

The Prudential Insurance Company of America

751 Broad Street, Newark, NJ 07102



Branch 003

Dealer Employee and Spouse Life Coverage Request Form

Please complete, detach and mail Form to Gilsbar, Inc., P.O. Box 998, Covington, LA 70434. Do not include payment now. You will be billed on a monthly basis when notified of your coverage effective date. Please note: National Automobile Dealers Association (NADA) membership is required for this insurance coverage. **If you have any questions, please call NADA Insurance at 1-888-461-6232.**

Please print all answers using black ink.

Group Contract No. 34371

1 Employee Information

NADART Code _____

First Name MI Last Name

Street Apt.

City State ZIP code -

Date of Birth (mm/dd/yyyy) Social Security Number - - Daytime Telephone Number - -

Sex Male Female Height ft. in. Weight lbs. Evening Telephone Number - -

E-Mail

Dealership Name Dealership Address

2 Spouse Information

Complete if you are requesting coverage for your spouse.

First Name MI Last Name

Date of Birth (mm/dd/yyyy) Social Security Number - - Daytime Telephone Number - -

Sex Male Female Height ft. in. Weight lbs. Evening Telephone Number - -

3 Health Questions

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

	Member		Spouse (if applicable)		
	Yes	No	Yes	No	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1. Within the last 12 months , have you smoked cigarettes?
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2. Are you currently performing all the duties of your job for the number of hours required? If no, please explain: _____
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3. Within the last five years , have you been evaluated for, medically treated for, diagnosed with, taken medications for, or experienced symptoms of any of the following conditions:
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	a. Disease or disorder of the heart, blood or circulatory system
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	b. High blood pressure
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	c. Cancer or tumors
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	d. Lung, respiratory or breathing disorders
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	e. Diabetes
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	f. Liver or kidney disorders
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	g. Gastrointestinal, stomach or intestine disorders, including ulcers or gallstones
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	h. Mental or nervous illness or disorder, alcoholism or drug addiction
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	i. Chronic pain or fatigue syndromes
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	j. Neurological disorders such as Multiple Sclerosis or Parkinson's Disease
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	k. Musculoskeletal disorders including arthritis, fractures, or carpal tunnel syndrome
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	l. HIV, Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC) or any other immune deficiency disorder (such as Lupus)?

3

Health Questions

continued from page 1

Member **Spouse** (if applicable)

Yes	No	Yes	No
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- 4. Within the last five years**, have you been in a hospital or other institution for observation, rest, diagnosis or treatment?
- 5. Within the last five years**, have you been attended by a doctor or licensed practitioner for anything other than a routine physical?
- 6. Do you have** any known symptoms, physical or mental impairments not mentioned in the previous questions?
- 7. Are you** taking any medication or being treated for any condition, including pregnancy, or disease not mentioned in the previous questions?

If you answered "Yes" to any of questions 3-7, please provide full details below.

(If more space is needed, please attach an additional sheet.)

Member	Spouse	Question Number	Date of Illness	Date of Full Recovery	Details of nature of illness, number of attacks, duration, severity, treatments and medications prescribed and taken	Names, complete addresses and phone numbers of physicians
<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Primary Care Physician Information

Name Date last seen Telephone

Address

Spouse's Primary Care Physician Information

Name Date last seen Telephone

Address

4

Coverage Amounts

Choose the coverage amount for which you are applying. *Note: you will be billed on a monthly basis.*

NADA Employee Life Insurance Coverage Amount Requested (please check one):

\$500,000
 \$400,000
 \$300,000
 \$200,000
 \$450,000
 \$350,000
 \$250,000
 \$150,000
 Other Coverage Amount (in \$25,000 increments up to a maximum of \$500,000: \$ _____

Spouse Life and Child Coverage Amounts*

Coverage Amount (in \$10,000 increments up to a maximum of 50% of coverage amount): \$ _____

**Your election is limited to 50% of the Employee's elected amount*

Monthly Rate per \$1,000 of Spouse Coverage: Under 40: \$.21 Age 40-49: \$.28 Age 50-64: \$.49

Optional Child Benefit amount=\$10,000 **Youngest Child's Date of Birth** (mm/dd/yyyy)

Monthly Rate for Child Coverage: \$1.00 per month covers the cost of all children.

5 Beneficiary Information

Full Name of Beneficiary	Relationship	Share
<input type="text"/>	<input type="text"/>	<input type="text"/> %
Address <input type="text"/>		
(If more space is needed, please attach a separate sheet.)		Total (Must equal 100%) <input type="text"/> 100%

AUTHORIZATION For the Release of Information. This authorization is intended to comply with the HIPAA Privacy Rule. I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, medical facility, or other health care provider that has provided payment, treatment, or services to me or on my behalf within the past 5 years ("My Providers") to disclose the entire medical record and any other health information concerning me and/or any dependent proposed for coverage in the application to The Prudential Insurance Company of America ("Prudential") and through it, to its reinsurers, authorized agents, and the Medical Information Bureau, Inc.. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection (In Vermont, this information is excluded.) and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol and/or drugs, but excludes psychotherapy notes. I also authorize the Medical Information Bureau, Inc. to release any data it may have about me and/or any dependent proposed for coverage to Prudential. By my signature below, I acknowledge that any agreements I or my dependents have made to restrict my health information do not apply to this Authorization and I instruct My Providers to release and disclose the entire medical record for me and/or my dependent without restriction. This health information is to be disclosed under this Authorization so that Prudential may: 1) underwrite an application for coverage and make risk determinations; 2) obtain reinsurance; 3) administer coverage; and 4) conduct other legally permissible activities that relate to any coverage I have or have applied for with Prudential. This Authorization shall remain in force for 24 months following the date of my signature below, and a copy of this Authorization is as valid as the original. I understand that I have the right to revoke this Authorization in writing, at any time, by sending a signed request for revocation to The Prudential Insurance Company of America, Group Medical Underwriting, P. O. Box 8796, Philadelphia, PA 19176, Attention: Senior Medical Underwriting Consultant. I understand that a revocation is not effective to the extent that Prudential has relied on this Authorization or to the extent that Prudential has a legal right to contest a claim under insurance coverage or to contest the coverage itself. I understand that any information that is disclosed pursuant to this Authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information. (In Montana only: I may request a record of any subsequent disclosures of protected health information.) I understand that if I refuse to sign this Authorization to release the entire medical record for me and/or my dependent, Prudential may not be able to process an application for coverage, or if coverage has been issued, may not be able to make any benefit payments. I understand that I, or a person authorized to act on my behalf, have the right to request and receive a copy of this Authorization.

Statement of Understanding: I (We) represent that all statements and answers made within or attached to this Request Form are true and complete to the best of my (our) knowledge and belief. I (We) understand that coverage shall be in effect only after all of these conditions have been met: this application has been approved by Prudential; the Contract has been issued while all persons to be insured thereunder are alive, and; the answers and statements in this application continue to be true and complete until the 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 as stated in the Authorization for the Release of Information and Important Notice sections. I (We) understand that completion of this application 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.

X _____	Date (mm/dd/yyyy) <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Member Signature	
X _____	Date (mm/dd/yyyy) <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Spouse Signature (if applying for Spouse Coverage)	

Important Notice: For residents of all states except Florida, New Jersey, New York, Pennsylvania, 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 or 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. **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 fact material 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.

Accelerated Death Benefits: Receipt of accelerated death benefits may affect eligibility for public assistance programs and may be taxable. There is no administrative fee to accelerate death benefits. The accelerated amount is not discounted.

Beneficiary Designation: If you name more than one beneficiary, settlement will be made in equal shares to the designated beneficiaries (or beneficiary) that survive you, unless otherwise provided in the designation. If no named beneficiary survives you, settlement will be made to your estate. The beneficiary named herein will be the beneficiary for your total amount of insurance coverage issued.

Please keep this notice for your records.