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Please return this form to:

The Prudential Insurance Company of America Group Life Record Keeping P.O. Box 13676 Philadelphia, PA 19176

Group Term Life Insurance Coverage Portability Election Form

1. Employee/Applicant D	ata be completed	by employee/app	plicant)				
Last Name	Firs	t Name		MI	Sex	k: ☐ Male ☐	Female
Street Address		Apartr	ment #	City	-	State	ZIP
Date of Birth	Social Security Nu	mber	Daytime	e Phone Nur	mber	Home Phone	Number
Email Address		MaritalStatus	☐ Married	☐ Single	☐ Divorced	d 🗆 Widower	
2. Group Term Life Insu	rance Coverage	Amount (se) con	mpleted by e	mployer)			
Coverage Termination Date							
Salary and Date of Last Day Ac	tively at Work						
Current Optional Term Life Cove	erage Amount – Em	ployee					
Current Dependent Term Life C \$	overage Amount – S	Spouse					
Current Dependent Term Life C	overage Amount – C	Children					
3. Assignment Dat@b be of Has this insurance been assigned Last Name of Assignee or True	Deceas□No IfNO,		tion at the bo		section. If YE	S, complete this	s section with assignee
Street Address		Apartm	nent # Cit	у		State	ZIP
Daytime Phone Number	Н	ome Phone Numl	ber		Social Sec	urity Number or	Tax Identi cation Number
4. Group Term Life Insu	rance Coverage	Amount(se)cor	mpleted by e	mployee/app	olicant)		

5. Employee/Applicant Bene ciary	Designatio(table	completed by employe	е/аррпсангог аз	ssignee, ii assigned)	
Last Name	First Name		MI	Telephone Numbe	er
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	l		ı		
		1			1
	ı		1		1
		1		1	
Last Name	First Name		MI	Telephone Numbe	er
			I		
6. Dependent Term Life Insurance	Coverage - Sp	@USE completed by emp	oloyee)		
			T		
7. Donondont Town Life Incomment	Cay (areas - Ob-				
7. Dependent Term Life Insurance	Coverage - Ch	il(to) be icompleted by em	ipioyee)		
V			1		
Youngest Child's Last Name	First Name	MI			

8. Employee/Applicant/Assignee Signature(ts)be completed by employee/applicant/assignee)
9. For Prudential Use Only
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IMPORTANT NOTICE REQUIRED BY CERTAIN STATE REGULATORS:

For residents of all states except Alabama, the District of Columbia, Florida, Kentucky, Maryland, New Jersey, New York, Pennsylvania, Rhode Island, 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 facilitating commission of a fraud, submits incomplete, false, fraudulent, deceptive or misleading facts or information when ling an insurance application or a statement of claim for payment of a loss or bene t commits a fraudulent insurance act, is/may be guilty of a crime and may be prosecuted and punished under state law. Penalties may nes, civil damages and criminal penalties, including con nement in prison. In addition, an insurer may deny insubene ts if false information materially related to a claim was provided by the applicant or if the applicant conceal the purpose of misleading, information concerning any fact material thereto.

ALABAMA RESIDENTS – Any person who knowingly presents a false or fraudulent claim for payment of a loss or bene to knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution in connement in prison, or any combination thereof.

DISTRICT OF COLUMBIA AND RHODE ISLAND RESIDENTS – Any person who knowingly presents a false or frauduler payment of a loss or bene t or knowingly presents false information in an application for insurance is guilty of a crime and to nes and con nement in prison.

KENTUCKY RESIDENTS – Any person who knowingly and with intent to defraud any insurance company or other person application for insurance containing any materially false information or conceals, for the purpose of misleading, information any fact material thereto commits a fraudulent insurance act, which is a crime.

MARYLAND RESIDENTS – Any person who knowingly or willfully presents a false or fraudulent claim for payment of a lost bene t or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be to nes and con nement in prison.

NEW JERSEY RESIDENTS – Any person who includes any false or misleading information on an application for an insurable subject to criminal and civil penalties.

PENNSYLVANIA and UTAH RESIDENTS – Any person who knowingly and with intent to defraud any insurance company person les an application for insurance or statement of claim containing any materially false information or conceals for the of misleading, information concerning any material fact thereto commits a fraudulent insurance act, which is a crime and such person to criminal and civil penalties.

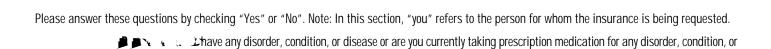
VERMONT RESIDENTS – Any person who knowingly presents a false or fraudulent claim for payment of a loss or knowir a false statement in an application for insurance may be guilty of a criminal offense under state law.

VIRGINIA RESIDENTS – Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or knowing that he is facilitating commission of a fraud, submits incomplete, false, fraudulent, deceptive or misleading fact when ling a statement of claim for payment of a loss or bene t may have violated state law, is guilty of a crime and may be and punished under state law. Penalties may include nes, civil damages and criminal penalties, including con nement in pan insurer may deny insurance bene ts if false information materially related to a claim was provided by the applicant or if 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 insufor the purpose of defrauding the company commits a crime. Penalties include imprisonment, nes, and denial of insurance

Short Form Health Statement For Portability	Only
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A , A , D , K. , A NING – 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.

ALABAMA E IDEN — Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

A KAN A , DI . IC OF COL MBIA, LO I IANA ... HODE I LAND E IDEN. — Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

KEN CK E IDEN — 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

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FLO IDA E IDEN Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

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, ,	e and belief, the statements made in this app become effective on the date or dates establ	·	0 11
Print Your First Name	Last Name		Your Social Security Number
Your Signature (unless a minor)			Date Signed (mm-dd-yyyy)
If Person for whom insurance is being r Signature of Parent, Guardian, or Perso	•	Relationship	Date Signed (mm-dd-yyyy)
. J			

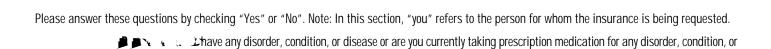
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FLO IDA E IDEN Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a scontaining any false, incomplete, or misleading information is guilty of a felony of the third degree.	tatement of claim or an application
I declare that, to the best of my knowledge and belief, the statements made in this application are complete and true. It is subject to the terms of the plan and shall become effective on the date or dates established by the plan, provided the events of the plan and shall become effective on the date or dates established by the plan, provided the events of the plan and shall become effective on the date or dates established by the plan, provided the events of the plan and shall become effective on the date or dates established by the plan and shall become effective on the date or dates established by the plan and shall become effective on the date or dates established by the plan and shall become effective on the date or dates established by the plan and shall become effective on the date or dates established by the plan and shall become effective on the date or dates established by the plan and shall become effective on the date or dates established by the plan and shall become effective on the date or dates established by the plan and shall become effective on the date or dates established by the plan and shall become effective on the date or dates established by the plan and shall become effective on the date or dates established by the plan and shall become effective or the date or dates established by the plan and shall be the plan and s	
Print Your First Name Last Name	Your Social Security Number
Your Signature (unless a minor)	Date Signed (mm-dd-yyyy
If Person for whom insurance is being requested is a minor Signature of Parent, Guardian, or Person Liable for Support	Date Signed (mm-dd-yyyy

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