



Prudential

**GROUP LIFE
ENROLLMENT/CHANGE CARD**
The Prudential Insurance Company of America

Please refer to the description of your plan for coverage options and amounts available to you.

Employee's Last Name	First Name	MI	Name of Employer Allegheny County	Group Policy No. #49156	Claim Branch
Employee's Address				Employee's Annual Salary \$	
Social Security No. - -	Date of Birth / /	Date Employed / /	<input type="checkbox"/> Married <input type="checkbox"/> Single	<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	<input type="checkbox"/> Male <input type="checkbox"/> Female

Please mark the appropriate box according to your plan.

Type of Coverage	<input type="checkbox"/> Basic Life/AD&D (Non Contrib.)	<input type="checkbox"/> Basic Life/AD&D (Contrib.)	<input type="checkbox"/> Optional Term Life (Employee)	<input type="checkbox"/> Optional Term Life (Spouse)	<input type="checkbox"/> Child Life (Dependent)	<input type="checkbox"/> Optional Accidental Death & Dismemberment (Employee)	<input type="checkbox"/> Optional Accidental Death & Dismemberment (Family)
Enter Amount							
Effective Date							

Note: Dependent Child is under age 20 and under age 25 for full time student.
Spouse life coverage amount may not exceed 100% of the amount of employee life coverage amount.

EMPLOYEE'S DEPENDENT INFORMATION

Dependent's Last Name	First Name	MI	Date of Birth	Relationship to Employee
			/ /	
			/ /	
			/ /	

EMPLOYEE'S SIGNATURE

- I am enrolling for coverage and I authorize my employer to deduct from my earnings until further notice my contributions for insurance under a contract issued by The Prudential Insurance Company of America. I understand that if I desire to increase the amount of my insurance or add dependent coverage hereafter, I may be required to furnish evidence of insurability for myself and/or my dependents. I declare the statement above is true and understand it is the basis for determining the monthly contribution for coverage.
- I do not wish to enroll for any of the above optional coverages. I certify that I have been given the opportunity by my above named employer to enroll for coverage. I understand that if I desire to enroll hereafter, I may be required to furnish evidence of insurability for myself and/or my dependents.

Employee Signature _____ Date (Month/Day/Year) _____ / _____ / _____

IMPORTANT NOTICE

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 a statement of claim for payment of a loss or benefit commits a fraudulent insurance act, 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.

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.

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.

PENNSYLVANIA 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.

FOR EMPLOYER'S USE ONLY										
CHANGES OF BENEFICIARY										
DATE OF CHANGE	NEW BENEFICIARY DESIGNATED					RELATIONSHIP				
ADDITIONAL INFORMATION:										
CHANGED AMOUNT OF INSURANCE										
COVERAGE	CHANGE 1		CHANGE 2		CHANGE 3		CHANGE 4		CHANGE 5	
	Eff. Date	Amount	Eff. Date	Amount	Eff. Date	Amount	Eff. Date	Amount	Eff. Date	Amount
Basic Life/AD&D (Non Contrib.)										
Basic Life/AD&D (Contrib.)										
Optional Term Life (Employee)										
Optional Term Life (Spouse)										
Child Life (Dependent)										
Optional Accidental Death & Dismemberment (Employee)										
Optional Accidental Death & Dismemberment (Family)										

NEW YORK: Receipt of accelerated death benefits may affect eligibility for public assistance programs and may be taxable.

Basic Term Life, Dependent Term Life, Optional Term Life, and Basic and Optional Accidental Death & Dismemberment coverages are issued by The Prudential Insurance Company of America, 751 Broad Street, Newark, NJ 07102. Prudential and the Rock logo are registered service marks of The Prudential Insurance Company of America and its affiliates. The Accidental Death & Dismemberment phone number is: 800-524-0542. Please refer to the Booklet-Certificate for all plan details, including any exclusions, limitations, and restrictions which may apply. Contract series: 83500. 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.

The Prudential Insurance Company of America is a Prudential Financial company.