Prudential

ENROLLMENT FORM – State of Louisiana

Agency #

All Eligible Active or Retired Employees Including Members of Boards and Commissions Control # **33624**

Employee General Information	Effective Date of Coverage (for office use only) / /		
Last Name First Name MI	Email Address	Phone Number	
Address City State Zip Code			
Your Annual Earnings $ _____	Social Security Number – –	Date of Birth (Month/Day/Year) / /	Date Employed (Month/Day/Year) / /
Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed		Spouse Date of Birth (Month/Day/Year) / /	

Basic Term Life or Enhanced Basic Term Life

Coverage amount chosen: ☐ $5,000 ☐ $15,000 ☐ No coverage chosen

Basic Plus Supplemental Term Life With Matching Accidental Death & Dismemberment (AD&D)

Enrollment in Employee AD&D coverage is automatic when electing Basic Plus Supplemental Term Life coverage.

☐ Coverage amount chosen: $ ☐ No coverage chosen

Basic Dependent Term Life

You must be enrolled for Basic Term Life to elect Basic Dependent Term Life coverage for your dependents. Spouse coverage cannot exceed 100% of your Basic Term Life coverage amount. Child(ren) coverage cannot exceed 100% of your Basic Term Life coverage amount.

Spouse/Children ☐ No coverage chosen

☐ Coverage amount chosen: $1,000/Children $500

☐ Coverage amount chosen: Spouse $2,000/Children $1,000

Basic Plus Supplemental Dependent Term Life

You must be enrolled for Basic Plus Supplemental Term Life to elect Basic Plus Supplemental Dependent Term Life coverage for your dependents. Spouse coverage cannot exceed 100% of your Basic Plus Supplemental Term Life coverage amount. Child(ren) coverage cannot exceed 100% of your Basic Plus Supplemental Term Life coverage amount.

Spouse/Children ☐ No coverage chosen

☐ Coverage amount chosen: Spouse $2,000/Children $1,000

☐ Coverage amount chosen: Spouse $4,000/Children $2,000

You must also complete a separate beneficiary designation form. If you have any questions, please see Human Resources for details.

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All Eligible Active or Retired Employees Including Members of Boards and Commissions Control # **33624**

Employee General Information

Last Name	First Name	Middle Initial	Last 4 digits of Social Security No.
			XXX-XX- _____

Acceptance or Waiver of Coverage

☐ 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. To the best of my knowledge and belief, I declare the statement above is true and understand it is the basis for determining the contribution for coverage. I also understand that for coverage to become effective, I must be actively at work during the enrollment period and on the effective date of the plan. If I apply for an amount that requires evidence of insurability satisfactory to The Prudential Insurance Company of America, I must be actively at work on the date of approval for the amount requiring satisfactory evidence of insurability.

☐ 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 satisfactory evidence of insurability to The Prudential Insurance Company of America for myself and/or my dependents.

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.

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 warning ONLY applies to accident and disability coverage.**

I have read and understand the terms and requirements of the fraud warnings included as part of this form.

The policy/certificate provides limited benefits. Review your certificate carefully.

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

Acceptance of Coverage

FOR INSUREDS WHO RESIDE IN MICHIGAN OR MINNESOTA ONLY – If you wish to enroll your Spouse, and/or eligible child 18 years of age or older for Dependent Life and/or Accidental Death and Dismemberment Insurance coverage, your Spouse, and/or each of your eligible children age 18 years or older must consent to such coverage by signing and dating this consent in the appropriate space(s) below.

Coverage on your Spouse and child(ren) age 18 or older will not become effective unless and until the requisite consent is provided.

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

Child Signature _____ Date Signed (Month/Day/Year) _____

Child Signature _____ Date Signed (Month/Day/Year) _____

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ENROLLMENT FORM – State of Louisiana

Agency #

All Eligible Active or Retired Employees Including Members of Boards and Commissions Control # **33624**

Employee General Information

Last Name	First Name	Middle Initial	Last 4 digits of Social Security No.
			XXX-XX- _____

Important Notices

For residents of all states and jurisdictions except Alabama, Alaska, Arizona, Arkansas, California, Colorado, Delaware, the District of Columbia, Florida, Idaho, Indiana, Kentucky, Louisiana, Maine, Maryland, Minnesota, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Puerto Rico, Rhode Island, Tennessee, Texas, Utah, Vermont, Virginia, Washington and West Virginia:
WARNING: Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person, or knowing that he or she 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 RESIDENTS – 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.

ALASKA RESIDENTS – A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

ARIZONA RESIDENTS - For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

ARKANSAS, DISTRICT OF COLUMBIA, LOUISIANA, MASSACHUSETTS, RHODE ISLAND, AND WEST VIRGINIA RESIDENTS – 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.

CALIFORNIA AND TEXAS RESIDENTS - For your protection, California and Texas law requires the following to appear on this form. Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

COLORADO RESIDENTS - It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

DELAWARE RESIDENTS - Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

IDAHO RESIDENTS - Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement containing any false, incomplete, or misleading information is guilty of a felony.

INDIANA RESIDENTS - A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

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.

MAINE, TENNESSEE, VIRGINIA, WASHINGTON RESIDENTS – **It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.**

MARYLAND RESIDENTS – Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

MINNESOTA RESIDENTS - A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

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Employee General Information

Last Name	First Name	Middle Initial	Last 4 digits of Social Security No.
			XXX-XX- _____

Important Notices

NEW HAMPSHIRE RESIDENTS - Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638.20.

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 MEXICO RESIDENTS - 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 CIVIL FINES AND CRIMINAL PENALTIES.

NORTH CAROLINA RESIDENTS – Any person who, with the intent to injure, defraud, or deceive an insurer or insurance claimant, knowing that the statement contains false information concerning a fact or matter material to the claim may be guilty of a class H felony.

OHIO RESIDENTS - Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

OKLAHOMA RESIDENTS - WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete, or misleading information is guilty of a felony.

OREGON RESIDENTS - Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurance company, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

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

PUERTO RICO RESIDENTS – Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances [be] present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

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.

Employees and/or Dependents may be ineligible for group insurance coverage while on active duty in the armed forces

Accelerated Death Benefit Option is a feature that is made available to group life insurance participants. It is not a health, nursing home, or long-term care insurance benefit and is not designed to eliminate the need for those types of insurance coverage. The death benefit is reduced by the amount of the accelerated death benefit paid. There is no administrative fee to accelerate benefits. Receipt of accelerated death benefits may affect eligibility for public assistance and may be taxable. The federal income tax treatment of payments made under this rider depends upon whether the insured is the recipient of the benefits and is considered terminally ill or chronically ill. You may wish to seek professional tax advice before exercising this option.

NOTICE TO CONSUMER: THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMAL ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES. ALSO, THE BENEFITS PROVIDED BY THIS POLICY CANNOT BE COORDINATED WITH THE BENEFITS PROVIDED BY OTHER COVERAGE. PLEASE REVIEW THE BENEFITS PROVIDED BY THIS POLICY CAREFULLY TO AVOID A DUPLICATION OF COVERAGE.

Basic Term Life, Accidental Death & Dismemberment, Optional Term Life, Dependent Term Life, Long-Term Disability, Short-Term Disability Insurance coverages are issued by The Prudential Insurance Company of America, 751 Broad Street, Newark, NJ 07102. Life Claims: 1-800-524-0542 and Disability Support 1-800-842-1718. The Booklet-Certificate contains all details, including any policy 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. California COA #1179, NAIC#68241. Contract Series: 83500.

Beneficiary Designation - State of Louisiana

Control# 33624

Employee General Information

Last Name	First Name	Middle Initial	Social Security No.
			_____ – _____ – _____

Employee / Applicant Beneficiary Designations (to be completed by Employee/applicant or assignee, if assigned)

Please designate at least one primary beneficiary. Use a separate sheet if you want to name more than two primary beneficiaries. If designating a Trust, Estate, or Corporation, please complete the corresponding fields. Do not name a beneficiary for Dependent Term Life Coverage; these benefits are paid to you while living. If more than one primary 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 there is no named beneficiary, or no beneficiary survives the insured, settlement will be made in accordance with the terms of your Group Contract.

Basic Term Life, Enhanced Basic, Basic Plus Supplemental Term Life - Primary Beneficiary Designation

1

Last Name	First Name	MI	Telephone Number
Social Security Number	Date of Birth	Relationship	Percentage
Street Address	City	State	Zip
Check one, if applicable:	☐ **Trust** ☐ **Estate** ☐ **Corporation**	**Entity Name:**	
Tax ID #/Tax Exempt #	Creation/Incorporation/Formation Date	Telephone Number	Percentage
Street Address	City	State	Zip

2

Last Name	First Name	MI	Telephone Number
Social Security Number	Date of Birth	Relationship	Percentage
Street Address	City	State	Zip
Check one, if applicable:	☐ **Trust** ☐ **Estate** ☐ **Corporation**	**Entity Name:**	
Tax ID #/Tax Exempt #	Creation/Incorporation/Formation Date	Telephone Number	Percentage
Street Address	City	State	Zip

Basic Term Life, Enhanced Basic, Basic Plus Supplemental Term Life - Contingent Beneficiary Designation

- Death benefits will be paid to the contingent beneficiaries if the primary beneficiary(ies) is not alive. Use a separate sheet if you want to name more than two contingent beneficiaries. If designating a Trust, Estate, or Corporation, please complete the corresponding fields.

1

Last Name	First Name	MI	Telephone Number
Social Security Number	Date of Birth	Relationship	Percentage
Street Address	City	State	Zip
Check one, if applicable:	☐ **Trust** ☐ **Estate** ☐ **Corporation**	**Entity Name:**	
Tax ID #/Tax Exempt #	Creation/Incorporation/Formation Date	Telephone Number	Percentage
Street Address	City	State	Zip

2

Last Name	First Name	MI	Telephone Number
Social Security Number	Date of Birth	Relationship	Percentage
Street Address	City	State	Zip
Check one, if applicable:	☐ **Trust** ☐ **Estate** ☐ **Corporation**	**Entity Name:**	
Tax ID #/Tax Exempt #	Creation/Incorporation/Formation Date	Telephone Number	Percentage
Street Address	City	State	Zip

Employee Signature _____ Date (mm/dd/yyy)_____

If you have any questions, please see Human Resources for details.

Group Insurance coverages are issued by The Prudential Insurance Company of America, a Prudential Financial company, Newark, NJ 07102. Life Claims: 800-524-0542, Disability Support: 800-842-1718. This brochure is intended to be a summary of your benefits and does not include all plan provisions, exclusions and limitations. 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 The Prudential Insurance Company of America, the Group Contract will govern. Contract provisions may vary by state. Contract Series:83500. California COA # 1179 NAIC #68241

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