The Prudential Insurance Company of America

GROUP CRITICAL ILLNESS CONTINUATION FORM

Record Keeping Services, PO Box 13676
Philadelphia, PA 19176

Please refer to the description of your plan for coverage options and amounts available to you.

Employee/Member Data (to be completed by employee/member)

Last Name	First Name MI	☐ Male ☐ Female	Group Contract No.

Address	City	State	ZIP Code

Social Security No. – –	Date of Birth / /	

Have smoked cigarettes or used another tobacco product (including cigars or chewing tobacco) or used any nicotine products (including patches, gum or e-cigarettes) within the past year? ☐ Yes ☐ No

Group Critical Illness and/or Accident Insurance Coverage Amount(s) (to be completed by employer)

Complete all blocks. If your current plan does not include some of the options below, or the employee is not enrolled in the option, please indicate "not applicable" **(NA)**.

Coverage Termination Date	Reason and Date of Termination of Employment
Last Date Actively at Work	Group Contract Number
Current Basic Critical Illness Coverage Amount – Employee $	Current Voluntary Critical Illness Coverage Amount – Employee $
Current Basic Dependent Critical Illness Coverage Amount – Spouse $	Current Voluntary Dependent Critical Illness Coverage Amount – Spouse $
Current Basic Dependent Critical Illness Coverage Amount – Children $	Current Voluntary Dependent Critical Illness Coverage Amount – Children $

I certify that, to the best of my knowledge and belief, the information provided in the Group Critical Illness Insurance Coverage Amount(s) section is correct and the employee who is named on this form is eligible for continuation according to the terms specified in the Prudential group contract. I have read and understand the terms and requirements of the fraud warnings included as part of this form.

X _______________________ / / _______________________

Signature of Employer Representative (employer certification for continuation eligibility). | Date | Representative Phone Number

Dependent Spouse Coverage (Please complete if dependent Spouse coverage is being retained) (to be completed by employee/member)

Last Name	First Name MI	☐ Male ☐ Female	DOB / /	SSN – –

Spouse's Address	City	State	ZIP Code

Selection of Coverage Section (to be completed by the employee/applicant)

I ELECT TO CONTINUE MY BASIC CRITICAL ILLNESS COVERAGE FOR: ☐ Employee ☐ Spouse ☐ Child
I ELECT TO CONTINUE MY VOLUNTARY CRITICAL ILLNESS COVERAGE FOR: ☐ Employee ☐ Spouse ☐ Child

NEW HAMPSHIRE RESIDENTS – It is understood that no person to be covered for Critical Illness is also covered by any Title XIX program, designated as Medicaid or any similar name.

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 health coverage.**

☐ I am enrolling for coverage continuation and I understand I will be direct billed for this coverage for the length of the continuation period. I can also elect to pay premiums via Electronic Funds Transfer (EFT) once payment of the initial billing statement is received. I declare the information above is true and understand it is the basis for determining the monthly contribution for coverage. I understand that this is not health insurance and it does not reimburse me for medical expenses. It does not substitute for essential health benefits or minimum essential coverage as defined in federal law.

☐ I do not wish to enroll for the above coverage continuation. I certify that I have been given the opportunity by my above named employer to enroll for coverage continuation.

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

Employee/Member Signature ____________________

Date (Month/Day/Year) ____ / ____ / ____

The certificate provides limited benefits.
Review your certificate carefully.

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: 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 fact material 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 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.

Group Critical Illness Insurance coverage is a limited benefit policy issued by The Prudential Insurance Company of America, a Prudential Financial company, 751 Broad Street, Newark, NJ 07102. Prudential's Critical Illness Insurance is not a substitute for medical coverage that provides benefits for medical treatment, including hospital, surgical and medical expenses and does not provide reimbursement for such expenses. The Booklet-Certificate contains all details, including any policy exclusions, limitations, and restrictions which may apply. If there is a discrepancy between this document and the Booklet-Certificate/Group Contract issued by The Prudential Insurance Company of America, the Group Contract will govern. A more detailed description of the benefits, limitations, and exclusions applicable are contained in the Outline of Coverage provided at time of enrollment. Please contact Prudential for more information. Contract provisions may vary by state. California COA #1179, NAIC #68241. Contract Series: 114774.

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