

Policyholders Name: State of Ohio
Group Policy Number: LG-93046-OH

SUPPLEMENTAL LIFE INSURANCE ENROLLMENT FORM

FOR EXEMPT EMPLOYEES OF THE STATE OF OHIO
(PLEASE PRINT)

Last Name _____ First _____ MI _____
Street Address _____ City _____ State _____ Zip Code _____
Social Security Number _____ Date of Birth _____ Office Telephone (____) _____
Occupation _____ Date Employed _____ Base Annual Earnings _____
Sex _____ Marital Status _____ Agency Payroll Number _____ Employee ID number _____

Enrollment Change Beneficiary Designation Terminate Member Coverage (includes spouse/children coverage)

Please mark the appropriate boxes if you are making a change (Check all that apply)

Increase employee coverage Add spouse coverage Add children coverage Change smoker status Change spouse smoker status
 Increase spouse coverage Drop spouse coverage Drop children coverage Change to exempt from union-represented
 Decrease employee coverage Decrease spouse coverage
 Other (Name change, address change, etc.) _____

*Note: Increases in coverage amounts can only be requested during the open enrollment period usually held in the spring.

Total amount of insurance requested: _____ Include the total amount of supplemental coverage desired, including your current amount if you are increasing your coverage. Coverage amounts must be in \$10,000 increments. Do not include spouse/children coverage. The amount which Prudential approves will be the amount you may port (take with you) when you leave State service.

Have you used tobacco in the past 12 months? Yes No
Has your spouse used tobacco in the past 12 months? Yes No

You must have supplemental life coverage in order to enroll your spouse and/or children.

The beneficiary on the lives of your spouse and children will automatically be you, if you survive them; otherwise the beneficiary will be the estate of your spouse and children, subject to policy provisions.

Spouse coverage desired? Yes No Spouse insurance total amount requested 10,000 20,000 30,000 40,000
(20,000, 30,000 and 40,000 subject to approval by carrier)

Spouse's Name (Last, Middle, First) _____ Spouse Social Security Number _____ DOB _____

Children coverage desired? (\$7,000 per child) Yes No Number of children _____

You have 90 days from your hire date to purchase supplemental life coverage for you, your spouse, and your dependent children. Coverage may also be elected or changed during each Open Enrollment period.

The right to change your beneficiary is reserved; to name beneficiaries, please use spaces on the back of this form. Your employee ID number is the eight digit number found on your payroll stub. Agency payroll number is three digit code and six digit number found on your payroll stub.

This plan is totally separate from your basic life insurance plan with the State of Ohio and the amount of insurance elected as supplemental does not change your basic life coverage. If you and your spouse are both state employees, you may have coverage as either a spouse or an employee, but not both. Children may only be covered as a dependent of one employee.

Please make a copy of this form for your own records. **Mail this form to: The Prudential Insurance Company of America, P.O. BOX 5072 Millville, NJ 08322-9931. Prudential's phone number is: 1-800-778-3827.**

Note: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

CERTIFICATION

I hereby request term insurance for myself and/or for my dependents and hereby authorize my employer or successor to make deductions from my earnings of the required contributions to apply towards the premiums for the insurance provided for in the policy of insurance issued to the state of Ohio by The Prudential Insurance Company of America.

Employee Signature _____ Date _____

SUPPLEMENTAL LIFE INSURANCE BENEFICIARY DESIGNATION

Use the space below to name beneficiaries of the employee. After you have completed your entries, sign and date in the space provided. Return to Prudential with the Supplemental Life Insurance Enrollment Form at the address shown on the Enrollment Form.

PRIMARY BENEFICIARY(IES)

First Name	Middle Name	Last Name	Relationship to Member	DOB
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Address	Social Security Number	% Share
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First Name	Middle Name	Last Name	Relationship to Member	DOB
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Address	Social Security Number	% Share
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First Name	Middle Name	Last Name	Relationship to Member	DOB
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Address	Social Security Number	% Share
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First Name	Middle Name	Last Name	Relationship to Member	DOB
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Address	Social Security Number	% Share
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CONTINGENT BENEFICIARY(IES)

First Name	Middle Name	Last Name	Relationship to Member	DOB
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Address	Social Security Number	% Share
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First Name	Middle Name	Last Name	Relationship to Member	DOB
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Address	Social Security Number	% Share
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First Name	Middle Name	Last Name	Relationship to Member	DOB
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Address	Social Security Number	% Share
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First Name	Middle Name	Last Name	Relationship to Member	DOB
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Address	Social Security Number	% Share
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Employees Signature _____ Date _____