Voluntary Term Life Insurance Program
for

SAN LUIS OBISPO COMMUNITY COLLEGE

Contract Number: AG-50948-CA

If you are eligible, Voluntary Term Life Insurance is available to you, your eligible spouse, and your eligible dependent children. This insurance option provides low cost, pure life insurance protection—it is an ideal way to help provide financial protection during your working years.

ELIGIBILITY FOR THIS PROGRAM

Employee: (1) if your employer requires that you must be continuously employed by them for a minimum number of days, you must be continuously employed for at least that number of days; and (2) you must be actively performing the regular duties of your job for at least the required number of hours as defined in the Group Contract and work in the usual manner and at the usual place of employment or business (if you are not working due to illness or injury, you will *not* be eligible until you return to work); and (3) you must provide evidence of insurability satisfactory to The Prudential Insurance Company of America (Prudential), if we ask for it. If you are not working due to illness or injury, you will not be eligible until you return to work.

Spouse: Your spouse who is legally married (as determined by the laws of the state in which you live) to you is eligible to participate in this program. Spouse also means your registered domestic partner* as defined in the Group Contract. A spouse does not include anyone who is personally eligible as an employee. You must be covered in order for your spouse to be eligible for coverage.

*Your registered domestic partner means a person whose domestic partnership with you has been validly registered by the California Secretary of State; or a person with whom you have established a union other than marriage, recognized under California law as the equivalent of a registered domestic partner.

Dependent Children: Dependent children are your unmarried children from live birth to 25 years old and dependent upon you for financial support. Your children include your legally adopted children, children placed with you for adoption prior to legal adoption, and each of your stepchildren, domestic partner's children, children for whom you are the legal guardian, and foster children who depend on you for support and maintenance. A child placed with you for adoption prior to legal adoption is considered your qualified dependent from the date of placement for adoption, and is treated as though the child were a newborn child born to you.

A dependent child does not include anyone who is personally eligible as an employee. If you and your spouse are both eligible as an employee, your children may be insured as dependent children of either you or your spouse, but not both of you. You must be covered in order for your dependent children to be eligible for coverage.

A qualified dependent may be confined for medical care or treatment, at home or elsewhere. If a qualified dependent is so confined on the day that your dependent's insurance under a coverage for that qualified dependent, or any change in that insurance that is subject to this section, would take effect, it will not then take effect. The insurance or change will take effect upon the qualified dependent's final medical release from all such confinement. The other requirements for the insurance or change must also be met.

BENEFITS

Employee Coverage:

Classification	Maximum Benefit	Non-Medical Limit*
Superintendent, Management, Board members, Certificated, and Classified Employees.	$10,000 increments to a maximum of $500,000 not to exceed five (5) times annual earnings (rounded to the next highest $10,000).	Two (2) times annual earnings, rounded to the next highest $10,000 not to exceed $100,000.

Evidence of Insurability will be required on all employee amounts over the non-medical limit amount.
*To be eligible for non-medical limit, you must be an active employee and apply within 31 days of first becoming eligible for this coverage.
Annual earnings are defined as the gross amount of money paid to you by the employer in cash for performing the duties required of your job. Bonuses, overtime pay, earnings for more than 40 hours per week, and all other benefits are not included.

Dependent(s) Coverage*:

Spouse: Your spouse's amount must be in **$10,000** increments, not to exceed **$500,000**. Non-Medical Limit of up to **$20,000** is available. The spouse can only select coverage if the employee enrolls.

Dependent Children: You may select from the following coverage amounts: **$2,500, $5,000, $10,000.**

Your spouse and dependent children can only participate if you have NOT been denied coverage.

***Dependents' coverage may not exceed 100% of your approved coverage amount.**

Benefit Reduction Schedule
The coverage you and your spouse apply for will be automatically reduced to the following percentages when each of you reaches the following ages:

Age 70 – Coverage reduced to 65% of the pre-age 70 amount.
Age 75 – Coverage reduced to 50% of the pre-age 70 amount.

HIGHLIGHTS

Waiver of Premium
Premium will be waived for you, your spouse, and your children if **you**, the employee, are insured and become totally disabled for at least six consecutive months. Your total disability must occur while coverage is in force and prior to your attaining age 70. During the six-month waiting period, premiums for all coverage must be paid. Limitations and exclusions apply. Refer to the Group Contract for details.

Accelerated Death Benefit
The Accelerated Death Benefit for Terminal Illness allows individuals to "tap into" life insurance proceeds early. You can receive up to **90%** of the applicable Voluntary Term Life Insurance amount in the event of an insured's terminal illness. The maximum benefit payable under this option is **$500,000**. The balance of the coverage will be paid to the beneficiary at the death of the insured. Limitations and exclusions apply. Refer to the Group Contract for details.

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.

Conversion to Permanent Coverage
If your employment terminates for any reason or an insured becomes ineligible, you and your family may convert your voluntary coverage to permanent life insurance. In addition, if your insured dependents are no longer eligible for group insurance under your certificate, they may convert their insurance coverage to permanent life insurance. Additional requirements and limitations will apply if your coverage terminates because the Group Contract terminates. You (or your insured dependent) must sign an application for conversion within 31 days following the termination of your employment or eligibility (or dependent insurance ends) in order to convert your coverage without being required to submit additional health evidence. Coverage will be billed monthly. No additional fees for direct payment will apply under this option.

Continuation of Coverage
If your employment terminates for any reason or you become ineligible, you and your covered family may continue your Voluntary Group Term Life Insurance coverage on a direct payment basis at the same rate as long as the Group Contract remains in effect. YOU MUST CONTINUE your coverage in order to continue dependent coverage. If you elect this option, you will be billed on a semiannual or annual basis. A fee per billing will apply, and your premium cost is subject to change. You must sign an application for continuation within 31 days following the termination of your employment or eligibility. An insured on continued coverage may apply for conversion to permanent coverage at any time, but in no event more than 31 days after the termination of the Group Contract.

EXCLUSIONS

Suicide Exclusion
If you or your covered dependent's death results from or is caused by suicide, while sane or insane: (1) A death benefit is not payable if you or your covered dependent dies within two years of the date you or your covered dependent became a covered person. But, Prudential will refund any premiums paid for your Voluntary Term Life Insurance or Voluntary Dependent Term Life Insurance under this coverage. (2) The amount of any increase in your or your dependent's death benefit is not payable if you or your covered dependent dies within two years of the date of the increase. But, Prudential will refund any premiums paid for that increase.

Beneficiary
You designate your own beneficiary. You, as the employee, will be the beneficiary of your spouse's and/or children's insurance.

PREMIUM COST

Premium per $1,000 of Coverage for Employees and Spouses		
AGE	TENTHLY	MONTHLY
Under 30	.048	.04
30-34	.048	.04
35-39	.072	.06
40-44	.108	.09
45-49	.192	.16
50-54	.288	.24
55-59	.468	.39
60-64	.780	.65
65-69	1.308	1.09
70+	2.220	1.85

Children Coverage Options	TENTHLY COST	MONTHLY
$2,500	.60	.50
$5,000	1.20	1.00
$10,000	2.40	2.00

Employee/Spouse rates are based on the age of the covered individual. Your rates will automatically increase on the Contract Anniversary following the date you advance into the next higher age-bracket listed above.

During the employee's or spouse's lifetime, a premium adjustment will be made immediately if any discrepancy is found in either the employee's or spouse's age or cost.

How to Apply
Select the amount of coverage that best meets your needs and those of your family. Calculate your premium, then complete and sign the enclosed application and its payroll deduction authorization. Be sure to complete all questions accurately. Your spouse must sign if he/she is requesting insurance coverage. All applications are subject to the underwriting review and approval by Prudential. If you do not want coverage, simply sign and date the appropriate line at the top of the application. Whether you apply for coverage or choose not to participate, all applications and waivers must be returned to your employer.

Effective Date
Your coverage will be effective on the first day of the month following the date that Prudential or its administrator approves your application. If you qualify for the non-medical limit, the first two times annual earnings, rounded to the next highest $10,000 not to exceed **$100,000** will be effective on the first day of the month following the date you enroll. Your spouse's coverage will be effective on the first day of the month following the date he/she is approved for coverage. If your spouse qualifies for Conditional Guaranteed Issue, up to the first **$20,000** will be effective on the first day of the month following the date you enroll your spouse. Children coverage is effective when your coverage becomes effective. Spouse and dependent children coverage will not become effective unless you apply for and are approved for coverage.

LIMITATIONS AND EXCLUSIONS
This booklet highlights the features of your Voluntary Group Term Life Insurance coverage. Only the provisions, definitions, limitations, and exclusions of the Group Contract, Certificate, Riders, Endorsements, Applications and/or Enrollment Form, which together constitute the formal legal contract, will apply. A copy of the Group Contract is held by your employer and can be viewed upon request during your employer's normal business hours.

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.

Voluntary Group Term Life Insurance coverage for this plan is issued by The Prudential Insurance Company of America, a Prudential Financial company, 751 Broad Street, Newark, NJ, 07102. Life Claims: 1-800-524-0542. 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. If there is a discrepancy between this document and the Booklet-Certificate/Group Contract issued by The Prudential Insurance Company of America, the terms of the Group Contract will govern. Contract provisions may vary by state. Contract Series: 83500.

Correspondence may be directed to the Program Administrator: The Prudential Insurance Company of America c/o Johnson Rooney Welch, Inc. 2250 Douglas Blvd., Suite 210 Roseville, CA 95661.

Prudential

The Prudential Insurance Company of America

Optional Term Life Insurance/ Dependents Term Life Insurance

Contract Holder: SAN LUIS OBISPO COMMUNITY COLLEGE — Group Contract No: AG-50948-CA

- ❑ I hereby authorize and direct my Employer to make necessary payroll deductions for the amount of insurance indicated.
- ❑ I hereby authorize and direct my Employer to record the below enrollment data for electronic recordkeeping.
- ❑ I DO NOT want to apply for Voluntary Life Insurance Coverage.

Indicate what action is being taken:

- ❑ First Application
- ❑ Annual Enrollment
- ❑ Decrease Coverage
- ❑ Increase Coverage
- ❑ Cancel all Coverage
- ❑ Life Status Change:
  - ❑ Marriage: ___/___/___
  - ❑ Birth of Child: ___/___/___
  - ❑ Termination of Domestic Partnership: ___/___/___
  - ❑ Divorce: ___/___/___
- ❑ Add Spouse Coverage
- ❑ Delete Spouse Coverage
- ❑ Add Child Coverage
- ❑ Delete Child Coverage

CLASSIFICATION SELECTION

- ❑ Superintendent
- ❑ Management
- ❑ Classified
- ❑ Certificated
- ❑ Board Member

TOTAL EMPLOYEE COVERAGE: $__________

You may elect **$10,000** increments to a maximum of **$500,000** not to exceed 5 times Annual Earnings (rounded to the next highest $10,000). The Annual Earnings is defined in the Group Contract. Non-Limit Maximum is available up to two times (2x) your annual earnings rounded to the next highest $10,000 not to exceed **$100,000** if you apply within 31 days of FIRST becoming eligible for this insurance.

TOTAL SPOUSE COVERAGE*: $__________

The spouse amount must be in **$10,000** increments not to exceed **$500,000** (or 100% of your approved amount, whichever is less). Non-Limit Maximum of up to **$20,000** is available if you apply within 31 days of FIRST becoming eligible for this insurance. The spouse can only select coverage if the Employee enrolls.

CHILD COVERAGE*:

❑ NONE ❑ $2,500 ❑ $5,000 ❑ $10,000 *Dependents' coverage may not exceed 100% of your approved coverage amount.

THIS APPLICATION AS DATED, REPLACES ANY PREVIOUS APPLICATION UNDER THIS POLICY.

ELIGIBILITY QUESTIONS

1. Are you actively at work? **Employee:** ❑ Yes ❑ No
2. Is your **Spouse** confined for medical care or treatment, at home or elsewhere? ❑ Yes ❑ No
3. Is your **Dependent Child(ren)** confined for medical care or treatment, at home or elsewhere? ❑ Yes ❑ No
4. How many hours per week do you work? Employee __________
5. (a) Date of Hire: **Employee** ___/___/___
   (b) The date you became eligible for benefits under your Employer's plan: **Employee** ___/___/___

Employee: ❑ Male ❑ Female Date of Birth: ___/___/___

Name: ______________________ (Last) (First) (Middle)

Address: ______________________

______________________ (City) (State) (Zip Code).

S.S.#: ___ ___ ___-___ ___-___ ___ ___ ___ Annual Earnings: $__________

Spouse: ❑ Male ❑ Female Date of Birth: ___/___/___

Name: ______________________ (Last) (First) Middle)

Spouse S.S.#: ___ ___ ___-___ ___-___ ___ ___ ___

I (we) understand that coverage shall be in effect only after all of these conditions have been met: (a) this application has been approved by the company; and (b) the Contract has been issued while all persons to be insured thereunder are alive; and (c) the answers and statements in this application continue to be true and complete up until the Group Contract's Effective Date. **I (we) also understand** that coverage will not take effect if the facts have changed. **I (we) have also read and understand and agree to** the additional terms, conditions and requirements mentioned on this form under: Important Notice; Authorization for the Release of Information; and Insurance Information Practices. **LASTLY, I (WE) UNDERSTAND THAT COMPLETION OF THIS ENROLLMENT FORM IN NO WAY IMPLIES THAT I (WE) WILL BE ACCEPTED FOR INSURANCE COVERAGE.**

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.

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.

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

Signed at:

______________________ (City) (State)

______________________ (Signature of Employee) (Date) (Signature of Spouse) (Date)

Return to Prudential's administrators at: [Johnson Rooney Welch, 2250 Douglas Blvd., Suite 210, Roseville, CA 95661]

For residents of all states except Alabama, the District of Columbia, Florida, Kentucky, Maryland, New Jersey, New York, 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.

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.

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.

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 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.

Group Life coverage is issued by The Prudential Insurance Company of America, a New Jersey company, 751 Broad Street, Newark, NJ 07102.

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IMPORTANT INFORMATION ABOUT BENEFICIARY DESIGNATIONS

Use this form to designate or make changes to the beneficiary(ies) of your Group Insurance death proceeds. The information on this form will replace any prior beneficiary designation. You may name anyone or any entity as your beneficiary and you may change your beneficiary at any time by completing a new Group Insurance Beneficiary Designation/Change form. Common designations include individuals, estates, corporation/organizations and trusts. **Payment will be made to the named beneficiary. If there is no named beneficiary, or the named beneficiary predeceased the insured, settlement will be made in accordance with the terms of your Group Contract.**

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.

INSTRUCTIONS FOR DESIGNATING A PRIMARY OR CONTINGENT BENEFICIARY

1. EMPLOYEE INFORMATION

- All information in this section is required.
- Unless otherwise indicated in Section 1, the information supplied on the form will apply to ALL coverages offered under the employer's group plan.

2. BENEFICIARY DESIGNATION

- You may name more than one primary and more than one contingent beneficiary. This form allows you to name up to four primary and four contingent beneficiaries. If you need additional space, please attach a separate sheet of paper.
- Please indicate the percentage share designated to each primary beneficiary. **The total for all primary beneficiaries must equal 100%.** If no percentages are specified, the proceeds will be split evenly among those named. Payment will be made to the named beneficiary. If there is no named beneficiary, or the named beneficiary predeceased the insured, settlement will be made in accordance with the terms of your Group Contract. **If designating percentages for contingent beneficiaries, the percentage for all contingent beneficiaries must also equal 100%.**
- You can name an individual, corporation/organization, trust, or an estate as a beneficiary. The following examples may be helpful in designating beneficiaries:

  Individual: "Mary A. Doe"
  - Each name should be listed as first name, middle initial, last name ("Mary A. Doe," not "Mrs. M. Doe")
  - Include the address, relationship and Date of Birth for each individual listed.
  - Indicate the percentage to be assigned to each individual.

  Estate: "Estate of the Insured"
  - Select "Other" as the Beneficiary Description and write "Estate" in the blank space provided.
  - Indicate the percentage to be assigned to the Estate of the Insured.

  Corporation/Organization: "ABC Charitable Organization"
  - Select "Corporation/Organization" as the Beneficiary Description.
  - Write the legal name of the corporation or organization in the space for the Beneficiary's First Name.
  - You must provide the address, city and state of operation for each organization or corporation listed.
  - Indicate the percentage to be assigned to the corporation or organization.

  Trust: "The John Doe Trust. A Trust with a trust agreement dated 1/1/99 whose Trustee is Jane Smith."
  - Select "Trust" as the Beneficiary Description.
  - Indicate the percentage to be assigned to the trust.
  - Complete Section 3, Trust Designation.

3. TRUST DESIGNATION

- Complete this section if you have named a trust as a primary or contingent beneficiary in Section 2. Fill in the name and address for each trustee.
- Fill in the title and date of the Trust Agreement in the space provided.

4. AUTHORIZATION/SIGNATURE

- The employee must read, sign and date the authorization.
- Submit the completed form to your Benefits Administrator or Human Resources (as directed by your employer) and keep a copy for your records.

Prudential

Group Insurance Beneficiary Designation/Change

1. EMPLOYEE INFORMATION (please print)

Last Name	First Name	MI	Employee ID # (if applicable)	Marital Status (check one) ☐ Married ☐ Widowed ☐ Single ☐ Divorced	Gender (check one) ☐ Male ☐ Female	Has this insurance been assigned? ☐ Yes ☐ No

Address	City	State	ZIP Code	Daytime Phone	Home Phone	Date of Birth	Date of Hire	Date of Retirement (if applicable)

Name of Employer/Group Policyholder	Group Policy No	**Unless otherwise indicated below, this Beneficiary Designation/Change form applies to ALL coverages offered under my employer's group plan.** This form applies only to my ______ coverage(s).

2. BENEFICIARY DESIGNATION: I hereby revoke any previous designations of primary beneficiary(ies) and contingent beneficiary(ies), if any, and in the event of my death, designate the following:

A. Primary Beneficiaries

Beneficiary Description (check one)	First Name MI	Last Name	Address (include city, state, ZIP)	Relationship	Date of Birth	SSN	Phone	% Share
☐ Individual ☐ Other______ ☐ Trust ☐ Corporation/Organization								
☐ Individual ☐ Other______ ☐ Trust ☐ Corporation/Organization								
☐ Individual ☐ Other______ ☐ Trust ☐ Corporation/Organization								
☐ Individual ☐ Other______ ☐ Trust ☐ Corporation/Organization								
							TOTAL: (must equal 100)	

B. Contingent Beneficiaries

Beneficiary Description (check one)	First Name MI	Last Name	Address (include city, state, ZIP)	Relationship	Date of Birth	SSN	Phone	% Share
☐ Individual ☐ Other______ ☐ Trust ☐ Corporation/Organization								
☐ Individual ☐ Other______ ☐ Trust ☐ Corporation/Organization								
☐ Individual ☐ Other______ ☐ Trust ☐ Corporation/Organization								
☐ Individual ☐ Other______ ☐ Trust ☐ Corporation/Organization								
							TOTAL: (must equal 100)	

3. TRUST DESIGNATION - COMPLETE IF A TRUST HAS BEEN NAMED AS A BENEFICIARY IN SECTION 2

Trustee's Name (First, MI, Last)	Address (include city, state, ZIP)

And successor(s) in trust, as Trustee(s) under ______________________ dated ______________ **as amended and executed by me and said Trustee.**

Title of Agreement *Date of Agreement*

Group Insurance Beneficiary Designation/Change

4. **AUTHORIZATION/SIGNATURE** I authorize my plan administrator to record and consider the individuals/institutions that I have named on this form as beneficiaries for benefits under the applicable employee benefit plans. If designating a trust as a beneficiary, I understand Prudential assumes no obligation as to the validity or sufficiency of any executed Trust Agreement and does not pass on its legality. In making payment to any Trustee(s), Prudential has the right to assume that the Trustee(s) is acting in a fiduciary capacity until notice to the contrary is received by Prudential at its Group Life Claim office. I agree that if Prudential makes any payment(s) to the Trustee(s) before notice is received, Prudential will not make payment(s) again.

Employee's Signature **X** ______________________________ Date ______________

The employee must sign and date this form. The signature date must be the date the employee actually signed the form.

MAIL THE COMPLETED FORM TO: Johnson Rooney Welch, Inc., 2250 Douglas Boulevard, Suite 210, Roseville, CA 95661

Group Life coverage is issued by The Prudential Insurance Company of America, 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. Prudential and the Rock logo are registered service marks of Prudential Financial, Inc, and its related entities, registered in many jurisdictions worldwide.

GROUP INSURANCE

The Prudential Insurance Company of America

Employer/Association Name:

S A N L U I S O B I S P O C C

Group Contract No.(s): 0 0 5 0 9 4 8

Branch No.: 0 0 0 0 0 1

Mail the completed form to:
Johnson Rooney Welch, Inc.
2250 Douglas Blvd., Suite 210
Roseville, CA 95661

Or fax the completed form to:
916-784-8151

Short Form Health Statement Questionnaire (A separate form must be completed for each person requiring Evidence of Insurability)

Employee/Member Information

First Name | MI | Last Name

Number and Street | P.O. Box / Apt. Number

City | State | ZIP Code

Social Security Number | Employee/Member ID Number | Telephone

E-Mail Address

Applicant Information

Relationship to Employee/Member: ☐ Self ☐ Spouse

First Name | MI | Last Name | Social Security Number

Applicant Coverage requiring Evidence of Insurability: **Employee/Member** ☐ Life **Spouse** ☐ Life

Gender: ☐ Female ☐ Male

Date of Birth: (mm-dd-yyyy)

Height: ft. in.

Weight: lbs.

Please answer these questions by checking "Yes" or "No."

Yes ☐ No ☐ **Do you currently** have any disorder, condition, or disease or are you currently taking medication prescribed or provided by a medical or other practitioner for any disorder, condition, or disease other than a cold, cough, or allergies?

Yes ☐ No ☐ **During the last five years,** have you been in a hospital or other institution for observation, rest, diagnosis, or treatment?

Yes ☐ No ☐ **During the last five years,** have you had life, disability, or health insurance declined, postponed, changed, rated-up, cancelled, or withdrawn by an insurer?

Yes ☐ No ☐ **Within the last five years,** have you been treated for or had any trouble with any of the following: heart; chest pain; high blood pressure; cancer or tumors; diabetes; lungs; kidneys; liver; alcoholism; mental, or nervous disorder or have you been diagnosed with, or treated by a member of the medical profession for, Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC)?

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

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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.

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.

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 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.

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Prudential reserves the right to request additional health information on the basis of the responses given to the above questions.

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 disability income coverage.**

I have read and understand the terms and requirements of the Important Notice included on this form. 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.

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

Applicant's Signature (unless a minor) ______ Date Signed (mm-dd-yyyy) __-__-____

If applicant is a minor, Signature of Parent, Guardian or Person Liable for Support of Applicant ______ Relationship ______ Date Signed (mm-dd-yyyy) __-__-____

Please keep a copy of this form for your records.

Group Life coverage is issued by The Prudential Insurance Company of America, a New Jersey company, 751 Broad Street, Newark, NJ 07102.

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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-for-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.