Prudential

Group Term Life Insurance Continuation Form

Employees must be actively at work at the time of employment termination or retirement in order to be eligible for the continuation plan. Coverage terminates according to the terms of the group contract; however, coverage will not be continued beyond age 75.

When To Apply

You must apply to continue your coverage within 31 days of your coverage termination date.
If you apply within 31 days, there will be no lapse in your coverage.

How To Apply

1. Your employer completes Sections 2 of the Continuation Election Form.
2. You need to complete Sections 1, 3, 4, 5, 6, and 7 of the Continuation Election Form. It is important to designate a beneficiary in Section 4 since this form replaces your previous beneficiary form for the Group Life Insurance plan. Please note that you are automatically the beneficiary on spouse and dependent children coverages.
3. Return the completed form(s) to this address:

   The Prudential Insurance Company of America
   Record Keeping Services
   P.O. Box 13676
   Philadelphia, PA 19176
4. Dependents may be eligible to continue coverage only if employee coverage is continued.
5. The employee term life coverage must not exceed the amount for which you were insured for Optional Term Life.

Confirmation of Coverage

After you have completed all of the above steps, Prudential will send you a billing statement within six weeks, which will confirm that your coverage is in effect. All payments must be made promptly to prevent lapse or termination of your Group Term Life Insurance coverage. Electronic Funds Transfer (EFT) is available as an option to pay premiums once payment of your initial billing statement is received. You can contact Prudential at the toll free number indicated below for further details or to request an EFT authorization form.

If You Have Questions

If you have questions about the continuation option, you may contact Prudential Record Keeping Services at **1-800-778-3827**.

Group Term Life coverage(s) are issued by The Prudential Insurance Company of America, a New Jersey 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 Prudential, the terms of the Group Contract will govern. Contract provisions may vary by state. Contract series: 83500. Prudential and the Rock logo are registered service marks of Prudential Financial, Inc, and its related entities, registered in many jurisdictions worldwide.

GL.2012.267 Ed. 10/2012 (MABE Continuation)

Group Term Life Insurance Coverage Continuation Election Form

Maryland Association Boards of Education

Please return this form to:
The Prudential Insurance Company of America
Record Keeping Services
P.O. Box 13676
Philadelphia, PA 19176

1. Employee/Applicant Data (to be completed by employee/applicant)

Last Name	First Name	MI	Sex: ☐ Male ☐ Female
Street Address	Apartment #	City	State ZIP
Date of Birth	Social Security Number	Daytime Phone Number	Home Phone Number
Email Address		Marital Status: ☐ Married ☐ Single ☐ Divorced ☐Widower	

2. Group Term Life Insurance Coverage Amount(s) (to be completed by employer)

Complete all blocks. If your current Optional Term plan does not include some of the options below (e.g. Dependent Term Life), or the employee is not enrolled in the option or the option is not eligible for Continuation based on your contract, please indicate 'not applicable' (**NA**).

Coverage Termination Date	Reason and Date of Termination of Employment
Salary and Date of Last Day Actively at Work	Group Contract Number **51586**
Current Optional Term Life Coverage Amount – Employee $	
Current Dependent Term Life Coverage Amount – Spouse $	
Current Dependent Term Life Coverage Amount – Children $	

I certify that, to the best of my knowledge and belief, the information provided in Section 2 is correct and the employee who is named on this form is eligible for Continuation according to the terms specified in the Prudential group contract.
Signature of Employer Representative (employer certification for Continuation eligibility)

X **Date** **Representative Phone Number**

3. Group Term Life Insurance Coverage Amount(s) (to be completed by employee/applicant)

Please note: The employee term life coverage must not exceed the amount for which you were insured for Optional Term Life.

Optional Term Life and Dependent Term Life Coverage

Employee (Optional Term Life Insurance):
Retain current face amount ☐ $ ____________________
Elect lower amount ☐

Spouse (Dependent Term Life Insurance):
Retain current face amount ☐ $ ____________________
Elect lower amount ☐ $ ____________________

Children (Dependent Term Life Insurance):
Retain current face amount ☐ $ ____________________
Elect lower amount ☐ $ ____________________

NOTE: round down to the nearest $1,000

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

A. PRIMARY BENEFICIARIES: Please designate at least one primary beneficiary. Use a separate sheet if you want to name more than two primary beneficiaries, or if the beneficiary is your estate or a trust.

Last Name	First Name	MI	Telephone Number

Social Security Number	Date of Birth	Relationship	Percentage

Street Address	Apartment #	City	State	ZIP

Last Name	First Name	MI	Telephone Number

Social Security Number	Date of Birth	Relationship	Percentage

Street Address	Apartment #	City	State	ZIP

B. CONTINGENT BENEFICIARIES: 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.

Last Name	First Name	MI	Telephone Number

Social Security Number	Date of Birth	Relationship	Percentage

Street Address	Apartment #	City	State	ZIP

Last Name	First Name	MI	Telephone Number

Social Security Number	Date of Birth	Relationship	Percentage

Street Address	Apartment #	City	State	ZIP

5. Dependent Term Life Insurance Coverage - Spouse (to be completed by employee/applicant)

This section should only be completed if you previously had dependent coverage with Prudential for your spouse and you wish to continue this dependent coverage. Child coverage begins at 14 days of age, and ends at 19 (25 if full-time student)
Note: Dependents may be eligible to continue coverage only if employee coverage is continued.

Is spouse confined for medical care or treatment at home or elsewhere?
☐ Yes ☐ No

Spouse's Last Name	First Name	MI	Social Security Number	Date of Birth

6. Dependent Term Life Insurance Coverage - Children (to be completed by employee/applicant)

This section should only be completed if you previously had dependent coverage with Prudential for your children and you wish to continue this dependent coverage. **Note: Dependents may be eligible to continue coverage only if employee coverage is continued.**

Is any child confined for medical care or treatment at home or elsewhere?
☐ Yes ☐ No if yes, provide name of child ____

Youngest Child's Last Name	First Name	MI	Social Security Number	Date of Birth

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.**

7. Employee/Applicant/Assignee Signature(s) (to be completed by employee/applicant/assignee)

I hereby request to exercise my rights to continue my Group Life Insurance Coverage on a direct bill basis. I understand that I will be billed on a quarterly basis and that a $3 billing fee per quarter will apply. I understand that if I elect to convert my coverage to an individual policy, I waive my right to continue under the group plan. I understand that by electing to continue under the group plan, my Group Life Insurance coverage and all applicable riders are subject to the rules of the Group Contract governing the plan. I also understand that I may only elect to continue coverage under the group plan subject to all of the following:

- This selection is made within 31 days of the date that I am no longer eligible for coverage through my former employer.
- I am subject to the age reductions outlined in the Group Contract.
- Group Life Insurance for my dependent spouse and child(ren) may only be continued in conjunction with my election to continue my Group Life Insurance.
- Group Life Insurance for my dependent spouse ends when my spouse no longer qualifies as an eligible dependent
- Group Life Insurance for my dependents ends when they no longer qualify as eligible dependents.
- Group Life Insurance and coverage under all applicable riders will end if I fail to make any payment needed to keep my coverage in force within 31 days from the date due.

I represent that supplied above is true and correct. I have thoroughly reviewed, understand and accurately responded to all questions on this form.

X	X
Employee's/Applicant's Signature *Date*	*Assignee's Signature (if applicable)* *Date*

8. For Prudential Use Only

Effective Date of Coverage: |__|__|__|__|__|__|__|__| (mm/dd/yyyy)

IMPORTANT NOTICE REQUIRED BY CERTAIN STATE REGULATORS:

For residents of all states except the Alabama, District of Columbia, Florida, Kentucky, Maryland, New Jersey, New York, Pennsylvania, 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.

DISTRICT OF COLUMBIA 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.

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.

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 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 a statement of claim for payment of a loss or benefit may have violated state law, is 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.

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.