The Prudential Insurance Company of America

751 Broad Street, Newark, New Jersey 07102

1-877-232-3619

General Information(Employee)			**Effective Date of Coverage(for office use only)_____/_____/_____**
Last Name First Name Middle Initial Email Phone			
Address City State Zip Code			
Social Security No.	Marital Status		Date of Birth
_____ – _____ – _____	☐ Single ☐ Divorced	☐ Married ☐ Widowed	Month Day Year _____/_____/_____
Date Employed Month Day Year	Your Annual Earnings	Spouse Date of Birth Month Day Year	**(For Prudential Use Only)**
_____/_____/_____	$_____	_____/_____/_____	**Control # 04161**

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

KNOX COLLEGE 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.**

Optional Dependent Term Life

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

Spouse/Domestic Partner	**Children**
☐ Coverage amount chosen: $_____	☐ Coverage amount chosen: $_____
Payroll deduction: $_____	Payroll deduction: $_____
☐ No coverage chosen	☐ No coverage chosen

Optional Accidental Death & Dismemberment (Optional AD&D).

Employee Only

☐ Employee coverage amount chosen: $_____	Payroll deduction: $_____

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

Voluntary Long Term Disability

☐ I wish to enroll for the Long Term Disability insurance coverage. Payroll deduction: $ _____

☐ No Long Term Disability insurance coverage chosen.

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 Life, Accidental Death and Dismemberment and Disability coverages are issued by The Prudential Insurance Company of America, a New Jersey company, 751 Broad Street, Newark, NJ 07102. Life Claims: 1-800-524-0542 and Disability Support 1-800-290-5903. 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 certificate will govern. Contract provisions may vary by state. California COA #1179, NAIC#68241. Contract Series: 83500.

Employee General Information

Last Name	First Name	Middle Initial	Social Security No.
_____			_____ - _____ - _____

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. I certify that 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.

FOR RESIDENTS OF ALL STATES EXCEPT ALABAMA, ARKANSAS, DISTRICT OF COLUMBIA, FLORIDA, KENTUCKY, LOUISIANA, MAINE, MARYLAND, NEW JERSEY, NEW YORK, 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.

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.

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.

Receipt of accelerated death benefits may affect eligibility for public assistance programs and may be taxable. There is no administrative fee to accelerate death benefits. The accelerated amount is not discounted.

Employee General Information			
Last Name	First Name	Middle Initial	Social Security No.
_____			_____ – _____ – _____

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.**

Employee Signature _____ Date (Month/Day/Year) ____/____/_____

You must also complete a separate beneficiary designation form.

Beneficiary Designation - KNOX COLLEGE

Control # 04161

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, Optional Life and OADD — Primary beneficiaries:

Last Name	First Name	MI	Telephone Number
Social Security Number	Date of Birth	Relationship	Percentage
Street Address	City	State	Zip

Check one, if applicable:	☐ **Trust** ☐ **Estate** ☐ **Corporation**	**Entity Name:**	
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

Check one, if applicable:	☐ **Trust** ☐ **Estate** ☐ **Corporation**	**Entity Name:**	
Tax ID #/Tax Exempt #	Creation/Incorporation/Formation Date	Telephone Number	Percentage
Street Address	City	State	Zip

Basic Life, Basic ADD, Optional Life and OADD — 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

Check one, if applicable:	☐ **Trust** ☐ **Estate** ☐ **Corporation**	**Entity Name:**	
Tax ID #/Tax Exempt #	Creation/Incorporation/Formation Date	Telephone Number	Percentage
Street Address	City	State	Zip

Beneficiary Designation - KNOX COLLEGE

Control # 04161

Last Name	First Name	MI	Telephone Number
Social Security Number	Date of Birth	Relationship	Percentage
Street Address	City	State	Zip

Check one, if applicable:	☐ **Trust** ☐ **Estate** ☐ **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 ☐ Optional AD&D

Employee Signature _____ **Date (Month/Day/Year)** ____/____/_____

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

Group Dependent Life,Optional DependentLife,Basic AD&D,Optional 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.