

# **ENROLL NOW**

**Help Protect Your Loved Ones and Your Income**

**THE GENERAL CHURCH OF THE NEW JERUSALEM**

**Basic Life  
Basic Accidental Death and Dismemberment  
Long Term Disability  
Optional Life  
Optional Dependent Life**

**The Prudential Insurance Company of America**

751 Broad Street, Newark, New Jersey 07102

# THE GENERAL CHURCH OF THE NEW JERUSALEM

## Insurance Benefit Summary

Dear Valued Employee:

THE GENERAL CHURCH OF THE NEW JERUSALEM is very pleased to provide you with the following Insurance as employee benefits at no cost to you.

**Basic Term Life Insurance 2 times your base annual earnings to a maximum of \$450,000.**

**Basic Accidental Death & Dismemberment (AD&D) Insurance 2 times your base annual earnings to a maximum of \$450,000.**

**Long Term Disability benefits in the amount of 60% of your monthly pre-disability earnings to a maximum of \$5,000.**

Because you may need additional coverage, we offer you an opportunity to purchase optional coverage from The Prudential Insurance Company of America (Prudential) at competitive group rate. The pages that follow this letter describe the additional insurance that you may purchase.

Your coverage will begin on the effective date of coverage if you are actively at work. If you apply for an amount that requires evidence of good health, your coverage will be effective on the date of approval for the amount requiring evidence if you are actively at work on that date. Otherwise, your coverage will begin on the date you return to active work. See your Booklet-Certificate for details.

### Peace of Mind from Prudential

Prudential's resources, financial strength, and stability allow us to honor our long-term commitments. That means that we'll be here when you and your family need us. We've been a top insurance provider for over 130 years. Plus, we have the advanced technology and caring professionals to provide your beneficiaries with the kind of customer support they want and deserve. Our Customer Service Representatives are well-trained, knowledgeable professionals who can quickly answer your family's questions. By choosing Prudential, you give yourself peace of mind, knowing you are providing for your loved ones ([www.prudential.com](http://www.prudential.com)).

For more information about Prudential's Group Insurance, visit us online at: [www.prudential.com/gi](http://www.prudential.com/gi)

### Enrolling is easy!

Simply complete the following enrollment form and return it. Don't miss out on this valuable employee benefit!

## What does group life insurance offer my family?

The choices for coverage available to you include the following special features.

**Accelerated Benefit Option** - If terminally ill, you can get a partial payment of your group term life insurance benefit. You can use this payment as you see fit. In the event of your death, your beneficiary will receive the benefit payout which has been reduced by the amount you receive.

**Waiver of Premium** - Payment of your premium can be waived if you meet certain conditions. The Waiver of Premium Benefit terminates at Age 65. This provision may vary by state.

**Conversion to Individual Insurance Coverage** - Upon termination of employment, you may convert your coverage to a Prudential individual life insurance policy, without having to provide evidence of good health.

**Portability of Group Insurance Coverage** - Upon termination of employment, you may continue a certain level of your employee and dependent coverage, without having to provide evidence of good health.

**Travel Assist** - With a single phone call, Travel Assist participants have access to assistance services when faced with an emergency while travelling internationally or domestically when more than 100 miles away from home.

## How much Life Insurance do I need?

The Consumer Federation of America (CFA, 1997) **recommends 6 to 8 times your income** for a married couple with children. While rules of thumb may be helpful, they do not take each individual's personal situation into consideration. Please use our needs calculator to evaluate how much you & your family may need. You can find our calculator by visiting [www.prudential.com/howmuchdoineed](http://www.prudential.com/howmuchdoineed).

## What does disability insurance offer me?

### For Long Term Disability

**Partial Disability Benefit** - Receive partial disability benefits while working a reduced schedule.

**Worksite Modification** - Remain at work or return to work with worksite modifications.

**Rehabilitation Program** - Receive vocational evaluation and job placement assistance.

**Waiver of Premium** - Disability premiums are waived while you are disabled.

### Why do I need Disability Insurance?

While nearly everyone has auto or homeowner's insurance, many people have not insured their most valuable asset - their ability to produce income. Studies show that American workers face at least a one-in-three chance of being disabled, for three months or longer, during their career. \*If you were sick or injured that long, how would you pay your monthly expenses? Could you afford essentials like food, utilities, and house and car payments? What about credit-card debt, college tuition, and retirement funding? Medical problems contributed to half of all home foreclosure filings in 2006. Please use our expense calculator to estimate how much you may need to meet your bills in the event of a disability. You can find our calculator by visiting [www.prudential.com/replacemyincome](http://www.prudential.com/replacemyincome).

\*Get Sick, Get Out: The Medical Causes of Home Mortgage Foreclosures, Christopher Tarver Robertson, Richard Egelhof, & Michael Hoke; August 8, 2008.

## Optional Employee Term Life

You may elect to purchase coverage amounts in increments of \$10,000 from \$10,000 to \$500,000, not to exceed 7 times your covered annual earnings.

- During the initial enrollment period get up to \$100,000 - no medical questions asked - when enrolling when first eligible. If you choose a coverage amount over \$100,000, you will need to provide evidence of insurability satisfactory to Prudential.
- During annual enrollment periods, if you have not been previously denied coverage, you may select to increase your current coverage amount by up to \$40,000, without providing evidence of insurability satisfactory to Prudential.
- Late entrants are required to provide evidence of insurability satisfactory to Prudential to enroll in all coverage amounts. A late entrant is someone who is enrolling more than 31 days after they were first eligible.
- Coverage will not reduce as you age.

### Optional Term Life Insurance For You

To determine the semi-monthly cost of your coverage, please see the chart below.

Age	\$10,000	\$20,000	\$30,000	\$40,000	\$50,000	\$60,000	\$70,000	\$80,000	\$90,000	\$100,000	\$110,000	\$120,000	\$130,000
0-19	\$0.33	\$0.65	\$0.98	\$1.30	\$1.63	\$1.95	\$2.28	\$2.60	\$2.93	\$3.25	\$3.58	\$3.90	\$4.23
20-24	\$0.33	\$0.65	\$0.98	\$1.30	\$1.63	\$1.95	\$2.28	\$2.60	\$2.93	\$3.25	\$3.58	\$3.90	\$4.23
25-29	\$0.33	\$0.65	\$0.98	\$1.30	\$1.63	\$1.95	\$2.28	\$2.60	\$2.93	\$3.25	\$3.58	\$3.90	\$4.23
30-34	\$0.42	\$0.84	\$1.26	\$1.68	\$2.10	\$2.52	\$2.94	\$3.36	\$3.78	\$4.20	\$4.62	\$5.04	\$5.46
35-39	\$0.51	\$1.02	\$1.53	\$2.04	\$2.55	\$3.06	\$3.57	\$4.08	\$4.59	\$5.10	\$5.61	\$6.12	\$6.63
40-44	\$0.65	\$1.30	\$1.95	\$2.60	\$3.25	\$3.90	\$4.55	\$5.20	\$5.85	\$6.50	\$7.15	\$7.80	\$8.45
45-49	\$1.01	\$2.02	\$3.03	\$4.04	\$5.05	\$6.06	\$7.07	\$8.08	\$9.09	\$10.10	\$11.11	\$12.12	\$13.13
50-54	\$1.67	\$3.34	\$5.01	\$6.68	\$8.35	\$10.02	\$11.69	\$13.36	\$15.03	\$16.70	\$18.37	\$20.04	\$21.71
55-59	\$2.83	\$5.65	\$8.48	\$11.30	\$14.13	\$16.95	\$19.78	\$22.60	\$25.43	\$28.25	\$31.08	\$33.90	\$36.73
60-64	\$4.25	\$8.50	\$12.75	\$17.00	\$21.25	\$25.50	\$29.75	\$34.00	\$38.25	\$42.50	\$46.75	\$51.00	\$55.25
65-69	\$6.83	\$13.65	\$20.48	\$27.30	\$34.13	\$40.95	\$47.78	\$54.60	\$61.43	\$68.25	\$75.08	\$81.90	\$88.73
70-74	\$12.90	\$25.80	\$38.70	\$51.60	\$64.50	\$77.40	\$90.30	\$103.20	\$116.10	\$129.00	\$141.90	\$154.80	\$167.70
75-79	\$12.90	\$25.80	\$38.70	\$51.60	\$64.50	\$77.40	\$90.30	\$103.20	\$116.10	\$129.00	\$141.90	\$154.80	\$167.70
80-84	\$12.90	\$25.80	\$38.70	\$51.60	\$64.50	\$77.40	\$90.30	\$103.20	\$116.10	\$129.00	\$141.90	\$154.80	\$167.70
85+	\$12.90	\$25.80	\$38.70	\$51.60	\$64.50	\$77.40	\$90.30	\$103.20	\$116.10	\$129.00	\$141.90	\$154.80	\$167.70

Age	\$140,000	\$150,000	\$160,000	\$170,000	\$180,000	\$190,000	\$200,000	\$250,000	\$300,000	\$350,000	\$400,000	\$450,000	\$500,000
0-19	\$4.55	\$4.88	\$5.20	\$5.53	\$5.85	\$6.18	\$6.50	\$8.13	\$9.75	\$11.38	\$13.00	\$14.63	\$16.25
20-24	\$4.55	\$4.88	\$5.20	\$5.53	\$5.85	\$6.18	\$6.50	\$8.13	\$9.75	\$11.38	\$13.00	\$14.63	\$16.25
25-29	\$4.55	\$4.88	\$5.20	\$5.53	\$5.85	\$6.18	\$6.50	\$8.13	\$9.75	\$11.38	\$13.00	\$14.63	\$16.25
30-34	\$5.88	\$6.30	\$6.72	\$7.14	\$7.56	\$7.98	\$8.40	\$10.50	\$12.60	\$14.70	\$16.80	\$18.90	\$21.00
35-39	\$7.14	\$7.65	\$8.16	\$8.67	\$9.18	\$9.69	\$10.20	\$12.75	\$15.30	\$17.85	\$20.40	\$22.95	\$25.50
40-44	\$9.10	\$9.75	\$10.40	\$11.05	\$11.70	\$12.35	\$13.00	\$16.25	\$19.50	\$22.75	\$26.00	\$29.25	\$32.50
45-49	\$14.14	\$15.15	\$16.16	\$17.17	\$18.18	\$19.19	\$20.20	\$25.25	\$30.30	\$35.35	\$40.40	\$45.45	\$50.50
50-54	\$23.38	\$25.05	\$26.72	\$28.39	\$30.06	\$31.73	\$33.40	\$41.75	\$50.10	\$58.45	\$66.80	\$75.15	\$83.50
55-59	\$39.55	\$42.38	\$45.20	\$48.03	\$50.85	\$53.68	\$56.50	\$70.63	\$84.75	\$98.88	\$113.00	\$127.13	\$141.25
60-64	\$59.50	\$63.75	\$68.00	\$72.25	\$76.50	\$80.75	\$85.00	\$106.25	\$127.50	\$148.75	\$170.00	\$191.25	\$212.50
65-69	\$95.55	\$102.38	\$109.20	\$116.03	\$122.85	\$129.68	\$136.50	\$170.63	\$204.75	\$238.88	\$273.00	\$307.13	\$341.25
70-74	\$180.60	\$193.50	\$206.40	\$219.30	\$232.20	\$245.10	\$258.00	\$322.50	\$387.00	\$451.50	\$516.00	\$580.50	\$645.00
75-79	\$180.60	\$193.50	\$206.40	\$219.30	\$232.20	\$245.10	\$258.00	\$322.50	\$387.00	\$451.50	\$516.00	\$580.50	\$645.00
80-84	\$180.60	\$193.50	\$206.40	\$219.30	\$232.20	\$245.10	\$258.00	\$322.50	\$387.00	\$451.50	\$516.00	\$580.50	\$645.00
85+	\$180.60	\$193.50	\$206.40	\$219.30	\$232.20	\$245.10	\$258.00	\$322.50	\$387.00	\$451.50	\$516.00	\$580.50	\$645.00

## Optional Spouse Term Life

Purchase coverage for your spouse or domestic partner in increments of \$5,000 from \$5,000 to \$100,000, not to exceed 50% of your Optional Life coverage amount.

- During the initial enrollment period get up to \$25,000 - no medical questions asked - when enrolling when first eligible. If you choose a coverage amount over \$25,000, you will need to provide evidence of insurability satisfactory to Prudential.
- Late entrants are required to provide evidence of insurability satisfactory to Prudential to enroll in all coverage amounts. A late entrant is someone who is enrolling more than 31 days after they were first eligible.
- If your spouse or domestic partner or other dependent is confined for medical care or treatment at home or elsewhere, coverage will begin when confinement ends.
- Spouse or domestic partner coverage will not reduce as the employee ages.

### Optional Term Life For Your Spouse or Domestic Partner

To determine the semi-monthly cost of your spouse or domestic partner's coverage, please see the chart below.

Age	\$5,000	\$10,000	\$15,000	\$20,000	\$25,000	\$30,000	\$35,000	\$40,000	\$45,000	\$50,000	\$55,000	\$60,000	\$65,000
0-19	\$0.16	\$0.33	\$0.49	\$0.65	\$0.81	\$0.98	\$1.14	\$1.30	\$1.46	\$1.63	\$1.79	\$1.95	\$2.11
20-24	\$0.16	\$0.33	\$0.49	\$0.65	\$0.81	\$0.98	\$1.14	\$1.30	\$1.46	\$1.63	\$1.79	\$1.95	\$2.11
25-29	\$0.16	\$0.33	\$0.49	\$0.65	\$0.81	\$0.98	\$1.14	\$1.30	\$1.46	\$1.63	\$1.79	\$1.95	\$2.11
30-34	\$0.21	\$0.42	\$0.63	\$0.84	\$1.05	\$1.26	\$1.47	\$1.68	\$1.89	\$2.10	\$2.31	\$2.52	\$2.73
35-39	\$0.26	\$0.51	\$0.77	\$1.02	\$1.28	\$1.53	\$1.79	\$2.04	\$2.30	\$2.55	\$2.81	\$3.06	\$3.32
40-44	\$0.33	\$0.65	\$0.98	\$1.30	\$1.63	\$1.95	\$2.28	\$2.60	\$2.93	\$3.25	\$3.58	\$3.90	\$4.23
45-49	\$0.51	\$1.01	\$1.52	\$2.02	\$2.53	\$3.03	\$3.54	\$4.04	\$4.55	\$5.05	\$5.56	\$6.06	\$6.57
50-54	\$0.84	\$1.67	\$2.51	\$3.34	\$4.18	\$5.01	\$5.85	\$6.68	\$7.52	\$8.35	\$9.19	\$10.02	\$10.86
55-59	\$1.41	\$2.83	\$4.24	\$5.65	\$7.06	\$8.48	\$9.89	\$11.30	\$12.71	\$14.13	\$15.54	\$16.95	\$18.36
60-64	\$2.13	\$4.25	\$6.38	\$8.50	\$10.63	\$12.75	\$14.88	\$17.00	\$19.13	\$21.25	\$23.38	\$25.50	\$27.63
65-69	\$3.41	\$6.83	\$10.24	\$13.65	\$17.06	\$20.48	\$23.89	\$27.30	\$30.71	\$34.13	\$37.54	\$40.95	\$44.36
70-74	\$6.45	\$12.90	\$19.35	\$25.80	\$32.25	\$38.70	\$45.15	\$51.60	\$58.05	\$64.50	\$70.95	\$77.40	\$83.85
75-79	\$6.45	\$12.90	\$19.35	\$25.80	\$32.25	\$38.70	\$45.15	\$51.60	\$58.05	\$64.50	\$70.95	\$77.40	\$83.85
80-84	\$6.45	\$12.90	\$19.35	\$25.80	\$32.25	\$38.70	\$45.15	\$51.60	\$58.05	\$64.50	\$70.95	\$77.40	\$83.85
85+	\$6.45	\$12.90	\$19.35	\$25.80	\$32.25	\$38.70	\$45.15	\$51.60	\$58.05	\$64.50	\$70.95	\$77.40	\$83.85

Age	\$70,000	\$75,000	\$80,000	\$85,000	\$90,000	\$95,000	\$100,000
0-19	\$2.28	\$2.44	\$2.60	\$2.76	\$2.93	\$3.09	\$3.25
20-24	\$2.28	\$2.44	\$2.60	\$2.76	\$2.93	\$3.09	\$3.25
25-29	\$2.28	\$2.44	\$2.60	\$2.76	\$2.93	\$3.09	\$3.25
30-34	\$2.94	\$3.15	\$3.36	\$3.57	\$3.78	\$3.99	\$4.20
35-39	\$3.57	\$3.83	\$4.08	\$4.34	\$4.59	\$4.85	\$5.10
40-44	\$4.55	\$4.88	\$5.20	\$5.53	\$5.85	\$6.18	\$6.50
45-49	\$7.07	\$7.58	\$8.08	\$8.59	\$9.09	\$9.60	\$10.10
50-54	\$11.69	\$12.53	\$13.36	\$14.20	\$15.03	\$15.87	\$16.70
55-59	\$19.78	\$21.19	\$22.60	\$24.01	\$25.43	\$26.84	\$28.25
60-64	\$29.75	\$31.88	\$34.00	\$36.13	\$38.25	\$40.38	\$42.50
65-69	\$47.78	\$51.19	\$54.60	\$58.01	\$61.43	\$64.84	\$68.25
70-74	\$90.30	\$96.75	\$103.20	\$109.65	\$116.10	\$122.55	\$129.00
75-79	\$90.30	\$96.75	\$103.20	\$109.65	\$116.10	\$122.55	\$129.00
80-84	\$90.30	\$96.75	\$103.20	\$109.65	\$116.10	\$122.55	\$129.00
85+	\$90.30	\$96.75	\$103.20	\$109.65	\$116.10	\$122.55	\$129.00

All benefit features may not be available in all states. Premiums may increase as you age. Cost of insurance for all coverages, may increase or decrease in the future based upon the claims experience of participants. All provisions that apply to this coverage are governed by the Certificate. Rates may be subject to change. Rates will not be changed on an individual basis.

## Optional Child Term Life

Purchase coverage for your child(ren) in increments of \$1,000 from \$1,000 to \$10,000, not to exceed 50% of your Optional Life coverage amount.

- There are no health requirements for this coverage.
- Your children include your natural children, legally adopted children, stepchildren and foster children who depend on you for support. Child Dependent Term Life coverage has one rate that covers all eligible children.
- Eligible children are unmarried from 14 days, up to age 19, or up to age 23 if a full-time student at an accredited college/university.

### Optional Term Life for Your Child(ren)

To determine the semi-monthly cost of your child(ren)'s coverage, please see the chart below.

\$1,000	\$2,000	\$3,000	\$4,000	\$5,000	\$6,000	\$7,000	\$8,000	\$9,000	\$10,000
\$0.12	\$0.24	\$0.36	\$0.48	\$0.60	\$0.72	\$0.84	\$0.96	\$1.08	\$1.20

All benefit features may not be available in all states. Premiums may increase as you age. Cost of insurance for all coverages, may increase or decrease in the future based upon the claims experience of participants. All provisions that apply to this coverage are governed by the Certificate. Rates may be subject to change. Rates will not be changed on an individual basis.

Group Life, Accidental Death and Dismemberment and Group Disability Insurance coverages are issued by The Prudential Insurance Company of America, a Prudential Financial company, 751 Broad Street, Newark, NJ 07102.

The Booklet-Certificate contains all details, including any policy exclusions, limitations and restrictions, which may apply. Contract Series: 83500.

This policy provides ACCIDENT insurance only. It does NOT provide basic hospital, basic medical or major medical insurance as defined by the New York Department of Financial Services.

**IMPORTANT NOTICE - THIS POLICY DOES NOT PROVIDE COVERAGE FOR SICKNESS.**

This policy provides disability income insurance only. It does NOT provide basic hospital, basic medical or major medical insurance as defined by the New York Department of Financial Services.

**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.**



**The Prudential Insurance Company of America**

751 Broad Street, Newark, New Jersey 07102

1-877-232-3619

<b>Employee General Information</b>		Effective Date of Coverage (for office use only) ____/____/____		
Last Name	First Name	Middle Initial	Email	Phone
Address		City	State	Zip Code
Social Security Number ____ - ____ - ____	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Divorced		Date of Birth Month Day Year ____/____/____	
Date Employed Month Day Year ____/____/____		Your Annual Earnings \$_____	Spouse or Domestic Partner Date of Birth Month Day Year ____/____/____	(For Prudential Use Only)  Control #

**Basic Term Life and Accidental Death & Dismemberment (AD&D)**

**THE GENERAL CHURCH OF THE NEW JERUSALEM Company offers you Basic Term Life and AD&D Insurance coverages at no cost to you. You will automatically be enrolled in these plans.**

**Optional Term Life**

Coverage amount chosen: \$\_\_\_\_\_ Payroll Deduction: \$\_\_\_\_\_

No coverage chosen  Continue current coverage amount

**Optional Dependent Term Life**

You must be enrolled for Optional Term Life to elect coverage for your dependents. Spouse or Domestic Partner coverage cannot exceed 50% of your Optional Term Life coverage amount. Child(ren) coverage cannot exceed 50% of your Optional Term Life coverage amount.

<b>Spouse or Domestic Partner</b> <input type="checkbox"/> No coverage chosen	<b>Children</b> <input type="checkbox"/> No coverage chosen
<input type="checkbox"/> Coverage amount chosen:\$_____	<input type="checkbox"/> Coverage amount chosen:\$_____
<input type="checkbox"/> Continue current coverage amount	<input type="checkbox"/> Continue current coverage amount
Payroll Deduction: \$_____	Payroll Deduction: \$_____

<b>Employee General Information</b>			
Last Name	First Name	Middle Initial	Last 4 digits of Social Security No. XXX – XX – _____
<b>Long Term Disability</b>			
<b>THE GENERAL CHURCH OF THE NEW JERUSALEM Company offers you Long Term Disability Insurance coverage at no cost to you. You will automatically be enrolled in this plan.</b>			

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 or chronically ill. You may wish to seek professional tax advice before exercising this option.

**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.**

Basic Life, Accidental Death & Dismemberment, Optional Term Life, Dependent Term Life, Long-Term Disability Insurance coverages are issued by The Prudential Insurance Company of America, 751 Broad Street, Newark, NJ 07102. Life Claims: 1-800-524-0542 and Disability Support 1-800-842-1718. 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 Prudential, the terms of the Group Contract will govern. Contract provisions may vary by state. California COA #1179, NAIC#68241. Contract Series: 83500.

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**Employee General Information**

Last Name	First Name	Middle Initial	Last 4 digits of Social Security No. XXX - XX - _____
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**Acceptance or Waiver of Coverage**

- I am enrolling for coverage and I 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 that if I desire to increase the amount of my insurance or add dependent coverage hereafter, I may be required to furnish evidence of insurability for myself and/or my dependents. To the best of my knowledge and belief, I declare the statement above is true and understand it is the basis for determining the monthly contribution for coverage. I also understand that for coverage to become effective, I must be actively at work during the enrollment period and on the effective date of the plan. If I apply for an amount that requires evidence of insurability satisfactory to The Prudential Insurance Company of America, I must be actively at work on the date of approval for the amount requiring satisfactory evidence of insurability.
- I do not wish to enroll for any of the above optional coverages. To the best of my knowledge and belief, I have been given the opportunity by my above named employer to enroll for coverage. I understand that if I desire to enroll hereafter, I may be required to furnish satisfactory evidence of insurability to The Prudential Insurance Company of America for myself and/or my dependents.

**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.

**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 warning ONLY applies to accident and disability coverage.**

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

Employee Signature \_\_\_\_\_ Date (Month/Day/Year) \_\_\_\_/\_\_\_\_/\_\_\_\_

**FOR INSURED WHO RESIDE IN MICHIGAN OR MINNESOTA ONLY**—If you wish to enroll your Spouse or 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 or 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 or Domestic Partner and child(ren) age 18 or older will not become effective unless and until the requisite consent is provided.

Spouse or Domestic Partner Signature \_\_\_\_\_ Date (Month/Day/Year) \_\_\_\_/\_\_\_\_/\_\_\_\_

Child Signature \_\_\_\_\_ Date (Month/Day/Year) \_\_\_\_/\_\_\_\_/\_\_\_\_

Child Signature \_\_\_\_\_ Date (Month/Day/Year) \_\_\_\_/\_\_\_\_/\_\_\_\_

Child Signature \_\_\_\_\_ Date (Month/Day/Year) \_\_\_\_/\_\_\_\_/\_\_\_\_

Child Signature \_\_\_\_\_ Date (Month/Day/Year) \_\_\_\_/\_\_\_\_/\_\_\_\_

<b>Employee General Information</b>			
Last Name	First Name	Middle Initial	Last 4 digits of Social Security No. XXX – XX – _____
<p><b>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:</b> 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.</p> <p><b>ALABAMA RESIDENTS</b> – 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.</p> <p><b>ARKANSAS, DISTRICT OF COLUMBIA, LOUISIANA AND RHODE ISLAND RESIDENTS</b> – 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.</p> <p><b>KENTUCKY RESIDENTS</b> – 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.</p> <p><b>MAINE AND WASHINGTON RESIDENTS</b> – 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.</p> <p><b>MARYLAND RESIDENTS</b> – 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.</p> <p><b>NEW JERSEY RESIDENTS</b> – Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.</p> <p><b>NORTH CAROLINA RESIDENTS</b> – 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.</p> <p><b>PENNSYLVANIA AND UTAH RESIDENTS</b> – 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.</p> <p><b>PUERTO RICO RESIDENTS</b> – 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.</p> <p><b>VERMONT RESIDENTS</b> – 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.</p> <p><b>VIRGINIA RESIDENTS</b> – 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.</p>			

**You must also complete a separate beneficiary designation form.**

If you have any questions, please see Human Resources for details.

# Beneficiary Designation - THE GENERAL CHURCH OF THE NEW JERUSALEM

**Control #**

Employee General Information			
Last Name	First Name	Middle Initial	Social Security No.
			____ - ____ - ____

**Employee/Applicant Beneficiary Designations (to be completed by employee/applicant or assignee, if assigned)**

Please designate at least one primary beneficiary. Use a separate sheet if you want to name more than two primary beneficiaries. If designating a Trust, Estate, or Corporation, please complete the corresponding fields. Do not name a beneficiary for Dependent Term Life Coverage; these benefits are paid to you while living. If more than one primary beneficiary is designated, settlement will be made in equal shares to the designated beneficiaries (or beneficiary) who are then still living, unless their shares are specified. If there is no named beneficiary, or no beneficiary survives the insured, settlement will be made in accordance with the terms of your Group Contract.

**Basic Life, Basic ADD and Optional Life — Primary beneficiaries:**

Last Name	First Name	MI	Telephone Number
Social Security Number	Date of Birth	Relationship	Percentage
Street Address	City	State	Zip
<b>Check one, if applicable:</b>	<input type="checkbox"/> Trust	<input type="checkbox"/> Estate	<input type="checkbox"/> Corporation
	<b>Entity Name:</b>		
Tax ID #/Tax Exempt #	Creation/Incorporation/Formation Date	Telephone Number	Percentage
Street Address	City	State	Zip
Last Name	First Name	MI	Telephone Number
Social Security Number	Date of Birth	Relationship	Percentage
Street Address	City	State	Zip
<b>Check one, if applicable:</b>	<input type="checkbox"/> Trust	<input type="checkbox"/> Estate	<input type="checkbox"/> Corporation
	<b>Entity Name:</b>		
Tax ID #/Tax Exempt #	Creation/Incorporation/Formation Date	Telephone Number	Percentage
Street Address	City	State	Zip

**Basic Life, Basic ADD and Optional Life — Contingent Beneficiary Designation -** Death benefits will be paid to the contingent beneficiaries if the primary beneficiary(ies) is not alive. Use a separate sheet if you want to name more than two contingent beneficiaries. If designating a Trust, Estate, or Corporation, please complete the corresponding fields.

Last Name	First Name	MI	Telephone Number
Social Security Number	Date of Birth	Relationship	Percentage
Street Address	City	State	Zip
<b>Check one, if applicable:</b>	<input type="checkbox"/> Trust	<input type="checkbox"/> Estate	<input type="checkbox"/> Corporation
	<b>Entity Name:</b>		
Tax ID #/Tax Exempt #	Creation/Incorporation/Formation Date	Telephone Number	Percentage
Street Address	City	State	Zip

# Beneficiary Designation - THE GENERAL CHURCH OF THE NEW JERUSALEM

**Control #**

Last Name	First Name	MI	Telephone Number
Social Security Number	Date of Birth	Relationship	Percentage
Street Address	City	State	Zip
<b>Check one, if applicable:</b>	<input type="checkbox"/> Trust	<input type="checkbox"/> Estate	<input type="checkbox"/> Corporation
Entity Name:			
Tax ID #/Tax Exempt #	Creation/Incorporation/Formation Date	Telephone Number	Percentage
Street Address	City	State	Zip

The above beneficiary designation only applies to:     Basic Term Life/AD&D     Optional Term Life

Employee Signature \_\_\_\_\_

Date (Month/Day/Year) \_\_\_\_/\_\_\_\_/\_\_\_\_

If you have any questions, please see Human Resources for details.

Group Optional DependentLife, Basic AD&D, Optional Life, Basic Life, Long Term Disability coverages are issued by The Prudential Insurance Company of America, 751 Broad Street, Newark, NJ 07102.

Life Claims: 800-524-0542 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 provisions may vary by state. Contract series: {83500} . Prudential, the Prudential logo and the Rock symbol are service marks of Prudential Financial, Inc. and its related entities, registered in many jurisdictions worldwide.

**Employer:**

T H E G E N E R A L C H U R C H O F T H E N E W

**Mail the completed form to:**

The Prudential Insurance Company of America  
Group Medical Underwriting, P.O. Box 8796  
Philadelphia, PA 19176

**Group Contract No.(s):**

0 0

**Branch No.:**

0 0 0 0 0 1

**Or fax the completed form to:**  
877-605-6671

**Short Form Health Statement** (Submit a separate form for each person whose coverage requires Evidence of Insurability.)

**Employee**

First Name  MI  Last Name

Number and Street  P.O. Box / Apt. Number

City  State  ZIP Code  -

Social Security Number  -  -  Employee ID Number  Telephone  -  -

Email Address

**Name of Person for Whom Insurance is Being Requested**

Relationship to Employee:  Self  Spouse or Domestic Partner

First Name  MI  Last Name  Social Security Number  -  -

Coverage that requires Evidence of Insurability: **Employee**  Life **Spouse or Domestic Partner**  Life

Gender:  Female  Male Height:  ft.  in. Weight:  lbs. Date of Birth: (mm-dd-yyyy)  -  -

Please answer these questions by checking "Yes" or "No". Note: In this section, "you" refers to the person for whom the insurance is being requested.

Yes  No  **Do you currently** have any disorder, condition, or disease or are you currently taking prescription medication for any disorder, condition, or disease (other than: acid reflux; allergies; cold; cough; herniated disc; high cholesterol; nonrheumatoid arthritis; overactive or underactive thyroid; or pregnancy)?

Yes  No  **In the last five years** have you been diagnosed with, treated for, had any symptoms of, or been in a hospital or other facility for any of the following?

- Chest pain, heart disease or disorder, high blood pressure;
- Cancer, tumors;
- Respiratory disease or disorder of the lungs;
- Multiple sclerosis, epilepsy, seizure, stroke;
- Kidney, liver or pancreas disease or disorder;
- AIDS, AIDS-related complex;
- Diabetes;
- Mental or nervous disorder;
- Alcoholism, drug addiction;
- Chronic pain, rheumatoid arthritis, lupus; or
- Colitis, Crohn's disease, gastric bypass.

**Prudential reserves the right to request additional health information on the basis of the responses given to the above questions.**



\* L S F A G 0 0 1 \*

**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/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.

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**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.

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**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.

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**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.

**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 material fact 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.





Group Contract No.(s):

Branch No.:

00

000001

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.

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

I declare that, to the best of my knowledge and belief, the statements made in this application are complete and true. I agree that the coverage applied for is subject to the terms of the plan and shall become effective on the date or dates established by the plan, provided the evidence of good health is satisfactory.

[First Name Input]

Print Your First Name

[Last Name Input]

Last Name

[SSN Input]

Your Social Security Number

\_\_\_\_\_  
Your Signature (unless a minor)

[Date Signed Input]

Date Signed (mm-dd-yyyy)

\_\_\_\_\_  
If Person for whom insurance is being requested is a minor,  
Signature of Parent, Guardian, or Person Liable for Support

Relationship

[Date Signed Input]

Date Signed (mm-dd-yyyy)

Please keep a copy of this form for your records.

Group Life Insurance coverage is issued by The Prudential Insurance Company of America, a New Jersey company, 751 Broad Street, Newark, NJ 07102.

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Prudential, the Prudential logo, and the Rock symbol are service marks of Prudential Financial, Inc. and its related entities, registered in many jurisdictions worldwide.



## Group Life and Disability Income Medical Underwriting NOTICE

Thank you for choosing The Prudential Insurance Company of America (Prudential) for your insurance needs. Before we can issue coverage we must review your application/enrollment form. To do this, we need to collect and evaluate personal information about you. This notice is being provided to inform you of certain information practices Prudential engages in, and your rights, with regard to your personal information. We would like you to know that:

- Personal information may be collected from persons other than yourself or other individuals, if applicable, proposed for coverage;
- This personal information as well as other personal or privileged information subsequently collected by us may in certain circumstances be disclosed to third parties without authorization;
- You have a right of access and correction with respect to personal information we collect about you; and
- Upon request from you, we will provide you with a more detailed notice of our information practices and your rights with respect to such information. Should you wish to receive this notice, please contact:

The Prudential Insurance Company of America  
Group Medical Underwriting  
P.O. Box 8796  
Philadelphia, PA 19176

Information regarding your insurability will be treated as confidential. We may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life, disability, or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file. In addition, upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901. If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400 Braintree, Massachusetts 02184-8734. Information for consumers about MIB may be obtained on its website at [www.mib.com](http://www.mib.com).

**Please keep this notice for your records.**