

SUPPLEMENTAL LIFE ENROLLMENT FORM

Policyholder's Name: Union Benefits Trust

Group Policy Number: LG-01049

New enrollment Change Terminate member coverage (includes spouse/children coverage)

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

Increase My Coverage Add Spouse Coverage Add Children Coverage Change Smoker Status Change Spouse Smoker Status
 Decrease My Coverage Increase Spouse Coverage Drop Children Coverage Change to Union-Represented from Exempt
 Other (Name Change, etc.) Drop Spouse Coverage

Payroll Number: _____ the State Department in which you work. It is the first six digits of the nine-digit number on your payroll stub.

Member Insurance Total Amount Requested: _____ Include current amount of supplemental coverage for the member, plus the amount of increase in \$10,000 increments (do not include spouse/children amounts). The amount for which you apply and which Prudential approves will be the amount you may port when you leave State service.

Member Name (Last, First, Middle Initial) _____

Member's Address _____ City _____ State _____ ZIP Code _____

Social Security No. _____ DOB _____ M F Married Single

Occupation _____ Date Employed _____ Base Annual Earnings _____

Telephone No. _____ Employee ID Number _____

Have you smoked cigarettes or used any form of tobacco in the past 12 months? Yes No

(The right to change the beneficiary is reserved. To name beneficiaries, please use the spaces on the back of this form.)

Member Must Have Supplemental Life Insurance to Enroll Spouse and/or Children.

You will automatically be the beneficiary for life insurance on the lives of your spouse and children, if surviving; otherwise it will be the estate of the spouse and children, subject to policy provisions.

Spouse Coverage Desired? Yes No Spouse Insurance Total Amount: \$10,000 \$20,000 \$30,000 \$40,000
_____ (Include current amount of coverage)

Spouse's Name (Last, First, Middle Initial) _____

Spouse's Social Security Number _____ DOB _____ Date of Marriage _____

Has your spouse smoked cigarettes or used any form of tobacco in the past 12 months? Yes No

Child(ren) Coverage Desired? Yes No Child(ren) Insurance Amount: \$7,000 per Child 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 is also available during each Trust-sponsored open enrollment period.

This plan is totally separate from your basic life plan with Union Benefits Trust, and the amount of insurance elected as supplemental does not change your basic life insurance. If a husband and wife are both State employees, they have coverage as either a spouse or a member, but not both. Children can only be covered as dependents of only one member.

I understand that when I leave State service I will be able to port the coverage I have purchased as an active member, and that I will not be able to apply for more coverage. I acknowledge that I have been informed that only member coverage is eligible for port, not dependent spouse or child coverage.

I hereby request group 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 toward the premiums for the insurance provided for in the policy of group insurance issued to Union Benefits Trust by The Prudential Insurance Company of America.

Member's Signature: _____ Date: _____

SUPPLEMENTAL LIFE BENEFICIARY DESIGNATION FORM

Use the space below to name beneficiaries of the member. If you wish, you may name one or more primary beneficiaries. You may also name one or more contingent beneficiaries. This form allows you to name up to two primary and two contingent beneficiaries. If you need additional space, please attach a separate sheet of paper. After you have completed your entries, please sign and date in the space below.

If you wish, you may indicate the percentage share designated to each primary beneficiary. The total for one or all primary beneficiaries must equal 100%. If no percentages are specified, the proceeds will be split evenly among those named. If no named beneficiary survives you, any amount of insurance will be made payable to the first of the following; Your (a) surviving spouse, (b) surviving child(ren) in equal shares, (c) surviving parents in equal shares, (d) surviving siblings in equal shares, (e) estate. If designating percentages for contingent beneficiaries, the percentage for all contingent beneficiaries must also equal 100%.

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.

PRIMARY BENEFICIARY(IES)

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

First Name	Middle Initial	Last Name	Relationship to member	DOB
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Address	Social Security Number	% Share
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First Name	Middle Initial	Last Name	Relationship to member	DOB
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Address	Social Security Number	% Share
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The Supplemental Life Coverage is issued by The Prudential Insurance Company of America, 751 Broad Street, Newark, NJ 07102. Contract Series 83500.

Member's Signature: _____ Date: _____

PLEASE KEEP A COPY OF THIS FORM FOR YOUR RECORDS.

Mail the original form to: The Prudential Insurance Company of America • P.O. Box 5072 • Millville, NJ 08332-9931
Call Prudential with questions: 800-778-3827