

General Information (Employee)			Effective Date of Coverage (for office use only) ____/____/____		
Last Name		First Name	Middle Initial	Social Security No.	
_____		_____	_____	____ - ____ - ____	
Address			City	State	Zip Code
_____			_____	_____	_____
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			Your Annual Earnings		(For Prudential Use Only)
			\$ _____		Control # 16000

Employee Group Universal Life

Coverage amount chosen: _____

Yes, I have smoked or used other forms of tobacco during the last 12 months.
 No, I have not smoked or used other forms of tobacco during the last 12 months.

Cancel coverage. **No change to coverage.**

Employee Certificate Fund: In addition to your insurance coverage, GUL provides an optional savings feature, which allows you to build cash value on a tax-deferred basis.

Complete the following (indicate "0" if you choose not to participate in this certificate fund):
 * Indicate extra monthly contribution to the certificate fund: \$ _____

Employee Optional Accidental Death & Dismemberment

If you have enrolled for GUL coverage you may choose to enroll for Optional AD&D coverage. Your Optional AD&D coverage amount will match the Group Universal Life coverage amount you've elected.

Yes, I wish to enroll for Optional AD&D coverage in an amount that matches my GUL coverage amount.
 Cancel coverage. **No change to coverage.**

Spouse/Domestic Partner Group Universal Life

Last Name	First Name	Middle Initial	Social Security No.	Spouse Date of Birth
_____	_____	_____	____ - ____ - ____	Month Day Year ____/____/____

Coverage amount chosen: \$ _____

Yes, my spouse has smoked or used other forms of tobacco during the last 12 months.
 No, my spouse has not smoked or used other forms of tobacco during the last 12 months.

Cancel coverage. **No change to coverage.**

Spouse Certificate Fund: In addition to your insurance coverage, GUL provides an optional savings feature, which allows you to build cash value on a tax-deferred basis.

Complete the following (indicate "0" if you choose not to participate in this certificate fund):
 * Indicate extra monthly contribution to the certificate fund: \$ _____

Spouse/Domestic Partner Optional Accidental Death & Dismemberment

If your Spouse/Domestic Partner elects Optional AD&D coverage, the amount of the Optional AD&D coverage will match his/her Group Universal Life coverage amount.

Yes, I wish to enroll for Optional AD&D coverage in an amount that matches my GUL coverage amount.
 Cancel coverage. **No change to coverage.**

Child(ren) Dependent Term Life

You must be enrolled in either Employee or Spouse GUL to elect coverage for your dependents.

\$10,000
 Cancel coverage. **No change to coverage.**

Youngest Child's Date of Birth: ____/____/____



Acceptance or Waiver of Coverage

Indicate your acceptance or waiver of coverage below, sign and date this form, and return it as instructed. If you have elected any coverages, you will be receiving a Booklet-Certificate with complete plan information. Once approved, your coverage will be effective provided you are actively at work on the effective date.

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 good health satisfactory to Prudential for myself and/or my dependents. I declare the statements above are true and understand it is the basis for determining my contribution for coverage.

I do not wish to enroll for 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 evidence of good health satisfactory to Prudential for myself and/or my dependents.

For residents of all states except New Jersey, New York, Pennsylvania and Virginia; 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.

FLORIDA RESIDENTS – Any person 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 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 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.

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. There is no administrative fee to accelerate death benefits. The accelerated amount is not discounted.

Employee Signature _____ Date (Month, Day, Year) _____