  
 Decrease My Coverage    Increase Spouse Coverage    Drop Children Coverage    Change to Union-Represented from Exempt  
 Other (Name Change, etc.)    Drop Spouse Coverage

Department ID Number: \_\_\_\_\_ (State Department in which you work)

Member Insurance Total Amount Requested: \_\_\_\_\_ Include current amount of supplemental coverage for the member, plus the amount of increase in \$10,000 increments (do not include spouse/children amounts). The amount for which you apply and the amount that Prudential approves may not be the same. You may port the approved amount when you leave State service.

Member Name (Last, First, Middle Initial) \_\_\_\_\_

Member's Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_

Social Security No. \_\_\_\_\_ DOB \_\_\_\_\_  M  F    Married  Single

Occupation \_\_\_\_\_ Date Employed \_\_\_\_\_ Base Annual Earnings \_\_\_\_\_

Telephone No. \_\_\_\_\_ Employee ID Number \_\_\_\_\_

Have you smoked cigarettes or used any form of tobacco in the past 12 months?  Yes  No

(The right to change the beneficiary is reserved. To name beneficiaries, please use the Supplemental Life Beneficiary Designation Form.)

Member Must Have Supplemental Life Insurance to Enroll Spouse and/or Children.

You will automatically be the beneficiary for life insurance on the lives of your spouse and children, if surviving; otherwise it will be the estate of the spouse and children, subject to policy provisions.

Spouse Coverage Desired?  Yes  No   Spouse Insurance Total Amount:  \$10,000    \$20,000    \$30,000    \$40,000

\_\_\_\_\_ (Include current amount of coverage)

Spouse's Name (Last, First, Middle Initial) \_\_\_\_\_

Spouse's Social Security Number \_\_\_\_\_ DOB \_\_\_\_\_ Date of Marriage \_\_\_\_\_

Has your spouse smoked cigarettes or used any form of tobacco in the past 12 months?  Yes  No

Child(ren) Coverage Desired?  Yes  No   Child(ren) Insurance Amount: \$7,000 per Child   Number of Children \_\_\_\_\_

You have 90 days from your hire date to purchase supplemental life coverage for you, your spouse, and your dependent children. Coverage is also available during each Trust-sponsored open enrollment period.

This plan is totally separate from your basic life plan with Union Benefits Trust, and the amount of insurance elected as supplemental does not change your basic life insurance. If a husband and wife are both State employees, they have coverage as either a spouse or a member, but not both. Children can only be covered as dependents of only one member.

I understand that when I leave State service I, my spouse, and child(ren) will be able to port the coverage I have purchased as an active member, and that I will not be able to apply for more coverage.

I hereby request group insurance for myself and/or for my dependents and hereby authorize my employer or successor to make deductions from my earnings of the required contributions to apply toward the premiums for the insurance provided for in the policy of group insurance issued to Union Benefits Trust by The Prudential Insurance Company of America.

**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.

Member's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# SUPPLEMENTAL LIFE BENEFICIARY DESIGNATION FORM

Policyholder's Name: Union Benefits Trust

Group Policy Number: LG-01049

Use the space below to name beneficiaries of the member. If you wish, you may name one or more primary beneficiaries. You may also name one or more contingent beneficiaries. This form allows you to name up to two primary and two contingent beneficiaries. If you need additional space, please attach a separate sheet of paper. After you have completed your entries, please sign and date in the space below.

If you wish, you may indicate the percentage share designated to each primary beneficiary. The total for one or all primary beneficiaries must equal 100%. If no percentages are specified, the proceeds will be split evenly among those named. If no named beneficiary survives you, any amount of insurance will be made payable to the first of the following; Your (a) surviving spouse, (b) surviving child(ren) in equal shares, (c) surviving parents in equal shares, (d) surviving siblings in equal shares, (e) estate. If designating percentages for contingent beneficiaries, the percentage for all contingent beneficiaries must also equal 100%.

DEFINITIONS. You may find the following definitions helpful in completing this form:

**Primary Beneficiary(ies)** - the person(s) or entity you choose to receive your life insurance proceeds. Payment will be made in equal shares unless otherwise specified. In the event that a designated primary beneficiary predeceases the insured, the proceeds will be paid to the remaining primary beneficiaries in equal shares or all to the sole remaining primary beneficiary.

**Contingent Beneficiary(ies)** - the person(s) or entity you choose to receive your life insurance proceeds if the primary beneficiary(ies) die (or the entity dissolves) before you die. Payment will be made in equal shares unless otherwise specified. In the event that a designated contingent beneficiary predeceases the insured, the proceeds will be paid to the remaining contingent beneficiaries in equal shares or all to the sole remaining contingent beneficiary.

## PRIMARY BENEFICIARY(IES)

First Name	Middle Initial	Last Name	Relationship to member	DOB
Address		Social Security Number	% Share	

First Name	Middle Initial	Last Name	Relationship to member	DOB
Address		Social Security Number	% Share	

## CONTINGENT BENEFICIARY(IES) (optional)

First Name	Middle Initial	Last Name	Relationship to member	DOB
Address		Social Security Number	% Share	

First Name	Middle Initial	Last Name	Relationship to member	DOB
Address		Social Security Number	% Share	

Supplemental Life Insurance coverage is issued by The Prudential Insurance Company of America, 751 Broad Street, Newark, NJ 07102. Contract Series 83500.

Member's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

PLEASE KEEP A COPY OF THIS FORM FOR YOUR RECORDS.

Mail the original form to: The Prudential Insurance Company of America • P.O. Box 5072 • Millville, NJ 08332-9931  
Call Prudential with questions: 800-778-3827

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

**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.

**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 there to commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**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.

Receipt of accelerated death benefits may affect eligibility for public assistance programs and may be taxable. Please contact your personal tax advisor for further information. There is no administrative fee to accelerate death benefits. The accelerated amount is not discounted.

Group Supplemental, Dependent, Basic Life Insurance and AD&D coverages are issued by The Prudential Insurance Company of America, a New Jersey company, 751 Broad Street, Newark, NJ 07102. Please refer to the Booklet-Certificate, which is made a part of the Group Contract, for all plan details, including any exclusions, limitations and restrictions which may apply. 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. Contract provisions may vary by state. Contract series: 83500