The Prudential Insurance Company of America – Enrollment and Beneficiary Form

751 Broad Street • Newark, NJ 07102

NCPERS $16 PLAN Control No.: 92860

Please submit your complete enrollment form to your employer. Your employer will begin payroll deductions and forward your enrollment information to HealthSmart Benefit Solutions, Inc. Questions? Call 1-800-525-8056.

FOR EMPLOYER:
Please complete this section. Additionally, it is important that you review the form for complete information. All sections must be completed in order for The Prudential Insurance Company of America to process claims.

Please show date of first deduction _____ (Mo. Day Yr.)

EMPLOYER Unit No. _____

Return completed form to:
HealthSmart Benefit Solutions, Inc.
PO Box 16346
Lubbock, Texas 79490
1-800-525-8056
Email: NCPERS@healthsmart.com

Member Information ☐ New Member Enrollment ☐ Open Enrollment ☐ Change of Beneficiary

Last Name _____ First Name _____ MI _____

Street Address _____ City _____ State _____ ZIP code _____

Social Security Number ___-___-____ Primary Phone Number _____ _____ Your Date of Birth (mm/dd/yyyy) ____/____/____

Date of Employment

____/____/____ Actively at work?* ☐ Yes ☐ No – If no, you are not eligible for this coverage. ☐ Male ☐ Female

*Active Work Requirement: A requirement that a member be actively at work as normally required by the employer or as predetermined by the member's Public Employee Retirement Systems group on the date of the insurance is to begin.

I declare the above statements and answers are complete and true and understand they are the basis for providing life insurance under a plan (or plans) issued by The Prudential Insurance Company of America (Prudential) to the National Conference on Public Employee Retirement Systems (NCPERS), in which I will participate upon becoming insured. I hereby authorize my employer to deduct from my wages amounts equal to the contributions required for me toward the premiums for Group Insurance under the NCPERS plan issued by Prudential. A photographic copy of this authorization shall be as valid as the original. The effective date of coverage will be the first day of the month following payment of my contribution through payroll deductions. I understand that my member coverage will be delayed if I am not actively at work on the coverage effective date. Instead, my coverage will begin on the date I meet the actively-at-work and other insurance requirements for covered members.

National Conference on
Public Employee Retirement Systems

Prudential

Member Information

Last Name	First Name	MI	Social Security Number
			___-___-____

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.

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.**

The District of Columbia requires insurers to provide the following notice to all employees being offered Accidental Death and Dismemberment, Accident Insurance and/or Critical Illness coverage:

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.

I have read and understand the terms and requirements of the fraud warnings included on the last page of this form.

Member Signature (Sign in ink.) _____ Date Signed _____

FOR INSUREDS 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.

Spouse/Domestic Partner Signature (Sign in ink.) _____ Date Signed _____

Child Signature (Sign in ink.) _____ Date Signed _____

Child Signature (Sign in ink.) _____ Date Signed _____

Please indicate your Primary and Contingent beneficiary designations on the next page.

Member Information

Last Name | First Name | MI | Social Security Number

Member Beneficiary Designations (to be completed by member or assignee, if assigned)

Please designate at least one primary beneficiary. Use a separate sheet if you want to name more than one primary beneficiary. If designating a Trust, Estate, or Corporation, please complete the corresponding fields. Do not name a beneficiary for Dependent Group Decreasing 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.

Primary Beneficiary

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

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

Member Signature (Sign in ink.) _____ Date Signed _____

NCPERS is a non-profit organization that provides education and support to public employment retirement systems. NCPERS has no role in the administration of the life insurance program and the benefits are guaranteed solely by the insurance carrier. NCPERS is compensated solely for the use of its name, service marks, and mailing lists.

The plan is administered by HealthSmart. HealthSmart and Gallagher Benefit Services, Inc. are not affiliates of Prudential.

Group Decreasing Term Life, Dependent Group Decreasing Term Life, and Accidental Death and Dismemberment Insurance coverages are issued by The Prudential Insurance Company of America, a Prudential Financial 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. 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. Contract provisions may vary by state. California COA # 1179, NAIC # 68241. Contract Series: 83500.

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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 – 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.

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 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.

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.