Evidence of Insurability

Instructions for Employer/Association

1. Complete the form below.
2. Also complete all sections of the form noted Part A including product related information as applicable to the plan(s) requiring medical evidence of insurability.
3. The entire package should then be given to your employee or member for completion of Part B.

For Employer/Association Use Only:

In the space below, insert mailing address to which the notice of action should be sent.

Employee/Member Name: ____________________

Employer/Association Name & Address:

____

____

____

Group Contract No.: __________ Branch No.: __________

Submitting Location: ____________________

Submitted by:

____
Name

____
Title

____
Telephone Number

____
E-mail Address

____
Date

Prudential Financial

Part A Employer/Association Information

Complete this page for those plans requiring evidence of insurability, then give this package to the employee/member.

Employee/Member First Name MI Last Name

Date of Birth Social Security Number Sex

☐ Male ☐ Female

Street Apt.

City State ZIP Code

Date individual first became eligible for coverage(s)/amount(s) of insurance this form applies to:

Employee/Member Annual Earnings: $________________________________

Is application being made for amounts above the life non-medical maximum?	Yes ☐	No ☐
Is application being made as a late entrant?	Yes ☐	No ☐
Is application being made for dependents?	Yes ☐	No ☐

Complete only for those coverages and persons requiring evidence of insurability.
(For example: Employee only, spouse only, or employee and spouse.)

Life/AD&D

Total Non-Medical Maximum $___________________

	Current Amount Inforce	+	Addt'l or Initial Amount Requested	=	Total Amount
Employee/Member	$___________________	+	$____________________________	=	$____________
Spouse (Life Only)	$___________________	+	$____________________________	=	$____________

Long Term Disability

	Current Amount Inforce	+	Addt'l or Initial Amount Requested	=	Total Amount
Employee/Member	$___________________/mo	+	$_______________________/mo	=	$__________/mo

Survivor Benefits Life

	Current Amount Inforce	+	Addt'l or Initial Amount Requested	=	Total Amount
Spouse	$_______________/mo	+	$_______________________/mo	=	$__________/mo
Child	$_______________/mo	+	$_______________________/mo	=	$__________/mo

Weekly Disability Income/Accident & Sickness Benefit

Amount $__________________________

Prudential Financial

Instructions for Employee/Member (Complete the required sections as noted below.)

1. If you are providing evidence of insurability for:

a) Employee/Member coverage only–Complete Sections 1, 2, 4, and 5.

b) Dependent coverage only–Complete Sections 1, 3, 4, and 5.

c) Employee/Member and Dependent coverage–Complete all sections of this form. (Note: Evidence of insurability is not required for children.)

2. Please complete the form in blue or black ink. Sign and date Sections 4 and 5.

3. Please read and tear off the important Medical Information Notice that accompanies these instructions and retain for your records. Please retain a copy of your completed application for your own records.

4. Mail the completed Part A and Part B forms to:

The Prudential Insurance Company of America
Group Medical Underwriting
P.O. Box 8796
Philadelphia, PA 19176

Or fax the completed form to:
877-605-6671

The evaluation of your request for coverage may be delayed if you do not follow these instructions, if you and/or your dependent do not answer all questions on the Part B form, if you do not give complete details for any answers requiring details, or if you do not provide complete names and addresses of doctors and hospitals.

NOTE: Coverage is not effective until this request has been approved. You will be notified whether or not coverage has been approved.

If you have questions regarding the completion of these forms, please contact Prudential Customer Service at 888-257-0412 or e-mail us at medical.uw@prudential.com.

Part B Employee/Member Information

Section 1

1. Employee/Member First Name ______ MI ___ Last Name ______

2. Employee/Member Social Security Number ___ – __ – ____

3. Employee/Member Phone Number

Daytime ___ – ___ – ____

Evening ___ – ___ – ____

4. Street ______ Apt. ____

City ______ State __ ZIP Code _____ – ____

5. E-mail Address ______

Section 2

6. Date of Birth __ __ ____
month day year

7. Birth Place ______ __
city state

8. Sex

☐ Male ☐ Female

9. Height __ ft. __ in.

10. Weight ___ lbs.

Section 2 (continued)

11. Name and address of current doctor:

Physician First Name ______ MI ______ Last Name ______

Street ______ Suite ______

City ______ State ______ ZIP Code ______ – ______

12. Are you currently able to perform all the duties of your job? ☐ Yes ☐ No
If "No", provide full details in item 17.

13. Have you **during the last five years:**

a. had any surgery or been advised to have surgery and have not done so? Yes ☐ No ☐
b. been in a hospital, sanitarium, or other institution for observation, rest, diagnosis, or treatment? Yes ☐ No ☐
c. used, or are now using, cocaine, barbiturates, amphetamines, marijuana or other hallucinatory drugs, heroin, opiates, or other narcotics, except as prescribed by a doctor? Yes ☐ No ☐
d. been treated or counseled for alcoholism? Yes ☐ No ☐
e. been treated or counseled by a psychologist or psychiatrist? Yes ☐ No ☐
f. applied for or received disability income benefits or pension benefits on account of sickness or injury? Yes ☐ No ☐
g. had life, disability, or health insurance declined, postponed, changed, rated-up, cancelled, or withdrawn? Yes ☐ No ☐
h. been diagnosed as having, or treated by a member of the medical profession for, Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? Yes ☐ No ☐

14. **Within the last five years**, have you been treated for, or had any trouble with, any of the following:

	Yes	No		Yes	No		Yes	No
a. Heart or chest pain?	☐	☐	g. Nervous or mental disorders?	☐	☐	m. Urinary system?	☐	☐
b. High blood pressure?	☐	☐	h. Arthritis or rheumatism?	☐	☐	n. Goiter or glands?	☐	☐
c. Abnormal pulse?	☐	☐	i. Ulcers or stomach disorders?	☐	☐	o. Pleurisy or asthma?	☐	☐
d. Cancer or tumors?	☐	☐	j. Intestines or kidneys?	☐	☐	p. Chronic diarrhea?	☐	☐
e. Diabetes?	☐	☐	k. Liver or gallstones?	☐	☐	q. Neuritis or sciatica?	☐	☐
f. Lungs?	☐	☐	l. Genital disorder?	☐	☐	r. Back or spinal disorders?	☐	☐

15. Do you **currently have** any disorder, condition (including pregnancy), disease, or defect not shown above, and/or are you currently taking medication prescribed or provided by a medical or other practitioner for any disorder, condition (including pregnancy), disease, or defect? Yes ☐ No ☐

16. Have you smoked cigarettes or used another tobacco product (including cigars or chewing tobacco) or used nicotine gum within the past year? If "Yes", which product? ______________ Yes ☐ No ☐

17. What are the full details of all "Yes" answers to each part of 13 through 15? Attach additional pages if needed.

Question Number and Letter	**Specify illness or condition. Include reason for any check-up, doctor's advice, treatment, and/or medication**	**Date illness or condition began** *Month Year*	**Time lost from normal activities**	**Full recovery (if applicable)** *Month Year*	**Print full names, addresses, and telephone numbers of doctors and/or hospitals**

Section 3

1. Employee/Member's eligible dependent that requires evidence of insurability.

Full Name	Social Security Number	Relationship to You	Date of Birth	Place of Birth	Height	Weight

2. Address of your dependent (if different from address in Section 1):

3. Is the person named above unable to perform all of the duties of his/her job or home-confined? Yes ☐ No ☐

4. Has the person named above **during the last five years**:
   a. had any surgery or been advised to have surgery and has not done so? Yes ☐ No ☐
   b. been in a hospital, sanitarium, or other institution for observation, rest, diagnosis, or treatment? Yes ☐ No ☐
   c. used, or is now using, cocaine, barbiturates, amphetamines, marijuana or other hallucinatory drugs, heroin, opiates, or other narcotics, except as prescribed by a doctor? Yes ☐ No ☐
   d. been treated or counseled for alcoholism? Yes ☐ No ☐
   e. been treated or counseled by a psychologist or psychiatrist? Yes ☐ No ☐
   f. applied for or received disability income benefits or pension benefits on account of sickness or injury? Yes ☐ No ☐
   g. had life, disability, or health insurance declined, postponed, changed, rated-up, cancelled, or withdrawn? Yes ☐ No ☐
   h. been diagnosed as having, or treated by a member of the medical profession for, Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? Yes ☐ No ☐

5. **Within the last five years**, has the person named above been treated for, or had any trouble with, any of the following:

	Yes	No		Yes	No		Yes	No
a. Heart or chest pain?	☐	☐	g. Nervous or mental disorders?	☐	☐	m. Urinary system?	☐	☐
b. High blood pressure?	☐	☐	h. Arthritis or rheumatism?	☐	☐	n. Goiter or glands?	☐	☐
c. Abnormal pulse?	☐	☐	i. Ulcers or stomach disorders?	☐	☐	o. Pleurisy or asthma?	☐	☐
d. Cancer or tumors?	☐	☐	j. Intestines or kidneys?	☐	☐	p. Chronic diarrhea?	☐	☐
e. Diabetes?	☐	☐	k. Liver or gallstones?	☐	☐	q. Neuritis or sciatica?	☐	☐
f. Lungs?	☐	☐	l. Genital disorder?	☐	☐	r. Back or spinal disorders?	☐	☐

6. Does the person named above **currently have** any disorder, condition (including pregnancy), disease, or defect not shown above, and/or is he/she currently taking medication prescribed or provided by a medical or other practitioner for any disorder, condition (including pregnancy), disease, or defect? Yes ☐ No ☐

7. What are the full details of all "Yes" answers to each part of 3 through 6 above? Attach additional pages if needed.

Dependent's Name	Question Number and Letter	Specify illness or condition. Include reason for any check-up, doctor's advice, treatment, and/or medication	Date illness or condition began *Month Year*	Time lost from normal activities	Full recovery (if applicable) *Month Year*	Print full names, addresses, and telephone numbers of doctors and/or hospitals

Section 4

In all states except Arkansas, Colorado, Florida, Maine, Maryland, Massachusetts, Ohio, Oregon, New York, New Jersey, Tennessee, Virginia, Washington, and the District of Columbia: 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.

In Arkansas, Colorado, Maine, Maryland, New York, Ohio, Tennessee, and the District of Columbia: 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. In addition, any person who commits such a fraudulent act:

- may be subject to fines and confinement in prison under Arkansas law.
- is subject to penalties that may include imprisonment, fines, denial of insurance, and civil damages under Colorado law. Also, 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 of award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.
- may be subject to penalties that may include imprisonment, fines, or a denial of insurance benefits under Maine law.
- may be found guilty of insurance fraud under Maryland law.
- is subject to civil penalties, with such penalties not exceeding $5,000 and the stated value of the claim for each such violation under New York law. This notice ONLY applies to disability income coverage in New York.
- is guilty of insurance fraud under Ohio law.
- is subject to penalties including imprisonment, fines, and denial of insurance benefits under Tennessee law.
- may be subject to imprisonment and/or fines under the law of the District of Columbia.

In Florida: 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.

In New Jersey: Any person who includes false or misleading information on an application for insurance under a group contract is subject to criminal and civil penalties.

In Virginia: Any person who knowingly provides false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company has committed a crime. Penalties include imprisonment, fines, and denial of insurance benefits.

In Massachusetts: 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 may subject such person to criminal and civil penalties.

In Oregon: 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 may be a crime and may subject such person to criminal and civil penalties.

In Washington: 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.

I declare that, to the best of my knowledge and belief, the statements made in this application are complete and true. I agree that the coverage applied for is subject to the terms of the plan and shall become effective on the date or dates established by the plan, provided the evidence of good health is satisfactory.

Signature of Employee/Member ______________________ Date ____________

Section 5 — AUTHORIZATION For the Release of Information

To: (1) Any licensed physician, medical practitioner, hospital, clinic, or other medically related facility; (2) any insurance company or health maintenance organization (or similar type organization or institution); and (3) the Medical Information Bureau. So that eligibility for life or disability coverage can be determined, I authorize you to give any data or records you may have about me or my mental or physical health to The Prudential Insurance Company of America and/or its subsidiaries and, through it, to its reinsurers, authorized agents, and the Medical Information Bureau. This also applies to any dependent proposed for coverage in the application. This authorization is valid for the lesser of (1) two years after the effective date of any coverage issued in connection with it or (2) 30 months after the date it is signed. A photocopy of this form will be as valid as the original. The person(s) who signed this form (1) have received a copy of the "Medical Information Notice" and (2) may have a copy of this authorization if they wish.

Signature of Employee/Member ____________ Employee/Member Social Security No. ____________ Date ____________

Signature of Spouse (if applicable) ____________ Date ____________

Medical Information Notice

When we evaluate your request for insurance, the state of health of the person(s) for whom insurance is requested is, of course, extremely important to us. Consequently, we need to ask you questions about the health and medical history of each person. In addition, you are also requested to authorize any physician or hospital to provide us with reports, if necessary, about the health of each person. In some instances, we may require a physical examination.

Any information we obtain regarding a person's insurability will be treated as confidential. We may, however, make a brief report of it to the Medical Information Bureau (the Bureau), a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. When you apply for life, disability, or health insurance to any company, including Prudential, which is a member of the Bureau, or submit a claim for benefits to such a company, the Bureau will, on request, give the company the information in its files. We may reveal this information, as necessary, to a doctor, if we find a serious health problem that you do not know about. We may also reveal this information to persons conducting mortality or morbidity studies. We will, if you ask, give you a description of other circumstances when we disclose information about you without your prior authorization.

You have the right to see any of the personal information we collect about you and to make corrections if necessary. If you ask, we will furnish you with instructions on how to exercise this right. In addition, upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If the information came from the Bureau and you question the accuracy of the information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's Information Office is P.O. Box 105, Essex Station, Boston, Massachusetts 02112. 617-426-3660.

It is required that you be given this notice.
Please read it carefully and keep it for your records.

Prudential Financial

100936 4/2006-PDF

Group Life and Disability Income Medical Underwriting NOTICE

Thank you for choosing The Prudential Insurance Company of America (Prudential) for your insurance needs. Before we can issue coverage we must review your application/enrollment form. To do this, we need to collect and evaluate personal information about you. This notice is being provided to inform you of certain practices Prudential engages in, and your rights, with regard to your personal information. We would like you to know that:

- Personal information may be collected from persons other than yourself or other individuals, if applicable, proposed for coverage;
- This personal information as well as other personal or privileged information subsequently collected by us may in certain circumstances be disclosed to third parties without authorization;
- You have a right of access and correction with respect to personal information we collect about you; and
- Upon request from you, we will provide you with a more detailed notice of our information practices and your rights with respect to such information. Should you wish to receive this notice, please contact:

    The Prudential Insurance Company of America
    Group Medical Underwriting
    P.O. Box 8796
    Philadelphia, PA 19176

Any information we obtain regarding a person's insurability will be treated as confidential. We may, however, make a brief report of it to the Medical Information Bureau (the Bureau), a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. When you apply for life, disability, or health insurance to any company, including Prudential, which is a member of the Bureau, or submit a claim for benefits to such a company, the Bureau will, on request, give the company the information in its files. In addition, upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If the information came from the Bureau and you question the accuracy of the information in the Bureau's files, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is: P.O. Box 105, Essex Station, Boston, MA 02112, (617) 426-3660.

Please keep this notice for your records.