

## Evidence of Insurability

### Instructions for Employer/Association

1. Complete the form below.
2. Also complete all sections of the form noted PART A including product related information as applicable to the plan(s) requiring medical evidence of insurability.
3. The entire package should then be given to your employee or member for completion of PART B.

#### For Employer/Association Use Only:

In the space below, insert mailing address to which the notice of action should be sent.

Employee/Member Name: \_\_\_\_\_

Employer/Association Name & Address:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Group Contract No.: \_\_\_\_\_ Branch No.: \_\_\_\_\_

Submitting Location: \_\_\_\_\_

Submitted by:

\_\_\_\_\_  
Name

\_\_\_\_\_  
Title

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
E-mail Address

\_\_\_\_\_  
Date

**Part A Employer/Association Information**

Complete this page for those plans requiring evidence of insurability, then give this package to the employee/member.

Employee/Member First Name  MI  Last Name

Date of Birth    Social Security Number -- Sex  Male  Female

Street  Apt.

City  State  ZIP Code -

Date individual first became eligible for coverage(s)/amount(s) of insurance this form applies to:

Employee/Member Annual Earnings: \$ \_\_\_\_\_

Is application being made for amounts above the life non-medical maximum? Yes  No   
 Is application being made as a late entrant? Yes  No   
 Is application being made for dependents? Yes  No

Complete only for those coverages and persons requiring evidence of insurability.  
 (For example: Employee only, spouse only, or employee and spouse.)

**Life/AD&D**

Total Non-Medical Maximum \$ \_\_\_\_\_

	Current Amount Inforce	+	Add'l or Initial Amount Requested	=	Total Amount
Employee/Member	\$ _____	+	\$ _____	=	\$ _____
Spouse (Life Only)	\$ _____	+	\$ _____	=	\$ _____

**Long Term Disability**

	Current Amount Inforce	+	Add'l or Initial Amount Requested	=	Total Amount
Employee/Member	\$ _____	+	\$ _____/mo	=	\$ _____

**Survivor Benefits Life**

	Current Amount Inforce	+	Add'l or Initial Amount Requested	=	Total Amount
Spouse	\$ _____/mo	+	\$ _____/mo	=	\$ _____
Child	\$ _____/mo	+	\$ _____/mo	=	\$ _____

**Weekly Disability Income/Accident & Sickness Benefit**

Amount \$ \_\_\_\_\_

**Instructions for Employee/Member** (Complete the required sections as noted below.)

1. If you are providing evidence of insurability for:
  - a) Employee/Member coverage only – Complete Sections 1, 2, 4, and 5.
  - b) Dependent coverage only – Complete Sections 1, 3, 4, and 5.
  - c) Employee/Member and Dependent coverage – Complete all sections of this form.

(Note: Evidence of insurability is not required for children.)
2. Please complete the form in blue or black ink. Sign and date Sections 4 and 5.
3. Please read and tear off the Important Medical Information Notice that accompanies these instructions and retain for your records. Please retain a copy of your completed application for your own records.
4. Mail the completed PART A and PART B forms to:

The Prudential Insurance Company of America  
 Group Medical Underwriting  
 P.O. Box 8796, Philadelphia, PA 19101

This form can also be sent by fax to 877-605-6671

The evaluation of your request for coverage may be delayed if you do not follow these instructions, if you and/or your dependent do not answer all questions on the PART B form, if you do not give complete details for any answers requiring details, or if you do not provide complete names and addresses of doctors and hospitals.

**NOTE:** Coverage is not effective until this request has been approved. You will be notified whether or not coverage has been approved.

If you have questions regarding the completion of these forms, please contact Prudential Customer Service at 888-257-0412 or e-mail us at [medical.uw@prudential.com](mailto:medical.uw@prudential.com).

**Part B Employee/Member Information**

**Section 1**

1. Employee/Member First Name	MI	Last Name
<input type="text"/>	<input type="text"/>	<input type="text"/>
2. Employee/Member Social Security Number	3. Employee/Member Phone Number	
<input type="text"/> - <input type="text"/> - <input type="text"/>	Daytime <input type="text"/> <input type="text"/> - <input type="text"/>	
	Evening <input type="text"/> <input type="text"/> - <input type="text"/>	
4. Street	Apt.	
<input type="text"/>	<input type="text"/>	
City	State	ZIP Code
<input type="text"/>	<input type="text"/>	<input type="text"/> - <input type="text"/>
5. E-mail Address <input type="text"/>		

**Section 2**

6. Date of Birth	7. Birth Place	
<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	
month day year	city state	
8. Sex	9. Height	10. Weight
<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="text"/> ft. <input type="text"/> in.	<input type="text"/> lbs.



**Section 3**

1. Employee/Member's eligible dependent that requires evidence of insurability.

Full Name	Social Security Number	Relationship to You	Date of Birth	Place of Birth	Height	Weight

2. Address of your dependent (if different from address in Section 1):

3. Is the person named above unable to perform all of the duties of his/her job or home-confined? Yes  No

4. Has the person named above **during the last five years**:

- a. had any surgery or been advised to have surgery and has not done so? Yes  No
- b. been in a hospital, sanitarium, other institution for observation, rest, diagnosis, or treatment? Yes  No
- c. used, or is now using, cocaine, barbiturates, amphetamines, marijuana or other hallucinatory drugs, heroin, opiates, or other narcotics, except as prescribed by a doctor? Yes  No
- d. been treated or counseled for alcoholism? Yes  No
- e. been treated or counseled by a psychologist or psychiatrist? Yes  No
- f. applied for or received disability income benefits or pension benefits on account of sickness or injury? Yes  No
- g. had life, disability, or health insurance declined, postponed, changed, rated-up, cancelled, or withdrawn? Yes  No
- h. been diagnosed as having, or treated by a member of the medical profession for, Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? Yes  No

5. **Within the last five years**, has the person named above been treated for, or had any trouble with, any of the following:

- |                         |                          |                          |                                 |                          |                          |                              |                          |                          |
|-------------------------|--------------------------|--------------------------|---------------------------------|--------------------------|--------------------------|------------------------------|--------------------------|--------------------------|
|                         | Yes                      | No                       |                                 | Yes                      | No                       |                              | Yes                      | No                       |
| a. Heart or chest pain? | <input type="checkbox"/> | <input type="checkbox"/> | g. Nervous or mental disorders? | <input type="checkbox"/> | <input type="checkbox"/> | m. Urinary system?           | <input type="checkbox"/> | <input type="checkbox"/> |
| b. High blood pressure? | <input type="checkbox"/> | <input type="checkbox"/> | h. Arthritis or rheumatism?     | <input type="checkbox"/> | <input type="checkbox"/> | n. Goiter or glands?         | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Abnormal pulse?      | <input type="checkbox"/> | <input type="checkbox"/> | i. Ulcers or stomach disorders? | <input type="checkbox"/> | <input type="checkbox"/> | o. Pleurisy or asthma?       | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Cancer or tumors?    | <input type="checkbox"/> | <input type="checkbox"/> | j. Intestines or kidneys?       | <input type="checkbox"/> | <input type="checkbox"/> | p. Chronic diarrhea?         | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Diabetes?            | <input type="checkbox"/> | <input type="checkbox"/> | k. Liver or gallstones?         | <input type="checkbox"/> | <input type="checkbox"/> | q. Neuritis or sciatica?     | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Lungs?               | <input type="checkbox"/> | <input type="checkbox"/> | l. Genital disorder?            | <input type="checkbox"/> | <input type="checkbox"/> | r. Back or spinal disorders? | <input type="checkbox"/> | <input type="checkbox"/> |

6. Does the person named above **currently have** any disorder, condition (including pregnancy), disease, or defect not shown above, and/or is he/she currently taking medication prescribed or provided by a medical or other practitioner for any disorder, condition (including pregnancy), disease, or defect? Yes  No

7. What are the full details of all "Yes" answers to each part of 3 through 6 above? Attach additional pages if needed.

Dependent's Name	Question Number and Letter	Specify illness or condition. Include reason for any check-up, doctor's advice, treatment, and/or medication	Date illness or condition began <i>Month Year</i>	Time lost from normal activities	Full recovery (if applicable) <i>Month Year</i>	Print full names, addresses, and telephone numbers of doctors and/or hospitals

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#### Section 4

**In all states except Arkansas, Colorado, Florida, Maine, Maryland, Massachusetts, Ohio, Oregon, New York, New Jersey, Tennessee, Virginia, and the District of Columbia:** 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 subjects such person to criminal and civil penalties.

**In Arkansas, Colorado, Maine, Maryland, New York, Ohio, Tennessee, and the District of Columbia:** 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 subjects such person to criminal and civil penalties. In addition, any person who commits such a fraudulent act:

- may be subject to fines and confinement in prison under Arkansas law.
- is subject to penalties that may include imprisonment, fines, denial of insurance, and civil damages under Colorado law. Also, any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding, or attempting to defraud, the policyholder or claimant with regard to a settlement of award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.
- may be subject to penalties that may include imprisonment, fines, or a denial of insurance benefits under Maine law.
- may be found guilty of insurance fraud under Maryland law.
- is subject to civil penalties, with such penalties not exceeding \$5,000 and the stated value of the claim for each such violation under New York law. This notice ONLY applies to disability income coverage in New York.
- is guilty of insurance fraud under Ohio law.
- is subject to penalties including imprisonment, fines, and denial of insurance benefits under Tennessee law.
- may be subject to imprisonment and/or fines under the law of the District of Columbia.

**In Florida:** 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.

**In New Jersey:** Any person who includes false or misleading information on an application for insurance under a group contract is subject to criminal and civil penalties.

**In Virginia:** Any person who knowingly provides false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company has committed a crime. Penalties include imprisonment, fines, and denial of insurance benefits.

**In Massachusetts:** 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 may subject such person to criminal and civil penalties.

**In Oregon:** 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 may be a crime and may subject such person to criminal and civil penalties.

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.

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Signature of Employee/Member

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Date

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**Section 5 — AUTHORIZATION For the Release of Information**

To: (1) Any licensed physician, medical practitioner, hospital, clinic, or other medically related facility, (2) any insurance company or health maintenance organization (or similar type organization or institution), and (3) the Medical Information Bureau. So that eligibility for life or disability coverage can be determined, I authorize you to give any data or records you may have about me or my mental or physical health to The Prudential Insurance Company of America and/or its subsidiaries and, through it, to its reinsurers, authorized agents, and the Medical Information Bureau. This also applies to any dependent proposed for coverage in the application. This authorization is valid for the lesser of (1) two years after the effective date of any coverage issued in connection with it or (2) 30 months after the date it is signed. A photocopy of this form will be as valid as the original. The person(s) who signed this form (1) have received a copy of the "Medical Information Notice" and (2) may have a copy of this authorization if they wish.

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Signature of Employee/Member

Employee/Member Social Security No.

Date

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Signature of Spouse (if applicable)

Date

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## Medical Information Notice

When we evaluate your request for insurance, the state of health of the person(s) for whom insurance is requested is, of course, extremely important to us. Consequently, we need to ask you questions about the health and medical history of each person. In addition, you are also requested to authorize any physician or hospital to provide us with reports, if necessary, about the health of each person. In some instances, we may require a physical examination.

Any information we obtain regarding a person's insurability will be treated as confidential. We may, however, make a brief report of it to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. When you apply for life, disability, or health insurance to any company, including Prudential, which is a member of the Medical Information Bureau, or submit a claim for benefits to such a company, the Bureau will, on request, give the company the information in its files. We may reveal this information, as necessary, to a doctor, if we find a serious health problem which you do not know about. We may also reveal this information to persons conducting mortality or morbidity studies. We will, if you ask, give you a description of other circumstances when we disclose information about you without your prior authorization.

You have the right to see any of the personal information we collect about you and to make corrections if necessary. If you ask, we will furnish you with instructions on how to exercise this right. In addition, upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If the information came from the Medical Information Bureau and you question the accuracy of the information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's Information Office is P.O. Box 105, Essex Station, Boston, Massachusetts 02112. 617-426-3660.

**It Is Required That You Be Given This Notice.**

**Please Read It Carefully, And Keep It For Your Records.**

