



Enrollment Form

Please print all information clearly in the sections below and return in the enclosed postage-paid envelope. Coverage will begin on the first day of the month after collection of one full monthly payroll deduction, provided you are actively at work. A disability that begins during the first 12 months of coverage and is due to a pre-existing condition is excluded. Your monthly deduction will be based on the benefit amount you elect.

NJEA Member Information

Last Name	First Name	Middle I.	Date of Birth (Mo, Day, Yr) / /	Social Security Number - -	
Home Address—Street		City		State	ZIP Code
Home Phone Number ()	Employment Date (Mo, Day, Yr) / /	Annual Salary \$	Occupation		Sex <input type="checkbox"/> M <input type="checkbox"/> F
Present School District Name	County	Name of School	District Last Year	County Last Year	

Are you employed at least 15 hours per week? Yes No

Are you actively at work on the date of this enrollment? Yes No

Are you an active NJEA member? Yes No If no, please call 609-599-4561 for membership information.

Are you returning from a leave of absence? Yes No If yes, please explain:

Plan Information

The maximum Monthly Benefit Amount must be in \$100 increments from \$500 to \$6,500 but not more than 66 2/3% of your salary (from the Board of Education, or from NJEA if a NJEA employee). If the Monthly Benefit Amount you indicate below exceeds your allowable maximum, your Monthly Benefit Amount will be limited to your maximum. Please note that the monthly benefit amount may be reduced by other sources.

New Enrollment **Plan Change** **District Transfer**

<input type="checkbox"/> PruProtect (disability coverage up to 6 months) Monthly Benefit Amount: \$ _____	<input type="checkbox"/> PruProtect Two-Year (disability coverage up to 2 years) Monthly Benefit Amount: \$ _____	<input type="checkbox"/> PruProtect Plus (disability coverage up to age 65) Elimination Period: <input type="checkbox"/> 14 Days <input type="checkbox"/> 30 Days <input type="checkbox"/> 90 Days <input type="checkbox"/> 180 Days Monthly Benefit Amount: \$ _____
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Authorization

I am enrolling for coverage and authorize my employer to deduct my contributions for the NJEA Endorsed Disability Insurance Program from my earnings until further notice. I understand that if I desire to increase the amount of my insurance, I may be required to furnish evidence of good health. A disability that begins during the first 12 months of coverage and is due to a pre-existing condition is excluded. I declare the statements above are true and understand they are the basis for determining my monthly contribution for coverage.

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 notice ONLY applies to disability income coverage.

X

NJEA Member Signature

Date (Mo, Day, Yr)

For Company Use Only:

School District ID#	School Meeting Date (Mo/Day/Yr) / /	Effective Date (Mo/Day/Yr) / /	Initial Monthly Deduction \$	Representative Number
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Important Notice

For residents of all states except Florida, New Jersey, New York, Pennsylvania, 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.

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.

Questions? Please call 800-727-3414

Enrollment services provided by Educators Insurance Services, Inc., 4000 Rte. 66-First Floor, Tinton Falls, NJ 07753

PruProtect, PruProtect Two-Year and PruProtect Plus Short- and Long-term Disability coverages are issued by The Prudential Insurance Company of America, 751 Broad Street, Newark, NJ 07102. Please refer to the Booklet-Certificate for all plan details, including any exclusions, limitations, and restrictions, which may apply. If there is a discrepancy between this document and the Group Contract issued by Prudential, the terms of the Group Contract will govern.

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