Please print and send completed enrollment form to Educators Insurance Services by mail or fax

Prudential

New Jersey School Administrators Group Disability Insurance Plans

Issued by The Prudential Insurance Company of America

Questions? Please call 800-913-8631

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.*

Applicant 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 ☐ M ☐ F	
Email Address					

Present School District Name	County	Name of School	District Last Year	Country Last Year

Are you employed at least 20 hours per week as a NJ school administrator? ☐ Yes ☐ No

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

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

Plan Information

The Monthly Benefit Amount must be selected from the schedule of available amounts. For the Extended Disability Insurance Plan, the Monthly Benefit Amount must be in $100 increments from $500 to $10,000. The maximum Monthly Benefit Amount may not be more than 66⅔% of your monthly salary. If the Monthly Benefit Amount you indicate below exceeds your monthly allowable maximum, your Monthly Benefit Amount will be limited to the highest available amount that does not exceed your maximum.

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

☐ **New!** Extended Disability Insurance Plan
(combined short-term and long-term)
Elimination Period: ☐ 14 Days ☐ 30 Days ☐ 60 Days ☐ 90 Days ☐ 180 Days
Monthly Benefit Amount: $_____

-or-

☐ Short-Term Disability Insurance Plan
Monthly Benefit Amount: $_____

☐ Sick Leave Coordinated Disability Insurance Plan
Monthly Benefit Amount: $_____

Authorization

I am enrolling for coverage and authorize my employer to deduct my contributions for the New Jersey School Administrators Group Disability Insurance Plans from my earnings until further notice. I understand if I desire to increase the amount of my insurance, I may be required to furnish proof of good health satisfactory to Prudential. A disability that begins during the first 12 months of coverage and is due to a pre-existing condition is excluded. A pre-existing condition is an injury or sickness for which you received medical treatment, consultation, care, or services including diagnostic measures; took prescribed drugs or medicines; or followed treatment recommendations in the three months prior to your effective date of coverage or the date an increase in coverage would otherwise be available. 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.

I have read and understand the terms and requirements of the fraud warnings included as part of this form.

✘ _____ / / _____

Applicant's 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

See additional state notices on page 2.

Important Notice

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.

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 800-913-8631

Education, enrollment, and services provided by Educators Insurance Services, Inc., 4000 Route 66, First Floor, Tinton Falls, NJ 07753.

Fax: 732-918-2001

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