# Evidence of Insurability

## Instructions for Employer/Association

1. Complete the form below.

2. Also complete all sections of the form noted PART A including product-related information as applicable to the plan(s) requiring medical evidence of insurability.

3. The entire package should then be given to your employee or member for completion of PART B.

**For Employer/Association Use Only:**

In the space below, insert mailing address to which the notice of action should be sent.

Employee/Member Name: _____

Employer/Association Name & Address:

_____

_____

_____

Group Contract No.: _____ Branch No.: _____

Submitting Location: _____

Submitted by:

_____
Name

_____
Title

_____
Telephone Number

_____
Email Address

_____
Date



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## Part A Employer/Association Information

Complete this page for those plans requiring evidence of insurability, then give this package to the employee/member.

Employee/Member First Name | MI | Last Name

Date of Birth | Social Security Number | Sex ☐ Male ☐ Female

Street | Apt.

City | State | ZIP Code

Date individual first became eligible for coverage(s)/amount(s) of insurance this form applies to:

Employee/Member Annual Earnings: $ _____

Is application being made for amounts above the life non-medical maximum? Yes ☐ No ☐

Is application being made as a late entrant? Yes ☐ No ☐

Is application being made for dependents? Yes ☐ No ☐

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Complete only for those coverages and persons requiring evidence of insurability.
(For example: Employee only, spouse only, or employee and spouse.)

### Life/AD&D

Total Non-Medical Maximum $ _____

| | Current Amount In Force | + | Addt'l or Initial Amount Requested | = | Total Amount |
|---|---|---|---|---|---|
| Employee/Member | $ _____ | + | $ _____ | = | $ _____ |
| Spouse (Life Only) | $ _____ | + | $ _____ | = | $ _____ |

### Long Term Disability

| | Current Amount In Force | + | Addt'l or Initial Amount Requested | = | Total Amount |
|---|---|---|---|---|---|
| Employee/Member | $ _____ | + | $ _____ /mo | = | $ _____ |

### Survivor Benefits Life

| | Current Amount In Force | + | Addt'l or Initial Amount Requested | = | Total Amount |
|---|---|---|---|---|---|
| Spouse | $ _____ /mo | + | $ _____ /mo | = | $ _____ |
| Child | $ _____ /mo | + | $ _____ /mo | = | $ _____ |

### Weekly Disability Income/Accident & Sickness Benefit

Amount $ _____

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

**1. If you are providing evidence of insurability for:**

**a) Employee/Member coverage only – Complete Sections 1, 2, 4, and 5.**

**b) Dependent coverage only – Complete Sections 1, 3, 4, and 5.**

**c) Employee/Member 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 PART A and PART B forms to:

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

**This form can also be sent by fax 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 dependent do not answer all questions on the PART B form, 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 email us at medical.uw@prudential.com.

# Part B Employee/Member Information

### Section 1

1. Employee/Member First Name | MI | Last Name

2. Employee/Member Social Security Number

3. Employee/Member Phone Number

Daytime

Evening

4. Street | Apt.

City | State | ZIP Code

5. Email Address

### Section 2

6. Date of Birth

month day year

7. Birth Place

city state

8. Sex

☐ Male ☐ Female

**Section 2 (continued)**

9. Name and address of current doctor:

Physician First Name | MI | Last Name

Street | Suite

City | State | ZIP Code

10. Are you currently able to perform all the duties of your job? Yes ☐ No ☐
If "No", provide full details in item 15.

11. Have you **during the last five years:**

a. had any surgery or been advised to have surgery and have not done so? Yes ☐ No ☐
b. been in a hospital, sanitarium, or other institution for observation, rest, diagnosis, or treatment? Yes ☐ No ☐
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 ☐

12. **Within the last five years,** have you been treated for, or had any trouble with, any of the following:

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

13. Do you **currently have** any disorder, condition (including pregnancy), disease, or defect not shown above, and/or are you currently taking medication prescribed or provided by a medical or other practitioner for any disorder, condition (including pregnancy), disease, or defect? Yes ☐ No ☐

14. Have you smoked cigarettes or used another tobacco product (including cigars or chewing tobacco) or used nicotine gum within the past year? If "Yes", which product? _____ Yes ☐ No ☐

15. What are the full details of all "Yes" answers to each part of 11 through 13? Attach additional pages if needed.

| 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 *Month Year* | Time lost from normal activities | Full recovery (if applicable) *Month Year* | Print full names, addresses, and telephone numbers of doctors and/or hospitals |
|---|---|---|---|---|---|
| | | | | | |
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## Section 3

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

| Full Name | Social Security Number | Relationship to You | Date of Birth | Place of Birth |
|---|---|---|---|---|
| | | | | |
| | | | | |

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? Yes ☐ No ☐
   c. used, or is 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? | ☐ | ☐ | g. Nervous or mental disorders? | ☐ | ☐ | m. Urinary system? | ☐ | ☐ |
| b. High blood pressure? | ☐ | ☐ | h. Arthritis or rheumatism? | ☐ | ☐ | n. Goiter or glands? | ☐ | ☐ |
| c. Abnormal pulse? | ☐ | ☐ | i. Ulcers or stomach disorders? | ☐ | ☐ | o. Pleurisy or asthma? | ☐ | ☐ |
| d. Cancer or tumors? | ☐ | ☐ | j. Intestines or kidneys? | ☐ | ☐ | p. Chronic diarrhea? | ☐ | ☐ |
| e. Diabetes? | ☐ | ☐ | k. Liver or gallstones? | ☐ | ☐ | q. Neuritis or sciatica? | ☐ | ☐ |
| f. Lungs? | ☐ | ☐ | l. Genital disorder? | ☐ | ☐ | r. Back or spinal disorders? | ☐ | ☐ |

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? Yes ☐ No ☐

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 *Month Year* | Time lost from normal activities | Full recovery (if applicable) *Month Year* | Print full names, addresses, and telephone numbers of doctors and/or hospitals |
|---|---|---|---|---|---|---|
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## Section 4

**Important Notice: For residents of all states except Alabama, District of Columbia, Florida, Kentucky, Maryland, New Jersey, New York, Pennsylvania, 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.

**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.

**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.

**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.**

**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.

**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.

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/Member

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 or health maintenance organization (or similar type organization or institution); and (3) the MIB Inc., formerly known as 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 MIB Inc., formerly known as 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/Member | Employee/Member 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.

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 non-profit membership organization of 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. We may reveal this information as necessary, to a doctor, if we find a serious health problem that 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 information we collect about you and to make corrections if necessary. If you ask, we will furnish you with instruction on how to exercise this right. 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.

**It is required that you be given this notice.**
**Please read it carefully and keep it for your records.**

Prudential

# 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 non-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.

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