



**Prudential**

# NJEA INCOME PROTECTION PROGRAM

## Disability, Hospital Indemnity, and Critical Illness Insurance Plans

Issued by The Prudential Insurance Company of America

### Enrollment Form

**Questions? Please call 800-727-3414, Option 3 Fax: 732-918-2001**

**Mailing:** Print all information clearly in the sections below and return in the enclosed postage-paid envelope.

**Faxing:** Make sure to fax the front and back side of the form.

\* A **Disability or Hospital Indemnity claim** that begins during the first 12 months of coverage and is due to a pre-existing condition is excluded.

\* A **Critical Illness** that begins during the first 6 months of coverage and is due to a pre-existing condition is excluded.

### NJEA Member Information

Coverage will begin on the first day of the month after collection of one full monthly payroll deduction, provided you are actively at work. Your monthly deduction will be based on the benefit amount you elect.

|                                                                                                                                                                                                                                                        |  |                                      |  |                |                                    |                    |                               |                                                                                |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------|--|----------------|------------------------------------|--------------------|-------------------------------|--------------------------------------------------------------------------------|
| Last Name                                                                                                                                                                                                                                              |  | First Name                           |  | MI             | Date of Birth (Mo./Day/Yr.)<br>/ / |                    | Social Security Number<br>- - |                                                                                |
| Home Address — Street                                                                                                                                                                                                                                  |  |                                      |  | City           |                                    | State              |                               | ZIP Code                                                                       |
| Phone Number<br>( )                                                                                                                                                                                                                                    |  | Employment Date (Mo./Day/Yr.)<br>/ / |  | Annual Salary  |                                    | Occupation         |                               | Sex Assigned at Birth<br><input type="checkbox"/> M <input type="checkbox"/> F |
| Email Address                                                                                                                                                                                                                                          |  |                                      |  |                |                                    |                    |                               |                                                                                |
| Present School District Name                                                                                                                                                                                                                           |  | County                               |  | Name of School |                                    | District Last Year |                               | County Last Year                                                               |
| Are you an active NJEA member employed at least 15 hours per week? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please call 609-599-4561 for membership information.                                                                |  |                                      |  |                |                                    |                    |                               |                                                                                |
| Are you actively at work on the date of this enrollment? <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                      |  |                                      |  |                |                                    |                    |                               |                                                                                |
| Are you returning from a leave of absence? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain:                                                                                                                            |  |                                      |  |                |                                    |                    |                               |                                                                                |
| <input type="checkbox"/> New Disability Enrollment <input type="checkbox"/> New Critical Illness Enrollment <input type="checkbox"/> New Hospital Indemnity Enrollment <input type="checkbox"/> Plan Change <input type="checkbox"/> District Transfer |  |                                      |  |                |                                    |                    |                               |                                                                                |

#### Disability Insurance Plan

The maximum Monthly Benefit Amount must be in \$100 increments from \$500 to \$7,500 but not more than 66⅔% of your salary. 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.

|                                                                                                                                                                                                          |                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> PruProtect (disability coverage up to 6 months)<br>Elimination Period:<br><input type="checkbox"/> 14 Days <input type="checkbox"/> 60 Days<br>Monthly Benefit Amount: \$ _____ | <input type="checkbox"/> PruProtect Two-Year (disability coverage up to 2 years)<br>Elimination Period:<br><input type="checkbox"/> 14 Days <input type="checkbox"/> 60 Days<br>Monthly Benefit Amount: \$ _____ | <input type="checkbox"/> PruProtect Plus (disability coverage up to age 65)<br>Elimination Period:<br><input type="checkbox"/> 14 Days <input type="checkbox"/> 30 Days <input type="checkbox"/> 90 Days <input type="checkbox"/> 180 Days<br>Monthly Benefit Amount: \$ _____ |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

#### Hospital Indemnity Insurance Plan

|                                                                                                               |                                                                                                             |                                                                                                            |
|---------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> <b>Employee:</b> <input type="checkbox"/> Enhanced <input type="checkbox"/> Standard | <input type="checkbox"/> <b>Spouse:</b> <input type="checkbox"/> Enhanced <input type="checkbox"/> Standard | <input type="checkbox"/> <b>Child:</b> <input type="checkbox"/> Enhanced <input type="checkbox"/> Standard |
|---------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------|

#### Critical Illness Insurance Plan

|                                                                     |                                                                 |                                                               |
|---------------------------------------------------------------------|-----------------------------------------------------------------|---------------------------------------------------------------|
| <input type="checkbox"/> <b>Employee:</b> Employee amount: \$ _____ | <input type="checkbox"/> <b>Spouse:</b> Spouse amount: \$ _____ | <input type="checkbox"/> <b>Child:</b> Child amount: \$ _____ |
|---------------------------------------------------------------------|-----------------------------------------------------------------|---------------------------------------------------------------|

#### Authorization

I am enrolling for coverage and authorize my employer to deduct from my earnings until further notice my contributions for insurance under a contract issued by The Prudential Insurance Company of America. I understand if I desire to increase the amount of my insurance or insurance for my Dependent(s), I may be required to furnish evidence of good health for myself and/or my dependent(s). I declare that the statements above are true, and understand they are the basis for determining my monthly contribution for coverage. I have received and reviewed the required Critical Illness Outline of Coverage prior to making my enrollment elections.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 NJEA Member Signature Date Signed (Mo./Day/Yr.)

**The Group Certificate provides limited benefits. Review your Group Certificate carefully.**

#### For Company Use Only:

|                     |                                          |                                     |                                 |                              |
|---------------------|------------------------------------------|-------------------------------------|---------------------------------|------------------------------|
| School District ID# | School Meeting Date (Mo./Day/Yr.)<br>/ / | Effective Date (Mo./Day/Yr.)<br>/ / | Initial Monthly Deduction<br>\$ | Representative Number<br>116 |
|---------------------|------------------------------------------|-------------------------------------|---------------------------------|------------------------------|

**ARIZONA RESIDENTS - For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.**

For residents of all states except Alabama, Alaska, Arizona, Arkansas, California, Delaware, the District of Columbia, Florida, Idaho, Indiana, Kentucky, Louisiana, Maine, Maryland, Minnesota, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Puerto Rico, Rhode Island, Tennessee, Texas, Utah, Vermont, Virginia, Washington and West Virginia; **GENERIC 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 RESIDENT -** 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.

**ALASKA RESIDENTS -** A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

**ARKANSAS, DISTRICT OF COLUMBIA, LOUISIANA, MASSACHUSETTS, RHODE ISLAND, and WEST VIRGINIA 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 in insurance is guilty of a crime and may be subject to fines and confinement in prison.

**CALIFORNIA and TEXAS RESIDENTS -** For your protection, California and Texas law requires the following to appear on this form. Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

**COLORADO RESIDENTS -** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. 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 or aware payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

**DELAWARE RESIDENTS -** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

**FLORIDA RESIDENTS -** 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.

**IDAHO RESIDENTS -** Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement containing any false, incomplete, or misleading information is guilty of a felony.

**INDIANA RESIDENTS -** A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

**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, TENNESSEE, VIRGINIA, and WASHINGTON RESIDENTS -** It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. 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.

**MINNESOTA RESIDENTS -** A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

**NEW HAMPSHIRE RESIDENTS -** Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638.20.

**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.

**NEW MEXICO 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 CIVIL FINES AND CRIMINAL PENALTIES.

**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 accident and disability income coverage.

**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 or misleading information concerning a fact or matter material to the claim may be guilty of a Class H felony.

**OHIO RESIDENTS -** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

**OKLAHOMA RESIDENTS - WARNING:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete, or misleading information is guilty of a felony.

**OREGON RESIDENTS -** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurance company, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

**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 fact material 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.

**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.

**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.

**This coverage is not health insurance coverage (often referred to as "Major Medical Coverage").**

PruProtect Six-Month, PruProtect Two-Year and PruProtect Plus short and long term disability insurance coverages are issued by The Prudential Insurance Company of America, a New Jersey 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. Contract provisions may vary by state. Contract series: 83500 (Term Life), California COA# 1179, NAIC# 68241

A Critical Illness that begins during the first 6 months of coverage and is due to a pre-existing condition is excluded.

**NOTICE TO CONSUMER: THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMAL ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES. ALSO, THE BENEFITS PROVIDED BY THIS POLICY CANNOT BE COORDINATED WITH THE BENEFITS PROVIDED BY OTHER COVERAGE. PLEASE REVIEW THE BENEFITS PROVIDED BY THIS POLICY CAREFULLY TO AVOID A DUPLICATION OF COVERAGE.**

Group Critical Illness Insurance coverage is a limited benefit policy issued by The Prudential Insurance Company of America, a Prudential Financial company, 751 Broad Street, Newark, NJ 07102. Prudential's Critical Illness Insurance is not a substitute for medical coverage that provides benefits for medical treatment, including hospital, surgical and medical expenses and does not provide reimbursement for such expenses. The Booklet-Certificate contains all details, including any policy 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. A more detailed description of the benefits, limitations, and exclusions applicable are contained in the Outline of Coverage provided at time of enrollment. Please contact Prudential for more information. Contract provisions may vary by state. California COA #1179, NAIC #68241. Contract Series: 114774.

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