Mercer Voluntary Benefits Ref# 51350
081712010101

Capgemini

Call Mercer Voluntary Benefits at 1-800-222-1623 if you need assistance

The Prudential Insurance Company of America
a New Jersey company
751 Broad Street
Newark, NJ 07012

Group Universal Life Enrollment Form

Important Instructions:
Please sign and date the form and return it to Mercer Voluntary Benefits, P.O. Box 9122, Des Moines, IA 50306-9122.

1 Personal Information

Employee's Name _____ ☐ Jr. ☐ Sr.
Last First M.I.

Address _____ Soc Sec # _____

City _____ State _____ Zip Code _____

Daytime Phone _____ Date of Birth _____ ☐ Male ☐ Female
(MM/DD/YYYY)

2 Employee Coverage

Select the amount of Group Universal Life coverage you desire as a multiple of your base annual earnings (rounded up to the next higher $10,000 increment if not an even $10,000 amount).

Mark One: ☐ 1X ☐ 1½X ☐ 2X ☐ 2½X ☐ 3X ☐ 3½X ☐ 4X ☐ 4½X ☐ 5X ☐ 5½X ☐ 6X

The maximum dollar amount of Group Universal Life Insurance coverage is the lesser of 6 times base annual earnings or $5,000,000.

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

3 Spouse/Domestic Partner Coverage

Spouse/Domestic Partner Name _____
Last First M.I.

Soc Sec # _____ Date of Birth _____ ☐ Male ☐ Female
(MM/DD/YYYY)

Select coverage in $10,000 increments. Your choice is from $10,000 to $500,000, not to exceed 3 times the employee's base annual earnings. **$**_____

Employees need to be enrolled in Group Universal Life in order to enroll for spouse/domestic partner coverage.

Has your spouse/domestic partner smoked or used any form of tobacco in the last 12 months? ☐ Yes ☐ No

4 Child Coverage

I would like child coverage: ☐ $10,000 ☐ $20,000 (The employee must be insured to elect child coverage.)

List each unmarried dependent child age 14 days to age 19 (or under age 25 if an unmarried, full-time student):

Child's Name	Child's Birth Date	Child's Social Security Number	Sex

Note: You must notify Mercer Voluntary Benefits within 90 days after a child ceases to be eligible for child coverage so that he/she may be given the opportunity to convert the coverage.

5 Optional Cash Accumulation Fund

Employee: In addition to the coverage premium, I elect to contribute via payroll deduction **a monthly dollar amount** to the Cash Accumulation Fund.

$_____

Spouse/Domestic Partner: In addition to the coverage premium, I elect to contribute via payroll deduction **a monthly dollar amount** to the Cash Accumulation Fund.

$_____

6 Eligibility Question

You must be actively at work on the date this Enrollment Form is signed.

I. Have you had any application for life, accidental death and dismemberment or disability insurance declined, postponed, withdrawn, rated, modified, or issued other than as applied for?

	Employee	Spouse/ Domestic Partner
	☐ Yes ☐ No	☐ Yes ☐ No

7 Evidence of Good Health

I. If you are applying for coverage, you must complete a Short Form Statement of Health Form for coverage elections exceeding 3 times your base annual earnings or $250,000, whichever is less. You must complete a Long Form Statement of Health Form for all coverage amounts above $750,000.

II. If you are applying for spouse/domestic partner coverage, he/she must complete a Short Form Statement of Health Form for coverage elections exceeding $50,000, up to $250,000. He/she must complete a Long Form Statement of Health Form for all coverage amounts between $260,000 and $500,000.

Mercer Voluntary Benefits will mail a Statement of Health Form to the address listed on this application for its completion. All coverage amounts will not be effective until the Statement of Health Form is reviewed and approved by Prudential.

Over please > > >

8 **Beneficiary Designation** (no white outs or cross outs in this section)

The employee's beneficiary for the coverage requested herein will be designated as the following: (a) spouse; (b) if no surviving spouse, then child(ren); (c) if no surviving spouse or children, then parents; (d) if no surviving spouse, children or parents, then benefits will be paid to the employee's estate. The employee is automatically the beneficiary for spouse or child coverage unless otherwise noted below.

If you'd like to make a different beneficiary designation, please complete below:

Primary Beneficiary Full Name (Last, First, Middle Initial)	Relationship	Social Security #	Date of Birth (MM/DD/YYYY)	Phone	Address (Street, City, State, Zip)	Share %
Unless otherwise indicated, payment will be made in equal shares to your surviving Primary Beneficiary(ies).					**TOTAL:**	**100%**

☐ Trust ☐ Estate ☐ Corporation Tax ID #/Tax Exempt ID #_____ Creation/Incorporation/Formation Date_____

If the Primary Beneficiary(ies) die before me, I designate as Contingent Beneficiary(ies):

Contingent Beneficiary Full Name (Last, First, Middle Initial)	Relationship	Social Security #	Date of Birth (MM/DD/YYYY)	Phone	Address (Street, City, State, Zip)	Share %
Unless otherwise indicated, payment will be made in equal shares to your surviving Contingent Beneficiary(ies).					**TOTAL:**	**100%**

☐ Trust ☐ Estate ☐ Corporation Tax ID #/Tax Exempt ID #_____ Creation/Incorporation/Formation Date_____

Spouse/domestic partner primary and contingent beneficiary: The employee is automatically the beneficiary for spouse/domestic partner or child coverage. If the beneficiary format is not sufficient for your needs, contact Mercer Voluntary Benefits.

9 **Employee: please sign, date and return Application Form to Mercer Voluntary Benefits:**

I certify that all of the information on this Application Form is true and complete to the best of my knowledge and belief. If coverage is provided on the basis of this information, and any of my statements or answers are incomplete, incorrect or untrue, Prudential shall not have any liability for the coverage provided. I understand that benefits will not be paid if proper documentation has not been filed with Mercer Health & Benefits Administration LLC, the program manager. I understand that if I am not actively at work on the date I sign this form and the effective date of coverage with the employer offering this plan coverage will not go into effect until my return to work. In addition, I recognize that it is my responsibility to notify Mercer Health & Benefits Administration LLC within 60 days of my return to work. If my spouse/domestic partner or any dependent child to be insured has been confined for medical care or treatment at home or elsewhere on the date insurance would have become effective, coverage will be deferred until they are released from medical care confinement. I understand that I must provide written notification of the release of a spouse/domestic partner or dependent child from medical care confinement. This notification must be sent to Mercer Health & Benefits Administration LLC, and be received within 60 days of the release. I hereby authorize my employer to deduct the required contribution from my salary for coverage under the Group Universal Life Insurance Program. I understand the rates are based on age and will change on the program anniversary when the insured enters a new age bracket. This request and authorization applies to this program until rescinded by me in writing.

For residents of all states except the District of Columbia, Florida, Kentucky, 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/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.

DISTRICT OF COLUMBIA RESIDENTS – It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insured may deny insurance benefits if false information, materially related to a claim, was provided by the applicant.

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.

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.

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.

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.

Employee Signature _____ Social Security Number _____ Date of Signature _____ (MM/DD/YYYY)

(Employee signs for all coverage)

DEPENDENT CONSENT FOR COVERAGE

If you wish to enroll your spouse/domestic partner and/or eligible child 18 years of age or older for $10,000 or more of Dependent Term Life Insurance coverage, your spouse/domestic partner and/or each eligible child age 18 years or older must acknowledge consent for such coverage below.

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

Child Signature:_____ Date(Month/Day/Year): _____

Child Signature:_____ Date(Month/Day/Year): _____

Receipt of accelerated death benefits may affect eligibility for public assistance programs and may be taxable. Please contact your personal tax advisor for further information. There is no administrative fee to accelerate death benefits. The accelerated amount is not discounted.

Group Universal Life coverage is issued by The Prudential Insurance Company of America, a New Jersey company, 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. 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 state by state. Contract Series: 96945-GUL

Please return the completed and signed Application Form to Mercer Voluntary Benefits at P.O. Box 9122, Des Moines, IA 50306-9122

Group Universal Life coverage is underwritten by Prudential Insurance Company of America 751 Broad Street, Newark, NJ 07102 Contract Series 96945.

Program Offered and Administered by Mercer Health & Benefits Administration LLC

In CA d/b/a Mercer Health & Benefits Insurance Services LLC AR Insurance License #100102691 CA Insurance License #0G39709