SUPPLEMENTAL TERM LIFE INSURANCE ENROLLMENT FORM

Policyholder's Name: **State of Ohio** Group Policy Number: **93046**

☐ New enrollment ☐ Change ☐ Terminate employee coverage (includes spouse/children coverage)

Please mark the appropriate boxes if you are making a change (check all that apply)

☐ Increase My Coverage	☐ Add Spouse Coverage	☐ Add Children Coverage	☐ Change to Union-Represented from Exempt	☐ Change Smoker Status
☐ Decrease My Coverage	☐ Increase Spouse Coverage	☐ Drop Children Coverage	☐ Change to Exempt from Union-Represented	☐ Change Spouse Smoker Status
☐ Other (Name Change, etc.)	☐ Drop Spouse Coverage	☐ Decrease Spouse Coverage		☐ Beneficiary Designation/Change

Agency Name: ______________________ (State Agency in which you work)

Employee Insurance Total Amount Requested: ______________ Include current amount of supplemental coverage for the employee, plus the amount of increase in $10,000 increments **(do not include spouse/children amounts).** The amount for which you apply and the amount that Prudential approves may not be the same. You may port the approved amount when you leave State service.

____

Employee Name (Last, First, Middle Initial)

____

Employee's Address City State ZIP Code

Social Security No. (Required) ______________ DOB ____________ ☐ M ☐ F ☐ Married ☐ Single

Occupation ______________ Date Employed __________ Base Annual Earnings ____________

Telephone No. ______________ Employee ID No. (Required) ______________

Have you smoked cigarettes or used any form of tobacco in the past 12 months? ☐ Yes ☐ No

(The right to change the beneficiary is reserved. To name beneficiaries, please use the spaces on the back of this form.)

____

Employee must have Supplemental Term Life Insurance to enroll spouse and/or children.

You will automatically be the beneficiary for life insurance on the lives of your spouse and children, if surviving; otherwise, it will be the estate of the spouse and children, subject to policy provisions.

Spouse Coverage Desired? ☐ Yes ☐ No Spouse Insurance Total Amount: ☐ $10,000 ☐ $20,000 ☐ $30,000 ☐ 40,000

____ (Include current amount of coverage)

Spouse's Name (Last, First, Middle Initial)

Spouse's Social Security No. ______________ DOB ____________ Date of Marriage ____________

Has your spouse smoked cigarettes or used any form of tobacco in the past 12 months? ☐ Yes ☐ No

Child(ren) Coverage Desired? ☐ Yes ☐ No Child(ren) Insurance Amount: $7,000 per Child Number of Children ____________

You have 90 days from your hire date to purchase supplemental term life coverage for you, your spouse, and your dependent children. Coverage is also available during each open enrollment period.

This plan is totally separate from your basic life plan with State of Ohio, and the amount of insurance elected as supplemental does not change your basic life insurance. If a husband and wife are both State employees, they have coverage as either a spouse or a employee, but not both. Children can only be covered as dependents of only one employee.

I understand that when I leave State service I, my spouse, and my child(ren) will be able to port the coverage I have purchased as an active employee, and that I will not be able to apply for more coverage.

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.

I hereby request Supplemental Term Life Insurance for myself and/or for my dependents and hereby authorize my employer or successor to make deductions from my earnings of the required contributions to apply toward the premiums for the insurance provided for in the policy of Supplemental Term Life Insurance issued to State of Ohio by The Prudential Insurance Company of America (Prudential).

Employee's Signature: ______________________________ Date: __________

SUPPLEMENTAL TERM LIFE INSURANCE BENEFICIARY DESIGNATION FORM

Policyholder's Name: **State of Ohio** Group Policy Number: **93046**

Use the space below to name beneficiaries of the employee. If you wish, you may name one or more primary beneficiaries. You may also name one or more contingent beneficiaries. This form allows you to name up to two primary and two contingent beneficiaries. If you need additional space, please attach a separate sheet of paper. After you have completed your entries, please sign and date in the space below.

If you wish, you may indicate the percentage share designated to each primary beneficiary. The total for one or all primary beneficiaries must equal 100%. If no percentages are specified, the proceeds will be split evenly among those named. If no named beneficiary survives you, any amount of insurance will be made payable to the first of the following: Your (a) surviving spouse, (b) surviving child(ren) in equal shares, (c) surviving parents in equal shares, (d) surviving siblings in equal shares, (e) estate. If designating percentages for contingent beneficiaries, the percentage for all contingent beneficiaries must also equal 100%.

DEFINITIONS. You may find the following definitions helpful in completing this form:
Primary Beneficiary(ies) - the person(s) or entity you choose to receive your life insurance proceeds. Payment will be made in equal shares unless otherwise specified. In the event that a designated primary beneficiary predeceases the insured, the proceeds will be paid to the remaining primary beneficiaries in equal shares or all to the sole remaining primary beneficiary.

Contingent Beneficiary(ies) - the person(s) or entity you choose to receive your life insurance proceeds if the primary beneficiary(ies) die (or the entity dissolves) before you die. Payment will be made in equal shares unless otherwise specified. In the event that a designated contingent beneficiary predeceases the insured, the proceeds will be paid to the remaining contingent beneficiaries in equal shares or all to the sole remaining contingent beneficiary.

PRIMARY BENEFICIARY(IES)

First Name	Middle Initial	Last Name	Relationship to employee	DOB
Address		Social Security No.	% Share	

First Name	Middle Initial	Last Name	Relationship to employee	DOB
Address		Social Security No.	% Share	

CONTINGENT BENEFICIARY(IES) (optional)

First Name	Middle Initial	Last Name	Relationship to employee	DOB
Address		Social Security No.	% Share	

First Name	Middle Initial	Last Name	Relationship to employee	DOB
Address		Social Security No.	% Share	

Supplemental Term Life Insurance coverage is issued by The Prudential Insurance Company of America, 751 Broad Street, Newark, NJ 07102. Contract Series 83500.

Employee's Signature: ______________________________ Date: ______________

PLEASE KEEP A COPY OF THIS FORM FOR YOUR RECORDS.

Mail the original form to: The Prudential Insurance Company of America • PO Box 5072 • Millville, NJ 08332-9931

Call Prudential with questions: 800-778-3827

PLEASE COMPLETE ALL REQUESTED INFORMATION
(Please see back of form for additional information)

OhioDAS
Ohio Department of Administrative Services

For residents of all states except the District of Columbia, Florida, Kentucky, New Jersey, 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.

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.

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.

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.

Group Supplemental Term Life and Dependent Term Life Insurance coverages 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.

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