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 ______________________________________________
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

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 ☐

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 = $___________

Survivor Benefits Life

Current Amount Inforce + Addt’l or Initial Amount Requested = Total Amount

Spouse $__________________/mo + $__________________/mo = $___________

Child $__________________/mo + $__________________/mo = $___________

Weekly Disability Income/Accident & Sickness Benefit

Amount $________________________
**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  19101**

   **This form can also be sent by fax 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.

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### Part B

**Employee/Member Information**

**Section 1**

1. Employee/Member First Name
   
2. Employee/Member Social Security Number

3. Employee/Member Phone Number


   City State ZIP Code

5. E-mail Address

**Section 2**

6. Date of Birth

7. Birth Place

8. Sex
   - Male
   - Female

9. Height

10. Weight

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

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.

<table>
<thead>
<tr>
<th>Question Number and Letter</th>
<th>Specify illness or condition. Include reason for any check-up, doctor's advice, treatment, and/or medication</th>
<th>Date illness or condition began Month Year</th>
<th>Time lost from normal activities</th>
<th>Full recovery (if applicable) Month Year</th>
<th>Print full names, addresses, and telephone numbers of doctors and/or hospitals</th>
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Section 3

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

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<tr>
<th>Full Name</th>
<th>Social Security Number</th>
<th>Relationship to You</th>
<th>Date of Birth</th>
<th>Place of Birth</th>
<th>Height</th>
<th>Weight</th>
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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?  Samoa ☐  No ☐
   b. been in a hospital, sanitarium, or other institution for observation, rest, diagnosis, or treatment?  Samoa ☐  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?  Samoa ☐  No ☐
   d. been treated or counseled for alcoholism?  Samoa ☐  No ☐
   e. been treated or counseled by a psychologist or psychiatrist?  Samoa ☐  No ☐
   f. applied for or received disability income benefits or pension benefits on account of sickness or injury?  Samoa ☐  No ☐
   g. had life, disability, or health insurance declined, postponed, changed, rated-up, cancelled, or withdrawn?  Samoa ☐  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)?  Samoa ☐  No ☐

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

   a. Heart or chest pain?  ☐  ☐
   b. High blood pressure?  ☐  ☐
   c. Abnormal pulse?  ☐  ☐
   d. Cancer or tumors?  ☐  ☐
   e. Diabetes?  ☐  ☐
   f. Lungs?  ☐  ☐
   g. Nervous or mental disorders?  ☐  ☐
   h. Arthritis or rheumatism?  ☐  ☐
   i. Ulcers or stomach disorders?  ☐  ☐
   j. Intestines or kidneys?  ☐  ☐
   k. Liver or gallstones?  ☐  ☐
   l. Genital disorder?  ☐  ☐
   m. Urinary system?  ☐  ☐
   n. Goiter or glands?  ☐  ☐
   o. Pleurisy or asthma?  ☐  ☐
   p. Chronic diarrhea?  ☐  ☐
   q. Neuritis or sciatica?  ☐  ☐
   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.

<table>
<thead>
<tr>
<th>Dependent's Name</th>
<th>Question Number and Letter</th>
<th>Specify illness or condition. Include reason for any check-up, doctor's advice, treatment, and/or medication</th>
<th>Date illness or condition began Month Year</th>
<th>Time lost from normal activities Month Year</th>
<th>Full recovery (if applicable) Month Year</th>
<th>Print full names, addresses, and telephone numbers of doctors and/or hospitals</th>
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Section 4

In all states except Arkansas, Colorado, Maine, Maryland, Massachusetts, Ohio, Oregon, New York, New Jersey, Tennessee, Virginia, 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 Ohio 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 civil 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.

I declare that, to the best of my knowledge and belief, the statements made in this application are complete and true. I certify that I have read, or had read to me, the completed application, and I realize that any false statement or misrepresentation in this application may result in loss of coverage under the plan. 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.

Any life insurance I am applying for will or will not replace existing life insurance.

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, an applicant or a person authorized to act on behalf of the applicant, (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, 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 Medical Information 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 which 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 Medical Information 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.