The Prudential Insurance Company of America - Enrollment and Beneficiary Form

751 Broad Street• Newark, NJ 07102

NCPERS \$16 PLAN Control No.: 92860

Please submit your complete enrollment form to your employer. Your employer will begin payroll deductions and forward your enrollment information to Member Benefits. Questions? Call 1-800-525-8056.

FOR EMPLOYER: Please complete this section. Additionally, form for complete information. All sections. The Prudential Insurance Company of Am Coverage Start Date/_1_/	s must be completed in order for erica to process claims. (Must be 1st of Month)	Return completed for Member Benefits PO Box 17639 Jacksonville, FL 323 1-800-525-8056 Email: NCPERS@me	
Member Information	D New Member Enrollment	D Open Enrollment	D Change of Beneficiary
Last Name	First Name	MI	:
Street Address	City	State	ZIP code
Social Security Number	Primary Phone Number	Your Date	e of Birth (mm/dd/yyyy) /
Actively at wo *Active Work Requirement: A requirement the predetermined by the member's Public Emp	•	normally required by the em	nployer or as
I declare the above statements and answers a plan (or plans) issued by The Prudential II Retirement Systems (NCPERS), in which I wages amounts equal to the contributions reprudential. A photographic copy of this author of the month following payment of my contributions are not actively at work on the coverage efficies unable to the coverage efficies under	nsurance Company of America (Pruc vill participate upon becoming insure equired for me toward the premiums norization shall be as valid as the origonation through payroll deductions. I usective date. Instead, my coverage will	dential) to the National Coned. I hereby authorize my offer Group Insurance under tinal. The effective date of understand that my membe	nference on Public Employee employer to deduct from my r the NCPERS plan issued by coverage will be the first day r coverage will be delayed if

Member Information			
Last Name	First Name	MI	Social Security Number
	ny person who knowingly and with intent alse, incomplete, or misleading informatio		y insurer files a statement of claim or an
insurance or statement of clamaterial thereto, commits a	aim containing any materially false inform	nation, or conceals for the purpos e, and shall also be subject to a c	pany or other person files an application for se of misleading, information concerning any fact civil penalty not to exceed five thousand dollars and disability income coverage.
	requires insurers to provide the follow at Insurance and/or Critical Illness co		being offered Accidental Death and
FOR MAJOR MEDIC ESSENTIAL COVERA BENEFITS PROVIDED	AL COVERAGE. LACK OF MA. GE) MAY RESULT IN AN ADE BY THIS POLICY CANNOT B PLEASE REVIEW THE BENEFI	JOR MEDICAL COVERAC DITIONAL PAYMENT WI E COORDINATED WITH	CE AND IS NOT A SUBSTITUTE GE (OR OTHER MINIMAL ITH YOUR TAXES. ALSO, THE THE BENEFITS PROVIDED BY POLICY CAREFULLY TO AVOID
I have read and understa	nd the terms and requirements of th	e fraud warnings included o	n the last page of this form.
Member Signature (Sign	in ink.)		Date Signed
years of age or older for Dep your eligible children age 18	endent Life and/or Accidental Death and years or older must consent to such cover	Dismemberment Insurance covera rage by signing and dating this co	spouse, domestic partner, and/or eligible child 18 age, your spouse, domestic partner, and/or each of nsent in the appropriate space(s) below. Coverage ess and until the requisite consent is provided.
Spouse/Domestic Partne	r Signature (Sign in ink.)		Date Signed
Child Signature (Sign in i	nk.)		Date Signed
Child Signature (Sign in i	nk.)		Date Signed
Please indicate your Prin	nary and Contingent beneficiary des	signations on the next page.	

Primary and Contingent Beneficiary Designations

Last Name	First Name	I	MI	Social Security Number	
Member Beneficiary De	esignations (to be completed l	by member or a	assignee, if assign	ed)	
please complete the corresponding one primary beneficiary is designate	ary beneficiary. Use a separate sheet if you wa fields. Do not name a beneficiary for Depende ad, settlement will be made in equal shares to ficiary, or no beneficiary survives the insured,	ent Group Decreasing o the designated bene	Term Life coverage; these be ficiaries (or beneficiary) who	nefits are paid to you while living. If more than are then still living, unless their shares are	
Primary Beneficiary					
Last Name	First Name	MI		Telephone Number	
Social Security Number	Date of Birth	te of Birth Relationship		Percentage	
Street Address	City	State		ZIP	
	,				
Check one, if applicable:	☐ Trust ☐ Estate ☐ Co	☐ Trust ☐ Estate ☐ Corporation Entity Name		-	
Tax ID #/Tax Exempt #	Creation/Incorporation/Formation	Date	Telephone Number	Percentage	
			0	710	
Street Address	City		State	ZIP	
	esignation — Death benefits will be paid gent beneficiaries. If designating a Trust, Esta			iciary(ies) is not alive. Use a separate sheet if y ling fields.	
ast Name	First Name	MI		Telephone Number	
2 10 2 11	D ((B))	D. I. C.			
Social Security Number	Date of Birth	Relation	iship	Percentage	
Street Address	City	State		ZIP	
Check one, if applicable:	☐ Trust ☐ Estate ☐ Co	☐ Trust ☐ Estate ☐ Corporation Entity N		ity Name	
Tax ID #/Tax Exempt #	Creation/Incorporation/Formation	Creation/Incorporation/Formation Date		Percentage	
Street Address	City	City		ZIP	
	<u>'</u>		!	<u> </u>	
Nember Sianature (Sian in	ı ink.)			Date Signed	

The plan is administered by Member Benefits. Member Benefits and Gallagher Benefit Services, Inc. are not affiliates of Prudential.

Group Decreasing Term Life, Dependent Group Decreasing Term Life, and Accidental Death and Dismemberment Insurance coverages are issued by The Prudential Insurance Company of America, a Prudential Financial company, 751 Broad Street, Newark, NJ 07102. 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. California COA # 1179, NAIC # 68241. Contract Series: 83500.

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For residents of all states except Alabama, Arkansas, the District of Columbia, Florida, Kentucky, Louisiana, Maine, Maryland, New Jersey, New York, North Carolina, Pennsylvania, Puerto Rico, 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 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 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.

ARKANSAS, DISTRICT OF COLUMBIA, LOUISIANA and RHODE ISLAND 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.

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 and 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.

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.

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.

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.

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.

VIRGINIA RESIDENTS — Any person who, with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

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." You may wish to seek professional tax advice before exercising this option.



