

**Employer:**

**Group Contract No.(s):**
**Branch No.:**


**Short Form Health Statement** (Submit a separate form for each person whose coverage requires Evidence of Insurability.)

**Employee**

First Name

MI

Last Name




Number and Street

P.O. Box / Apt. Number



City

State

ZIP Code


 - 

Social Security Number

Employee ID Number

Telephone

 -  - 

 -  - 

Email Address

**Name of Person for Whom Insurance is Being Requested**

 Relationship to Employee:  Self  Spouse or Domestic Partner

First Name

MI

Last Name

Social Security Number



 -  - 

 Coverage that requires Evidence of Insurability: **Employee**  Life **Spouse or Domestic Partner**  Life

Gender:

Height:

Weight:

Date of Birth: (mm-dd-yyyy)

 Female  Male

 ft.

 in.

 lbs.

 -  - 

Please answer these questions by checking "Yes" or "No". Note: In this section, "you" refers to the person for whom the insurance is being requested.

 Yes  No  **As of the date of this Health Statement**, do you have any disorder, condition, or disease or are you currently taking prescription medication for any disorder, condition, or disease (other than: acid reflux; allergies; cold; cough; herniated disc; high cholesterol; nonrheumatoid arthritis; overactive or underactive thyroid; or pregnancy)?

 Yes  No  **In the last five years** have you been diagnosed with or treated by a medical or other practitioner for, or been in a hospital or other facility for any of the following?

- Chest pain, heart disease or disorder, high blood pressure;
- Cancer, tumors;
- Respiratory disease or disorder of the lungs;
- Multiple sclerosis, epilepsy, seizure, stroke;
- Kidney, liver or pancreas disease or disorder;
- Diabetes;
- Mental or nervous disorder;
- Alcoholism, drug addiction;
- Chronic pain, rheumatoid arthritis, lupus; or
- Colitis, Crohn's disease, gastric bypass.

 Yes  No  **In the last five years**, have you been diagnosed with or treated by a member of the medical profession for immune deficiency disorder, Acquired Immune Deficiency Disorder (AIDS), AIDS Related Complex (ARC) or test results indicating exposure to the AIDS virus?

**Prudential reserves the right to request additional health information on the basis of the responses given to the above questions.**


\* L S F A W A 0 0 1 \*

Group Contract No.(s):

Branch No.:

0 0

**Important Notice: For residents of all states except: Alabama, Arkansas, District of Columbia, Florida, Kentucky, Louisiana, Maine, Maryland, New Jersey, New York, North Carolina, Pennsylvania, Puerto Rico, 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.

**ARKANSAS, DISTRICT OF COLUMBIA, LOUISIANA 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.

**MAINE and 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.

**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.

**NORTH CAROLINA RESIDENTS**—Any person who, with the intent to injure, defraud, or deceive an insurer or insurance claimant, knowing that the statement contains false or misleading information concerning a fact or matter material to the claim may be guilty of a Class H felony.

**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.

**PUERTO RICO RESIDENTS**—Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars (\$5,000) and not more than ten thousand dollars (\$10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances [be] present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

**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, with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.



\* L S F A W A 0 0 2 \*

Group Contract No.(s):

Branch No.:

0 0

**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 have read and understand the terms and requirements of the fraud warnings included as part of this form.**

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.

Print Your First Name

Print Your First Name

Last Name

Last Name

Your Social Security Number

Your Social Security Number

Your Signature (unless a minor)

Date Signed (mm-dd-yyyy)

Date Signed (mm-dd-yyyy)

If Person for whom insurance is being requested is a minor,  
Signature of Parent, Guardian, or Person Liable for Support

Relationship

Date Signed (mm-dd-yyyy)

Date Signed (mm-dd-yyyy)

**Please keep a copy of this form for your records.**

Group Life Insurance coverage is issued by The Prudential Insurance Company of America, a New Jersey company, 751 Broad Street, Newark, NJ 07102.

© 2015 Prudential Financial, Inc. and its related entities.

Prudential, the Prudential logo, and the Rock symbol are service marks of Prudential Financial, Inc. and its related entities, registered in many jurisdictions worldwide.



\* L S F A W A 0 0 3 \*

## Group Life and Disability Income Medical Underwriting NOTICE

Thank you for choosing The Prudential Insurance Company of America (Prudential) for your insurance needs. Before we can issue coverage we must review your application/enrollment form. To do this, we need to collect and evaluate personal information about you. This notice is being provided to inform you of certain information practices Prudential engages in, and your rights, with regard to your personal information. We would like you to know that:

- Personal information may be collected from persons other than yourself or other individuals, if applicable, proposed for coverage;
- This personal information as well as other personal or privileged information subsequently collected by us may in certain circumstances be disclosed to third parties without authorization;
- You have a right of access and correction with respect to personal information we collect about you; and
- Upon request from you, we will provide you with a more detailed notice of our information practices and your rights with respect to such information. Should you wish to receive this notice, please contact:

The Prudential Insurance Company of America  
Group Medical Underwriting  
P.O. Box 8796  
Philadelphia, PA 19176

Information regarding your insurability will be treated as confidential. We may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life, disability, or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file. In addition, upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901. If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400 Braintree, Massachusetts 02184-8734. Information for consumers about MIB may be obtained on its website at [www.mib.com](http://www.mib.com).

**Please keep this notice for your records.**