

Evidence of Insurability

The University of California - Group Contract Number: 97000

Use this form to enroll in group life insurance outside of your Period of Initial Eligibility (P.I.E.), or to increase life insurance at any time.

Instructions for Employer

1. Complete the information below.
2. Complete all sections of the form noted Part A.
3. The entire package should then be given to your employee for completion of Part B.

Employee Name: _____

Please check the employee's University location:

- | | |
|---|--|
| <input type="checkbox"/> ANR (B8) | <input type="checkbox"/> OP (B7) |
| <input type="checkbox"/> ASUCLA (B4) | <input type="checkbox"/> RIVERSIDE (A5) |
| <input type="checkbox"/> BERKELEY (A1) | <input type="checkbox"/> SAN DIEGO (A6) |
| <input type="checkbox"/> DAVIS (A3) | <input type="checkbox"/> SAN DIEGO MC (B6) |
| <input type="checkbox"/> DAVIS MC (B3) | <input type="checkbox"/> SAN FRANCISCO (A2) |
| <input type="checkbox"/> HASTINGS (B2) | <input type="checkbox"/> SAN FRANCISCO MC (C2) |
| <input type="checkbox"/> IRVINE (A9) | <input type="checkbox"/> SANTA BARBARA (A8) |
| <input type="checkbox"/> IRVINE MC (B9) | <input type="checkbox"/> SANTA CRUZ (A7) |
| <input type="checkbox"/> LANL (B1) | <input type="checkbox"/> UCLA (A4) |
| <input type="checkbox"/> LBL (B5) | <input type="checkbox"/> UCLA MC (C0) |
| <input type="checkbox"/> LLNL (B0) | |

Instructions for Employee (Complete the required sections as noted below.)

1. If you are providing evidence of insurability for:
 - a) Employee coverage only—Complete Sections 1, 2, 4, and 5.
 - b) Dependent coverage only—Complete Sections 1, 3, 4, and 5.
 - c) Employee and Dependent coverage—Complete all sections of this form.
(Note: Evidence of insurability is not required for children.)
2. Please complete the form in blue or black ink. Sign and date Sections 4 and 5.
3. Please read and tear off the important Medical Information Notice that accompanies these instructions and retain for your records. Please retain a copy of your completed application for your own records.
4. Mail the completed form Part A and Part B to:

**The Prudential Insurance Company of America
Group Medical Underwriting
P.O. Box 8796
Philadelphia, PA 19101**

**Or fax the completed form to:
877-605-6671**

The evaluation of your request for coverage may be delayed if you do not follow these instructions, if you and/or your dependents do not answer all questions on the Part B form, or if you do not give complete details for any answers requiring details, or if you do not provide complete names and addresses of doctors and hospitals.

NOTE: Coverage is not effective until this request has been approved. You will be notified whether or not coverage has been approved.

If you have questions regarding the completion of these forms, please contact Prudential Customer Service at 888-257-0412 or e-mail us at medical.uw@prudential.com.

Part B

Employee Information

Section 1

1. Employee First Name	MI	Last Name
<input type="text"/>	<input type="text"/>	<input type="text"/>
2. Employee Social Security Number	3. Employee Phone Number	
<input type="text"/> - <input type="text"/> - <input type="text"/>	Daytime <input type="text"/> <input type="text"/> - <input type="text"/>	
	Evening <input type="text"/> <input type="text"/> - <input type="text"/>	
4. Street	Apt.	
<input type="text"/>	<input type="text"/>	
City	State	ZIP code
<input type="text"/>	<input type="text"/>	<input type="text"/> - <input type="text"/>
5. E-mail Address <input type="text"/>		

Section 2

6. Date of Birth	7. Birth Place	
<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	
month day year	city state	
8. Sex	9. Height	10. Weight
<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="text"/> ft. <input type="text"/> in.	<input type="text"/> lbs.

Section 3

1. Employee's eligible dependent that requires evidence of insurability.

Full Name	Social Security Number	Relationship to You	Date of Birth	Place of Birth	Height	Weight

2. Address of your dependent (if different from address in Section 1):

3. Is the person named above unable to perform all of the duties of his/her job or home-confined? Yes No

4. Has the person named above **during the last five years**:

- a. had any surgery or been advised to have surgery and has not done so? Yes No
- b. been in a hospital, sanitarium, or other institution for observation, rest, diagnosis, or treatment?
- c. used, or are now using, cocaine, barbiturates, amphetamines, marijuana or other hallucinatory drugs, heroin, opiates, or other narcotics, except as prescribed by a doctor? Yes No
- d. been treated or counseled for alcoholism? Yes No
- e. been treated or counseled by a psychologist or psychiatrist? Yes No
- f. applied for or received disability income benefits or pension benefits on account of sickness or injury? Yes No
- g. had life, disability, or health insurance declined, postponed, changed, rated-up, cancelled, or withdrawn? Yes No
- h. been diagnosed as having, or treated by a member of the medical profession for, Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? Yes No

5. **Within the last five years**, has the person named above been treated for, or had any trouble with, any of the following:

- | | | | | | | | | |
|-------------------------|--------------------------|--------------------------|---------------------------------|--------------------------|--------------------------|------------------------------|--------------------------|--------------------------|
| | Yes | No | | Yes | No | | Yes | No |
| a. Heart or chest pain? | <input type="checkbox"/> | <input type="checkbox"/> | g. Nervous or mental disorders? | <input type="checkbox"/> | <input type="checkbox"/> | m. Urinary system? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. High blood pressure? | <input type="checkbox"/> | <input type="checkbox"/> | h. Arthritis or rheumatism? | <input type="checkbox"/> | <input type="checkbox"/> | n. Goiter or glands? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Abnormal pulse? | <input type="checkbox"/> | <input type="checkbox"/> | i. Ulcers or stomach disorders? | <input type="checkbox"/> | <input type="checkbox"/> | o. Pleurisy or asthma? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Cancer or tumors? | <input type="checkbox"/> | <input type="checkbox"/> | j. Intestines or kidneys? | <input type="checkbox"/> | <input type="checkbox"/> | p. Chronic diarrhea? | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Diabetes? | <input type="checkbox"/> | <input type="checkbox"/> | k. Liver or gallstones? | <input type="checkbox"/> | <input type="checkbox"/> | q. Neuritis or sciatica? | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Lungs? | <input type="checkbox"/> | <input type="checkbox"/> | l. Genital disorder? | <input type="checkbox"/> | <input type="checkbox"/> | r. Back or spinal disorders? | <input type="checkbox"/> | <input type="checkbox"/> |

6. Does the person named above **currently have** any disorder, condition (including pregnancy), disease, or defect not shown above, and/or is he/she currently taking medication prescribed or provided by a medical or other practitioner for any disorder, condition (including pregnancy), disease, or defect?

7. What are the full details of all "Yes" answers to each part of 3 through 6 above? Attach additional pages if needed.

Dependent's Name	Question Number and Letter	Specify illness or condition. Include reason for any check-up, doctor's advice, treatment, and/or medication	Date illness or condition began		Time lost from normal activities	Full recovery (if applicable)		Print full names, addresses, and telephone numbers of doctors and/or hospitals
			Month	Year		Month	Year	

Section 4

In all states except Arkansas, Colorado, Florida, Maine, Maryland, Massachusetts, Ohio, Oregon, New York, New Jersey, Tennessee, Virginia, and the District of Columbia: 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 subjects such person to criminal and civil penalties.

In Arkansas, Colorado, Maine, Maryland, New York, Ohio, Tennessee, and the District of Columbia: 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 subjects such person to criminal and civil penalties. In addition, any person who commits such a fraudulent act:

- may be subject to fines and confinement in prison under Arkansas law.
- is subject to penalties that may include imprisonment, fines, denial of insurance, and civil damages under Colorado law. Also, any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement of award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.
- may be subject to penalties that may include imprisonment, fines, or a denial of insurance benefits under Maine law.
- may be found guilty of insurance fraud under Maryland law.
- is subject to civil penalties, with such penalties not exceeding \$5,000 and the stated value of the claim for each such violation under New York law. This notice ONLY applies to disability income coverage in New York.
- is guilty of insurance fraud under Ohio law.
- is subject to penalties including imprisonment, fines, and denial of insurance benefits under Tennessee law.
- may be subject to imprisonment and/or fines under the law of the District of Columbia.

In Florida: 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.

In New Jersey: Any person who includes false or misleading information on an application for insurance under a group contract is subject to criminal and civil penalties.

In Virginia: Any person who knowingly provides false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company has committed a crime. Penalties include imprisonment, fine, and denial of insurance benefits.

In Massachusetts: 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 may subject such person to criminal and civil penalties.

In Oregon: 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 may be a crime and may subject such person to criminal and civil penalties.

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.

Signature of Employee

Date

Section 5 — AUTHORIZATION For the Release of Information

To: (1) Any licensed physician, medical practitioner, hospital, clinic, or other medically related facility, (2) any insurance company, health maintenance organization (or similar type organization or institution), and (3) the Medical Information Bureau. So that eligibility for life or disability coverage can be determined, I authorize you to give any data or records you may have about me or my mental or physical health to The Prudential Insurance Company of America and/or its subsidiaries and, through it, to its reinsurers, authorized agents, and the Medical Information Bureau. This also applies to any dependent proposed for coverage in the application. This authorization is valid for the lesser of (1) two years after the effective date of any coverage issued in connection with it or (2) 30 months after the date it is signed. A photocopy of this form will be as valid as the original. The person(s) who signed this form (1) have received a copy of the "Medical Information Notice" and (2) may have a copy of this authorization if they wish.

Signature of Employee

Employee Social Security No.

Date

Signature of Spouse (if applicable)

Date

Medical Information Notice

When we evaluate your request for insurance, the state of health of the person(s) for whom insurance is requested is, of course, extremely important to us. Consequently, we need to ask you questions about the health and medical history of each person. In addition, you are also requested to authorize any physician or hospital to provide us with reports, if necessary, about the health of each person. In some instances we may require a physical examination.

Any information we obtain regarding a person's insurability will be treated as confidential. We may, however, make a brief report of it to the Medical Information Bureau (the Bureau), a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. When you apply for life, disability, or health insurance to any company, including Prudential, which is a member of the Bureau, or submit a claim for benefits to such a company, the Bureau will, on request, give the company the information in its files. We may also reveal this information, as necessary, to a doctor, if we find a serious health problem you do not know about. We may also reveal this information to persons conducting mortality or morbidity studies. We will, if you ask, give you a description of other circumstances when we disclose information about you without your prior authorization.

You have the right to see any of the personal information we collect about you and to make corrections if necessary. If you ask, we will furnish you with instructions on how to exercise this right. In addition, upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If the information came from the Bureau and you question the accuracy of the information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's Information Office is P.O. Box 105, Essex Station, Boston, Massachusetts 02112, 617-426-3660.

It is required that you be given this notice.

Please read it carefully and keep it for your records.