

SUPPLEMENTAL TERM LIFE INSURANCE ENROLLMENT FORM

Policyholder's Name: Union Benefits Trust

Group Policy Number: LG-01049

Enrollment options: New enrollment, Change, Terminate member coverage. Includes checkboxes for coverage changes like 'Increase My Coverage' and 'Add Spouse Coverage'.

Members Residing in All States Other Than North Carolina and Florida

State Agency: (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).

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 8 Digit ID

Have you smoked cigarettes or used any form of tobacco in the past 12 months?
Are you transferring to UBT from the State of Ohio?
(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).
Spouse Coverage Desired? Spouse Insurance Total Amount:
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?
Child(ren) Coverage Desired? Child(ren) Insurance Amount: Number of Child(ren)
Child(ren) coverage is from 15 days after live birth to age 26.

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).

- * Premium deductions may increase due to age increases.
* Early Voluntary Termination of Coverage- Voluntarily coverage will be active until the last day of month following last premium deduction.
* Members on unpaid leave are responsible for voluntary coverage premium payments while on leave. Contact Prudential for direct bill.

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." You may wish to seek professional tax advice before exercising this option.

For residents of all states except Alabama, Arkansas, the 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.

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.

PENNSYLVANIA -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.

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.

© 2019 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.



SUPPLEMENTAL TERM LIFE INSURANCE ENROLLMENT FORM

Policyholder's Name: Union Benefits Trust

Group Policy Number: LG-01049

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

Member's Signature _____ Date _____

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 Insurance 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. Coverage on your spouse and/or eligible children age 18 or older will not become effective unless and until the requisite consent is provided.

Spouse Signature _____ Date _____

Child Signature _____ Date _____ Child Signature _____ Date _____

PLEASE KEEP A COPY OF THIS FORM FOR YOUR RECORDS.

Fax the completed form to: 888-772-5265
Mail the original form to: The Prudential Insurance Company of America • PO Box 13676 • Philadelphia, PA 19176
Call Prudential with questions: 800-778-3827

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%. You/member are automatically the beneficiary for any coverage on your spouse and children.

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 _____

Member's Signature _____ Date _____

