

MBA Insurance Application and/or CHANGE FORM



CHECK ALL THAT APPLY

<input type="checkbox"/> Enrollment	<input type="checkbox"/> Birth or Adoption	<input type="checkbox"/> Name Change	<input type="checkbox"/> Loss of Coverage	<input type="checkbox"/> Divorce, Separation or Death
<input type="checkbox"/> Termination (last day worked): ____/____/____	<input type="checkbox"/> Marriage	<input type="checkbox"/> Address Change	<input type="checkbox"/> Other Change	<input type="checkbox"/> Change of Spouse's Employment
	<input type="checkbox"/> Waiver	<input type="checkbox"/> Beneficiary Change	<input type="checkbox"/> Cobra/Cont.	<input type="checkbox"/> Date of Change: ____/____/____

REQUIRED	Employee Name (first)		MI	Last Name		Prior Name (if changing)		
	Employee Address (Dental Only)				CITY/STATE/ZIP CODE		Part-time employment date: ____/____/____	Full-time employment date: ____/____/____
	Employee Date of Birth: ____/____/____	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Married <input type="checkbox"/> Y <input type="checkbox"/> N	Officer <input type="checkbox"/> Y <input type="checkbox"/> N	Earnings (for Life/Disability): \$ _____ <input type="checkbox"/> Hourly – No. of hours per week _____		Employee Social Security Number	
	Job Title or Position			<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly <input type="checkbox"/> Other _____			Employment Location/Bank Name	

WAIVER

WAIVER OF BENEFIT: THE GROUP INSURANCE AVAILABLE THROUGH MY EMPLOYER HAS BEEN EXPLAINED TO ME. AFTER CAREFUL CONSIDERATION I HAVE DECIDED THAT I DO NOT WANT TO ENROLL IN ONE OR MORE PLANS. COVERAGE MAY NOT BE WAIVED FOR 100% EMPLOYER PAID PLANS.

I WISH TO WAIVE MY RIGHT TO AND NOT APPLY FOR: Basic **LIFE INSURANCE** Optional Dependent Disability Dental

I UNDERSTAND THAT IF I WANT TO BECOME INSURED LATER FOR LIFE AND DISABILITY I WILL BE REQUIRED TO PROVIDE INSURING CARRIER WITH SATISFACTORY EVIDENCE OF INSURABILITY AND THAT INSURING CARRIER WILL HAVE THE RIGHT TO REFUSE MY REQUEST FOR INSURANCE. PLEASE SIGN THE BOTTOM OF THIS FORM. IF WAIVING DENTAL COVERAGE, A WAITING PERIOD MAY APPLY IF COVERAGE IS REQUESTED AT A LATER DATE.

ENROLL/TERM	COVERAGE ELECTIONS:	Add/Terminate	Coverage Requested	Effective Date	DENTAL COVERAGE	Add/Terminate	Effective Date	
	Basic Life			Amount \$ _____	/ /	<input type="checkbox"/> Employee Only		/ /
Optional Life (requires Basic Life)			Amount \$ _____	/ /	<input type="checkbox"/> Employee Plus One		/ /	
Dependent Life			For Dependent Coverage please fill out dependent information immediately below		<input type="checkbox"/> Employee and Family		/ /	
MBA Long Term Disability								
MBA Short Term Disability								

DEP. LIFE/DENTAL

DEPENDENT INFORMATION: Dental and Dependent Life (includes spouse & eligible dependent children) *See booklet

Life Add/Delete	Dental Add/Delete	Name	Relationship	Gender	Date of Birth Month/Day/Year
				M F	/ /
				M F	/ /
				M F	/ /
				M F	/ /

LIFE ONLY

Beneficiary Information-New Enrollment/Change (Complete Only if Life Coverage is Selected)

I realize that this designation is effective on the date signed below and will override any previous designations. If more than one 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 no beneficiary is designated or if no designated beneficiary survives the insured, settlement will be made to the estate of the insured, unless otherwise provided in the Group Policy. Beneficiary designations are the same for both the Basic and Optional Insurance. Percentages may be reflected to separate or divide benefits.

Primary Beneficiary Name(s)	Relationship	Social Security No.	Date of Birth	% of Proceeds
		- -	/ /	%
		- -	/ /	%
		- -	/ /	%
Contingent Beneficiary Name(s)	Relationship	Social Security No.	Date of Birth	% of Proceeds
		- -	/ /	%
		- -	/ /	%

I authorize payroll deductions, if applicable, and declare that, to the best of my knowledge, I have reviewed all relevant disclosures and the information on this form is complete and true.

DATE	Signature of Employee:
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Receipt of accelerated death benefits may affect eligibility for public assistance programs and may be taxable. Please contact your personal tax advisor for further information. There is no administrative fee to accelerate death benefits. The accelerated amount is not discounted.

For residents of all states except Florida, New Jersey, New York, Pennsylvania, 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.

Group Life coverage is issued by The Prudential Insurance Company of America, a New Jersey company, 751 Broad Street, Newark, NJ 07102. {Life Claims 1-800-524-0542} 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

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