



**3****Health Questions**

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<b>Member</b>		<b>Spouse or Domestic Partner</b> (if applicable)		
Yes	No	Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>4. Within the last five years</b> , have you been in a hospital or other institution for observation, rest, diagnosis or treatment?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>5. Within the last five years</b> , have you been attended by a doctor or licensed practitioner for anything other than a routine physical?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>6. Do you have</b> any known symptoms, physical or mental impairments not mentioned in the previous questions?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>7. Are you</b> taking any medication or being treated for any condition, including pregnancy, or disease not mentioned in the previous questions?

**If you answered "Yes" to any of questions 3-7, please provide full details below.**

(If more space is needed, please attach an additional sheet.)

Member	Spouse or Domestic Partner	Question Number	Date of Illness	Date of Full Recovery	Details of nature of illness, number of attacks, duration, severity, treatments and medications prescribed and taken	Names, complete addresses and phone numbers of physicians
<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

**Primary Care Physician Information (for Member)**

Name	Date last seen	Telephone
<input type="text"/>	<input type="text"/>	<input type="text"/>
Address		
<input type="text"/>		

**Primary Care Physician Information (for Spouse)**

Name	Date last seen	Telephone
<input type="text"/>	<input type="text"/>	<input type="text"/>
Address		
<input type="text"/>		

**4****Coverage Amounts**

Choose the type of coverage and amounts for which you are applying.

 **Life Insurance Plan**

Coverage Amounts (please check one):

<input type="checkbox"/> \$50,000	<input type="checkbox"/> \$150,000	<input type="checkbox"/> \$250,000	<input type="checkbox"/> \$350,000	<input type="checkbox"/> \$450,000
<input type="checkbox"/> \$100,000	<input type="checkbox"/> \$200,000	<input type="checkbox"/> \$300,000	<input type="checkbox"/> \$400,000	<input type="checkbox"/> \$500,000

Optional Coverage(s) Requested:  Spouse or Domestic Partner Coverage Amount - 50% of Member's coverage amount up to \$250,000**5****Beneficiary Information**

Full Name of Beneficiary	Relationship	Share
<input type="text"/>	<input type="text"/>	<input style="text-align: center; width: 50px;" type="text" value="%"/>
Address		
<input type="text"/>		
(If more space is needed, please attach a separate sheet.)		<b>Total (Must equal 100%)</b>
		<b>100%</b>

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**Contribution  
Payment Basis**

**I request the following payment basis (please check one):**

*If paying Semi-Annually or Quarterly, payment must be made via automatic bank draft.*

Annual       Semi-Annual       Quarterly

**Payment Options:**

ACH       Direct Billing

Checking     Savings

Account Owner's Name

Bank Name

Type of Account

Bank's Routing Number

Your Account Number

**\*\*PLEASE INCLUDE A VOIDED CHECK/SAVINGS WITHDRAWAL SLIP FROM THE BANK ACCOUNT YOU WANT DEBITED.\*\***

**AUTHORIZATION For the Release of Information. This authorization is intended to comply with the HIPAA Privacy Rule.**

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, medical facility, or other health care provider that has provided payment, treatment, or services to me or on my behalf within the past 5 years ("My Providers") to disclose the entire medical record and any other health information concerning me and/or any dependent proposed for coverage in the application to The Prudential Insurance Company of America ("Prudential") and through it, to its reinsurers, authorized agents, and the Medical Information Bureau, Inc.. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection (In Vermont, this information is excluded.) and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol and/or drugs, but excludes psychotherapy notes. I also authorize the Medical Information Bureau, Inc. to release any data it may have about me and/or any dependent proposed for coverage to Prudential. By my signature below, I acknowledge that any agreements I or my dependents have made to restrict my health information do not apply to this Authorization and I instruct My Providers to release and disclose the entire medical record for me and/or my dependent without restriction. This health information is to be disclosed under this Authorization so that Prudential may: 1) underwrite an application for coverage and make risk determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with Prudential. This Authorization shall remain in force for 24 months following the date of my signature below, and a copy of this Authorization is as valid as the original. I understand that I have the right to revoke this Authorization in writing, at any time, by sending a signed request for revocation to The Prudential Insurance Company of America, Group Medical Underwriting, P. O. Box 8796, Philadelphia, PA 19176, Attention: Senior Medical Underwriting Consultant. I understand that a revocation is not effective to the extent that Prudential has relied on this Authorization or to the extent that Prudential has a legal right to contest a claim under insurance coverage or to contest the coverage itself. I understand that any information that is disclosed pursuant to this Authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information. (In Montana only: I may request a record of any subsequent disclosures of protected health information.) I understand that if I refuse to sign this Authorization to release the entire medical record for me and/or my dependent, Prudential may not be able to process an application for coverage, or if coverage has been issued, may not be able to make any benefit payments. I understand that I have the right to request and receive a copy of this Authorization.

**Statement of Understanding:** I (We) represent that all statements and answers made within or attached to this Request Form are true and complete to the best of my (our) knowledge and belief. I (We) understand that coverage shall be in effect only after all of these conditions have been met: this application has been approved by Prudential; the Contract has been issued while all persons to be insured thereunder are alive, and; the answers and statements in this application continue to be true and complete until the Effective Date. I (We) also understand that coverage will not take effect if the facts have changed. I (we) have also read and understand and agree to the additional terms, conditions and requirements as stated in the Authorization for the Release of Information and Important Notice sections. I (We) understand that completion of this application in no way implies that I (we) will be accepted for insurance coverage.

REPLACING YOUR LIFE INSURANCE POLICY? Are you thinking about buying a new policy and discontinuing or changing an existing policy? If you are, your decision could be a good one—or a mistake. You will not know for sure unless you make a careful comparison of your existing policy and the proposed policy. Make sure you understand the facts. You should ask the company or agent that sold you your existing policy to give you information about it. Hear both sides before you decide. This way you can be sure you are making a decision that is in your best interest.

**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 false, incomplete or misleading information is guilty of a felony of the third degree.

**X**

Member Signature

Date (mm/dd/yyyy)

□□ □□ □□□□

**X**

Spouse/Domestic Partner Signature (if applying for Spouse/Domestic Partner Coverage)

Date (mm/dd/yyyy)

□□ □□ □□□□

**Important Notice: For residents of all states except Florida, 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 or 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. **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. **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. **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 fact material 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.

**Accelerated Death Benefits:** Receipt of accelerated death benefits may affect eligibility for public assistance programs and may be taxable. There is no administrative fee to accelerate death benefits. The accelerated amount is not discounted.

**Beneficiary Designation:** If you name more than one beneficiary, settlement will be made in equal shares to the designated beneficiaries (or beneficiary) that survive you, unless otherwise provided in the designation. If no named beneficiary survives you, settlement will be made to the first of the following: your (a) surviving spouse or registered domestic partner; (b) surviving child(ren) in equal shares; (c) surviving parents in equal shares; (d) surviving siblings in equal shares; (e) estate.

**Please keep this notice for your records.**