

751 Broad Street, Newark, NJ 07102

Control #: 50164

Return this completed form to:
Virginia State Bar Members' Insurance Center
9954 Mayland Drive, Suite 2200, Richmond, VA 23233
Tel. 877-214-5239 Fax 855-862-8452

Please print all answers using black ink.

First Name															MI	Last Name																		
Street																														Apt.				
City															State					ZIP code														
Date of Birth (mm/dd/yyyy)										Social Security Number										Daytime Telephone Number														
Sex					Height					Weight					Evening Telephone Number																			
☐ Male ☐ Female					ft. in.					lbs.																								

Complete if you
are requesting
coverage for
your spouse.

First Name															MI	Last Name														
Date of Birth (mm/dd/yyyy)					Social Security Number					Daytime Telephone Number																				
Sex		Height		Weight		Evening Telephone Number																								
Male Female		ft. in.		lbs.																										

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

[illegible]

- 1. Within the last 12 months, have you smoked cigarettes?**
- 2. 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
 - l.** HIV, Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC) or any other immune deficiency disorder (such as Lupus)?
- 3. Within the last five years, have you been in a hospital or other institution for observation, rest, diagnosis or treatment?**
- 4. Within the last five years, have you been attended by a doctor or licensed practitioner for anything other than a routine physical?**
- 5. Do you have any known symptoms, physical or mental impairments not mentioned in the previous questions?**
- 6. Are you taking any medication or being treated for any condition, including pregnancy, or disease not mentioned in the previous questions?**

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Health Questions

continued from page 1

If you answered "Yes" to any of questions 2-6, please provide full details below.

(If more space is needed, please attach an additional sheet.)

Member	Spouse	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		

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Coverage Amounts

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

Life Insurance Plan (Coverage will be billed on a semi-annual basis.)

Coverage Amounts (please check one):

☐ \$1,000,000	☐ \$500,000	☐ \$350,000	☐ \$200,000	☐ \$100,000	☐ Other Amount*
☐ \$750,000	☐ \$400,000	☐ \$300,000	☐ \$150,000	☐ \$50,000	\$ _____

Optional Coverage(s) Requested: ☐ Spouse Coverage: Requested Coverage Amount: \$ _____
☐ Dependent Child Coverage (\$10,000 each child)

*Amount must be in a \$50,000 increment

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Beneficiary Designation

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:

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

B. Contingent Beneficiaries

Total (Must equal 100%) 100%

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

Total (Must equal 100%) 100%

(If more space is needed, please attach a separate sheet.)

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 coverage; and 4) 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, or a person authorized to act on my behalf, 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.

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 false, incomplete or misleading information is guilty of a felony of the third degree.

X

Member Signature

Date (mm/dd/yyyy)

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FOR INSURED WHO RESIDE IN MICHIGAN OR MINNESOTA ONLY: If you wish to enroll your spouse, domestic partner, and/or eligible child 18 years of age or older for Dependent Life and/or Accidental Death and Dismemberment Insurance coverage, your spouse, domestic partner, and/or each of your eligible children age 18 years or older must consent to such coverage by signing and dating this consent in the appropriate space(s) below. Coverage on your spouse, domestic partner, and/or eligible children age 18 or older will not become effective unless and until the requisite consent is provided.

X

Spouse/Domestic Partner Signature

Date (mm/dd/yyyy)

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X

Child Signature

Date (mm/dd/yyyy)

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X

Child Signature

Date (mm/dd/yyyy)

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Important Notice: For residents of all states except Alabama, Arkansas, 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 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. **Alabama Residents:** 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. **Arkansas, District of Columbia, Louisiana, and Rhode Island 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 fines and confinement in prison. **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 and Washington Residents:** Any person who knowingly provides false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company commits a crime. 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. **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. **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 information concerning a fact or matter material to the claim may be guilty of a class H felony. **Pennsylvania and 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 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. **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. **Virginia Residents:** Any person who, with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

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 your estate. The beneficiary named herein will be the beneficiary for your total amount of insurance coverage issued.

Please keep this notice for your records.

Member Term Life Coverage is issued by The Prudential Insurance Company of America, 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. 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 provision may vary by state. California COA #1179, NAIC 68241. Contract Series 83500.