Prudential

# ENROLLMENT FORM – HAMPSHIRE COLLEGE
## All Eligible Employees Other Than Those Residing in New York

Control # **60351**

| **Employee General Information** | Effective Date of Coverage (for office use only) / / | | |
|---|---|---|---|
| Last Name First Name MI | Email Address | Phone Number | |
| Address City State Zip Code | | | |
| Your Annual Earnings $ _____ | Social Security Number – – | Date of Birth (Month/Day/Year) / / | Date Employed (Month/Day/Year) / / |
| Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed | Spouse or Domestic Partner Date of Birth (Month/Day/Year) / / | | |

### Basic Term Life and Accidental Death & Dismemberment (AD&D)

**Your employer offers you Basic Term Life and AD&D Insurance coverage at no cost to you. You will automatically be enrolled in this plan.**

### Optional Term Life

☐ Coverage amount chosen: $_____ ☐ No coverage chosen

### Optional Dependent Term Life

You must be enrolled for Optional Term Life to elect coverage for your dependents. Spouse or Domestic Partner coverage cannot exceed 50% of your Optional Term Life coverage amount. Child(ren) coverage cannot exceed 50% of your Optional Term Life coverage amount.

**Spouse or Domestic Partner** ☐ No coverage chosen
☐ Coverage amount chosen: $_____

**Children** ☐ No coverage chosen
☐ Coverage amount chosen: $ _____

### Optional Accidental Death & Dismemberment (OAD&D)

You must be enrolled for Optional Term Life to elect OAD&D coverage for your dependents. Your dependents be must enrolled for Optional Dependent Term Life to elect OAD&D coverage for your dependents.

☐ Employee coverage amount chosen matches my Employee Optional Term Life coverage. ☐ No coverage chosen

☐ Spouse or Domestic Partner: Coverage amount chosen matches my Optional Dependent Term Life coverage. ☐ No coverage chosen

☐ Child(ren): Coverage amount chosen matches my Optional Dependent Term Life coverage. ☐ No coverage chosen

### Long Term Disability

**Your employer offers you Long Term Disability Insurance coverage at no cost to you. You will automatically be enrolled in this plan.**

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### Employee General Information

| Last Name | First Name | Middle Initial | Last 4 digits of Social Security No. |
|---|---|---|---|
| | | | XXX-XX- _____ |

### Acceptance or Waiver of Coverage

☐ I am enrolling for coverage and I authorize my employer to deduct from my earnings until further notice my contributions for insurance under a contract issued by The Prudential Insurance Company of America. I understand that if I desire to increase the amount of my insurance or add dependent coverage hereafter, I may be required to furnish evidence of insurability for myself and/or my dependents. To the best of my knowledge and belief, I declare the statement above is true and understand it is the basis for determining the contribution for coverage. I also understand that for coverage to become effective, I must be actively at work during the enrollment period and on the effective date of the plan. If I apply for an amount that requires evidence of insurability satisfactory to The Prudential Insurance Company of America, I must be actively at work on the date of approval for the amount requiring satisfactory evidence of insurability.

☐ I do not wish to enroll for any of the above optional coverages. I certify that I have been given the opportunity by my above named employer to enroll for coverage. I understand that if I desire to enroll hereafter, I may be required to furnish satisfactory evidence of insurability to The Prudential Insurance Company of America for myself and/or my dependents.

**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 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 warning ONLY applies to accident and disability coverage.**

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

Employee Signature _____ Date Signed (Month/Day/Year) _____

**FOR INSUREDS WHO RESIDE IN MICHIGAN OR MINNESOTA ONLY** – If you wish to enroll your Spouse or Domestic Partner and/or eligible child 18 years of age or older for Dependent Life and/or Accidental Death and Dismemberment Insurance coverage, your Spouse or Domestic Partner 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 or Domestic Partner and child(ren) age 18 or older will not become effective unless and until the requisite consent is provided.

Spouse or Domestic Partner Signature _____ Date Signed (Month/Day/Year) _____

Child Signature_____ Date Signed (Month/Day/Year) _____

Child Signature_____ Date Signed (Month/Day/Year) _____

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.

NOTICE TO CONSUMER: THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMAL ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES. ALSO, THE BENEFITS PROVIDED BY THIS POLICY CANNOT BE COORDINATED WITH THE BENEFITS PROVIDED BY OTHER COVERAGE. PLEASE REVIEW THE BENEFITS PROVIDED BY THIS POLICY CAREFULLY TO AVOID A DUPLICATION OF COVERAGE.

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| Employee General Information | | | |
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| Last Name | First Name | Middle Initial | Last 4 digits of Social Security No.<br>XXX-XX- _____ |

### Important Notices

**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.

**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 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 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, with the 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.

**You must also complete a separate beneficiary designation form.** If you have any questions, please see Human Resources for details.

Basic Term Life, Accidental Death & Dismemberment, Optional Term Life, Dependent Term Life, Long-Term Disability, Short-Term Disability Insurance coverages are issued by The Prudential Insurance Company of America, 751 Broad Street, Newark, NJ 07102. Life Claims: 1-800-524-0542 and Disability Support 1-800-842-1718. 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 Prudential, the terms of the Group Contract will govern. Contract provisions may vary by state. California COA #1179, NAIC#68241. Contract Series: 83500.

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