Prudential

# NEA GROUP TERM LIFE ENROLLMENT FORM

COVERAGE ISSUED BY THE PRUDENTIAL INSURANCE COMPANY OF AMERICA

**80267-Q GTNJ2223** **ANY QUESTIONS?** Please call 1-800-704-1365 **077042010101**

**Please use blue or black ink only. ALL FIELDS ARE REQUIRED. An incomplete enrollment form will delay the processing of your form.**

## 1. Please tell us about yourself:

**Rep Code: 517** Member's Soc. Security # ____-____-____ Current Coverage Amount (if applicable) $ _____

First and Last Name _____ Street Address _____

City _____ State _____ Zip _____ Date of Birth ____/____/____ Gender ☐ Female ☐ Male

Height ____ ft. ____ in. Weight _____ lbs. Phone # (____) ____-____ Home E-mail _____

## 2. Please check who you want to protect:

| **Member only:** | **Add my spouse*:** |
|---|---|
| ☐ **$100,000** ☐ **$50,000** | ☐ **$50,000** ☐ **$25,000** |
| ☐ **$200,000** | ☐ **$100,000** |
| **Tobacco product use in the past 24 months:** ☐ Yes ☐ No (If not answered you will be billed higher smoker rates.) | **Tobacco product use in the past 24 months:** ☐ Yes ☐ No (If not answered you will be billed higher smoker rates.) |

***Members and/or *spouse must be age 64 or under to apply for $100,000 or $50,000 of coverage on this form. Must be age 54 or under to apply for $200,000 of coverage on this form.***

*Includes domestic partnerorregistered domestic partner.Spousecannot enrollfor Group Term Life coverage unless member enrolls or already has Group Term Life coverage. Spouse/Domestic Partner coverage amount cannot exceed 50% of the Member's coverage amount.

**Add my eligible child(ren) Coverage** ☐ Yes ☐ No
**Coverage Amount: $10,000 each child**
Number of eligible children ____

| Name | Date of Birth |
|---|---|
| | |
| | |
| | |
| | |

(Complete only if requesting coverage for spouse)

*Spouse's Name _____ Date of Birth ____/____/____ ☐ Female ☐ Male

Height ____ ft. ____ in. Weight _____ lbs. Spouse's Soc. Security # ____-____-____

## 3. Select your payment option:

☐ **Pay now electronically:** ☐ Mastercard ☐ Visa Account #: _____ Exp. Date: _____
☐ Checking account Bank's Transit number _____ Bank Account #: _____

I authorize the NEA Members Insurance Trust to automatically post my monthly premium to my account or credit card on the first business day of the month. I also authorize my financial institution to pay from my account accordingly. If my premium changes, **I will be notified** and my payment amount will be adjusted accordingly.

☐ **Bill me.** You will be billed quarterly, which may be slightly higher than three times the monthly rate.

## 4. Please read, complete, sign and date:

**Authorization for the Release of Information. This authorization is intended to comply with the HIPAA Privacy Rule.** I authorize and instruct any health plan, physician, health care professional, hospital, clinic, laboratory, medical facility, pharmacy benefit manager, retail pharmacy, clearinghouse, data warehouse or other comparable organization that aggregates and maintains pharmacy data, or other health care provider that has provided treatment or services to me within the past 5 years ("My Providers") to disclose my entire medical record and any other health information concerning me to The Prudential Insurance Company of America ("Prudential"). This includes information on the diagnosis and treatment of Human Immunodeficiency Virus (HIV) infection (In Vermont and Wisconsin, this information is excluded) and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes. By my signature below, I acknowledge that any agreements I have made to restrict the disclosure of health information do not apply to this Authorization and I instruct any of My Providers to release and disclose my entire medical record without restriction, including without limitation any restrictions on health care items or services for which a health care provider has been paid out of pocket in full.

This health information is to be disclosed under this Authorization so that Prudential may: 1) underwrite an application for coverage and make risk determinations; 2) administer coverage; and 3) conduct other legally permissible activities that relate to any coverage I have or have applied for with Prudential. This Authorization shall remain in force for 24 months following the date of my signature below, and a copy of this Authorization is as valid as the original.

I understand that I have the right to revoke this Authorization in writing, at any time, by sending a signed request for revocation to The Prudential Insurance Company of America; Group Medical Underwriting, P.O. Box 8796, Philadelphia, PA 19176, Attention: Senior Medical Underwriting Consultant. I understand that such a revocation is not effective to the extent that Prudential has taken action in reliance on this Authorization or to the extent that Prudential has a legal right to contest a claim under the insurance contract or to contest the contract itself. I understand that any information that is disclosed pursuant to this authorization may be redisclosed to other parties and will not be protected by the HIPAA Privacy Rule. (In Montana only, I may request a record of any subsequent disclosures of protected health information). I understand that if I refuse to sign this Authorization to release my entire medical record and any other health information concerning me, Prudential may not be able to process an application for coverage. I understand that I have the right to request and receive a copy of this Authorization.

I/We declare by signing this form that all the information I/We have provided is complete and true, and understand that it is the basis of providing insurance under a contract(s) issued by The Prudential Insurance Company of America to the NEA Members Insurance Trust. **I/We have never been diagnosed with, or taken medications for any of the following: heart disease or disorder, high blood pressure, cancer or tumors, lung, liver, or kidney disease or disorder, diabetes, disease or disorder of the brain or nervous system, disorder or disease of the immune system or mental disorder.** I certify by signing this Enrollment Form that I am currently an Active, Education Support, Life, Retired, Reserved, Student, Substitute, or Staff member in good standing of the National Education Association. I/We understand that if any statement is found to be inaccurate, it may adversely impact my benefits. I/We understand that if ineligible for the coverage amount requested, I/We will be issued any amount of coverage for which I /We am/are approved.

**We cannot process your Enrollment Form without your signature. Please indicate the date the Enrollment Form is signed.**

X _____ _____
Member's Signature Today's Date (MM/DD/YYYY)

X _____ _____
*Spouse's Signature (if enrolling) Today's Date (MM/DD/YYYY)

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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. **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.

If you are approved for coverage, you may change your payment mode to semi-annual or annual at any time. Monthly billing is available through Electronic Funds Transfer (EFT) or Credit Card. You have 30 days to review your Certificate of Insurance. If you are in any way dissatisfied, you can return it within this time period, as long as you have not submitted a claim. Your coverage is effective on the first day of the month following The Prudential Insurance Company of America's approval of your Enrollment Form. Subject to receipt of your first premium payment.

**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.**

**Please Note: You can name your Beneficiary once you receive your issuance materials. Assign your Beneficiary online at neamb.com/myaccount, or complete and return the Beneficiary Designation Form included in your issuance packet. Any amount of insurance for which there is no Beneficiary at your death will be payable to the first of the following: (a) surviving spouse or registered domestic partner; (b) surviving child(ren) in equal shares; (c) surviving parents in equal shares; (d) surviving siblings in equal shares; (e) estate.**

**Simply mail your Enrollment Form in the enclosed prepaid envelope to:**
**Educators Insurance Services, 4000 Route 66, Suite 144 Tinton Falls, NJ 07753-7300**
**or fax enrollment form to 732 918-2001**

nea Members Insurance Trust

NEA Group Term Life Insurance is issued by The Prudential Insurance Company of America, Newark, New Jersey. 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 Prudential, the terms of the Group Contract will govern. Contract Series 83500.