The Prudential Insurance Company of America

751 Broad Street, Newark, New Jersey, 07102

Request for Coverage Form:
Return this completed form to:
Plan Administrator
Bollinger
400 Market Street, Suite 450
Philadelphia, PA 19106
Tel: 800-952-4050

WCBA
Westchester County Bar Association

Westchester County Bar Association
Term Life Enrollment Form

Please print all answers using black ink.

Control #: 49785

1 Member Information

First Name | MI | Last Name

Street | Apt.

City | State | ZIP code

Date of Birth (mm/dd/yyyy) | Social Security Number | Daytime Telephone Number

Sex: ☐ Male ☐ Female | Height: ft. in. | Weight: lbs. | Evening Telephone Number

E-Mail

2 Spouse or Domestic Partner Information

Complete if you are requesting coverage for your spouse or domestic partner.

Please check: ☐ Spouse ☐ Registered Domestic Partner ☐ Domestic Partner

First Name | MI | Last Name

Date of Birth (mm/dd/yyyy) | Social Security Number | Daytime Telephone Number

Sex: ☐ Male ☐ Female | Height: ft. in. | Weight: lbs. | Evening Telephone Number

3 Health Questions

Please answer these questions by checking "Yes" or "No."

	Member		Spouse or Domestic Partner (if applicable)	
	Yes	No	Yes	No
1. Within the last 12 months, have you smoked cigarettes?	☐	☐	☐	☐
2. Are you currently performing all the duties of your job for the number of hours required? If no, please explain:_____ You may attach additional sheets of paper if needed.	☐	☐	☐	☐
3. Within the last five years, have you been evaluated for, medically treated for, diagnosed with, taken medications for, or experienced symptoms of any of the following conditions:				
a. Disease or disorder of the heart, blood or circulatory system	☐	☐	☐	☐
b. High blood pressure	☐	☐	☐	☐
c. Cancer or tumors	☐	☐	☐	☐
d. Lung, respiratory or breathing disorders	☐	☐	☐	☐
e. Diabetes	☐	☐	☐	☐
f. Liver or kidney disorders	☐	☐	☐	☐
g. Gastrointestinal, stomach or intestine disorders, including ulcers or gallstones	☐	☐	☐	☐
h. Mental or nervous illness or disorder, alcoholism or drug addiction	☐	☐	☐	☐
i. Chronic pain or fatigue syndromes	☐	☐	☐	☐
j. Neurological disorders such as Multiple Sclerosis or Parkinson's Disease	☐	☐	☐	☐
k. Musculoskeletal disorders including arthritis, fractures, or carpal tunnel syndrome	☐	☐	☐	☐
Within the last five years have you been medically treated for, diagnosed with or taken medications for AIDS-Related Complex (ARC), Acquired Immune Deficiency Syndrome (AIDS) or any other immune deficiency disorder, such as Lupus (except HIV)?	☐	☐	☐	☐

3 Health Questions

continued from page 1

Member		Spouse or Domestic Partner (if applicable)		
Yes	No	Yes	No	
☐	☐	☐	☐	**4. Within the last five years,** have you been in a hospital or other institution for observation, rest, diagnosis or treatment?
☐	☐	☐	☐	**5. Within the last five years,** have you been attended by a doctor or licensed practitioner for anything other than a routine physical?
☐	☐	☐	☐	**6. Do you have** any known symptoms, physical or mental impairments not mentioned in the previous questions (except HIV)?
☐	☐	☐	☐	**7. Are you** taking any medication or being treated for any condition or disease not mentioned in the previous questions (except HIV)?

If you answered "Yes" to any of questions 3-7, please provide full details below.
(If more space is needed, please attach an additional sheet.)

Member	Spouse or Domestic Partner	Question Number	Date of Illness	Date of Full Recovery	Details of nature of illness, number of attacks, duration, severity, treatments and medications prescribed and taken	Names, complete addresses and phone numbers of physicians
☐	☐					
☐	☐					
☐	☐					

Primary Care Physician Information (for Member)

Name | Date last seen | Telephone

Address

Primary Care Physician Information (for Spouse)

Name | Date last seen | Telephone

Address

4 Coverage Amounts

Choose the type of coverage and amounts for which you are applying.

☐ **Life Insurance Plan**

Coverage Amounts *(please check one)*:

☐ $50,000 ☐ $100,000 ☐ $150,000 ☐ $200,000 ☐ $250,000 ☐ $300,000 ☐ $350,000 ☐ $400,000 ☐ $450,000 ☐ $500,000 ☐ $750,000 ☐ $1,000,000

Optional Coverage(s) Requested:

☐ Spouse or Domestic Partner Coverage Amount—
50% of Member's coverage amount up to $500,000

☐ Dependent Children Coverage (each dependent child is covered for ($10,000)

5 Beneficiary Information

A. Primary Beneficiaries I hereby revoke any previous designations of primary beneficiary(ies) and contingent beneficiary(ies), if any, and in the event of my death, designate the following:

First Name	MI	Last Name	Address (include city, state, ZIP)	Relationship	Social Security #	Phone #	Date of Birth	% Share

Total (Must equal 100%) **100%**

B. Contingent Beneficiaries

First Name	MI	Last Name	Address (include city, state, ZIP)	Relationship	Social Security #	Phone #	Date of Birth	% Share

Total (Must equal 100%) **100%**

6 Contribution Payment Basis

I request the following payment basis

[X] Semi-annual Direct Billing

AUTHORIZATION For the Release of Information. This authorization is intended to comply with the HIPAA Privacy Rule. I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, medical facility, or other health care provider that has provided payment, treatment, or services to me or on my behalf within the past 5 years ("My Providers") to disclose the entire medical record and any other health information concerning me and/or any dependent proposed for coverage in the application to The Prudential Insurance Company of America ("Prudential") and through it, to its reinsurers, authorized agents, and the MIB, Inc.. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection (In Vermont, 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 and/or drugs, but excludes psychotherapy notes. I also authorize the MIB, Inc. to release any data it may have about me and/or any dependent proposed for coverage to Prudential. By my signature below, I acknowledge that any agreements I or my dependents have made to restrict my health information do not apply to this Authorization and I instruct My Providers to release and disclose the entire medical record for me and/or my dependent without restriction. 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) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) 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 a revocation is not effective to the extent that Prudential has relied on this Authorization or to the extent that Prudential has a legal right to contest a claim under insurance coverage or to contest the coverage itself. I understand that any information that is disclosed pursuant to this Authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information. (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 the entire medical record for me and/or my dependent, Prudential may not be able to process an application for coverage, or if coverage has been issued, may not be able to make any benefit payments. I understand that I have the right to request and receive a copy of this Authorization.

Statement of Understanding: I (We) represent that all statements and answers made within or attached to this Request Form are true and complete to the best of my (our) knowledge and belief. I (We) understand that coverage shall be in effect only after all of these conditions have been met: this application has been approved by Prudential; the Contract has been issued while all persons to be insured thereunder are alive, and; the answers and statements in this application continue to be true and complete until the Effective Date. I (We) also understand that coverage will not take effect if the facts have changed. I (we) have also read and understand and agree to the additional terms, conditions and requirements as stated in the Authorization for the Release of Information and Important Notice sections. I (We) understand that completion of this application in no way implies that I (we) will be accepted for insurance coverage.

Date (mm/dd/yyyy)

X _____

Member Signature

Date (mm/dd/yyyy)

X _____

Spouse/Domestic Partner Signature (if applying for Spouse/Domestic Partner Coverage)

Important Notice: For residents of all states except New Jersey, Pennsylvania: 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 or 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 fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Accelerated Death Benefits: 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.

Beneficiary Designation: If you name more than one beneficiary, settlement will be made in equal shares to the designated beneficiaries (or beneficiary) that survive you, unless otherwise provided in the designation. If no named beneficiary survives you, settlement will be made to the first of the following: your (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.

Please keep this notice for your records.