The Prudential Insurance Company of America, 751 Broad Street, Newark, New Jersey 07102

SUPPLEMENTAL TERM LIFE INSURANCE ENROLLMENT FORM

Policyholder's Name: **Union Benefits Trust** Group Policy Number: **LG-01049**

☐ New enrollment ☐ Change ☐ Terminate member coverage (includes spouse/child(ren) coverage)

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

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

Department ID Number: ______________________________ (State department in which you work)

Member Insurance Total Amount Requested: ____________ Include current amount of supplemental coverage for the member, plus the amount of increase in $10,000 increments **(do not include spouse/child(ren) 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.

Member Name (Last, First, Middle Initial) ______________________________

Member's Address ____________ City ____________ State ______ ZIP Code ________

Social Security No. ____________ DOB ________ ☐ M ☐ F ☐ Married ☐ Single

Occupation ____________ Date Employed ________ Base Annual Earnings ____________

Telephone No. ______________________ State of Ohio User ID ____________

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

Are you transferring to UBT from the State of Ohio? ☐ Yes ☐ No If yes, Original Date of Hire ____________

(The right to change the beneficiary is reserved. To name beneficiaries, please use the next page of this form or the Supplemental Term Life Beneficiary Designation Form.)

Member must have Supplemental Term Life Insurance to enroll spouse and/or child(ren).
You will automatically be the beneficiary for life insurance on the lives of your spouse and child(ren), if surviving; otherwise, it will be the estate of the spouse and child(ren), subject to policy provisions.

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

Spouse's Name (Last, First, Middle Initial) ______________________ (Include current amount of coverage.)

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 Child(ren) ________

Child(ren) coverage is from 15 days after live birth to age 26, if dependent upon the employee for maintenance and support.

You have 90 days from your hire date to purchase supplemental term life coverage for you, your spouse, and your dependent child(ren). Coverage is also available during each Trust-sponsored open enrollment period.

This plan is totally separate from your basic life plan with Union Benefits Trust, 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 may have coverage as either a spouse or a member, but not both. Child(ren) can only be covered as dependents of only one member. 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 member, and that I will not be able to apply for more coverage. 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 Union Benefits Trust by The Prudential Insurance Company of America (Prudential).

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.

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. This notice ONLY applies to accident and disability income coverage.

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

Member's Signature: ______________________ Date: ____________

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

SUPPLEMENTAL TERM LIFE INSURANCE ENROLLMENT FORM

Policyholder's Name: **Union Benefits Trust** Group Policy Number: **LG-01049**

Use the space below to name beneficiaries of the member. 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 Member ____ DOB ____________________

Address ____

Phone No. _________________________ Social Security No. _______________________ % Share __________

First Name ______________________ Middle Initial ________ Last Name ______________________________

Relationship to Member ____ DOB ____________________

Address ____

Phone No. _________________________ Social Security No. _______________________ % Share __________

CONTINGENT BENEFICIARY(IES) (optional)

First Name ______________________ Middle Initial ________ Last Name ______________________________

Relationship to Member ____ DOB ____________________

Address ____

Phone No. _________________________ Social Security No. _______________________ % Share __________

First Name ______________________ Middle Initial ________ Last Name ______________________________

Relationship to Member ____ DOB ____________________

Address ____

Phone No. _________________________ 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.

Member'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 13676 • Philadelphia, PA 19176

Call Prudential with questions: 800-778-3827

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

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

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.

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.

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 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.

FOR INSUREDS WHO RESIDE IN MICHIGAN ONLY—If you wish to enroll your spouse, and/or eligible child 18 years of age or older for Dependent Life coverage, your spouse, and/or each of your eligible children age 18 years or older must consent to such coverage by signing and dating this consent in the appropriate space(s) below.

Spouse Signature ______________________________ Date ______________

Child Signature ______________________________ Date ______________

Child Signature ______________________________ Date ______________

Accelerated Death Benefit option is a feature that is made available to group life insurance participants. It is not a health, nursing home, or long-term care insurance benefit and is not designed to eliminate the need for those types of insurance coverage. The death benefit is reduced by the amount of the accelerated death benefit paid. There is no administrative fee to accelerate benefits. Receipt of accelerated death benefits may affect eligibility for public assistance and may be taxable. The federal income tax treatment of payments made under this rider depends upon whether the insured is the recipient of the benefits and is considered “terminally ill” or “chronically ill.” You may wish to seek professional tax advice before exercising this option.

Group Supplemental Term Life and Dependent Term Life Insurance coverages are issued by The Prudential Insurance Company of America, a Prudential Financial 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. Contract provisions may vary by state. California COA #1179, NAIC #68241. Contract series: 83500.

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