Prudential

Please return the completed and signed Application Form to:
Mercer Voluntary Benefits
PO Box 9122
Des Moines, IA 50306-9122

Group #: **50409**
Client Name: **Capgemini- All Employees residing in New York**

Group Life Services PO Box 8769, Philadelphia, PA 19176

Please print using blue or black ink.

Instructions

Please complete all sections of this form.
Please be sure to sign all appropriate sections and return the form to Mercer Voluntary Benefits at the address above. If your coverage has been assigned, this form must be signed by the assignee. Please call Mercer Voluntary Benefits customer service center toll-free at 1-800-222-1623 with any questions, Monday through Friday, from 9 AM to 6 PM ET.

1 Employee Information

First Name of Employee _____ MI _____ Last Name _____ **Sex** ❑Male ❑Female

Street _____ Apt. _____

City _____ State _____ ZIP Code _____

Date of Birth _____ (*month* *day* *year*) Social Security Number _____ – _____ – _____ Employment Date _____ (*month* *day* *year*)

Annual Base Salary $ _____ Telephone _____ – _____ – _____

Have you smoked cigarettes or used another tobacco product (including cigars or chewing tobacco) or used any nicotine products (including patches, gum or e-cigarettes) within the past year? ❑Yes ❑No

2 Group Universal Life Insurance Coverage Selection Group number: 50409

Section A – Complete if electing GUL coverage.

1) Select coverage amount. The maximum dollar amount of Group Universal Life Insurance Coverage is the lesser of 6 times base annual salary or $5,000,000.
Mark One: ❑1X ❑1½X ❑2X ❑2½X ❑3X ❑3½X ❑4X ❑4½x ❑5X ❑5½X ❑6x

2) Contribution to the Cash Accumulation Fund

In addition to your insurance coverage, GUL provides an optional feature which allows for the building of cash value on a tax-deferred basis.
Complete the following (indicate "0" if you choose not to make optional contributions to your Cash Accumulation Fund):

*Indicate extra **weekly** contribution to the Cash Accumulation Fund: $ _____

If left blank, no optional contribution will be made to your Cash Accumulation Fund.

The Prudential Insurance Company of America
751 Broad Street, Newark, New Jersey 07102 877-232-3619
Group Universal Life Insurance (GUL)
Enrollment Form

Section B – Complete if electing Spouse GUL coverage. (Please Note that dependents are not eligible for GUL or term life while on active duty in the armed forces.)

First Name of Spouse | MI | Last Name

Street | Apt.

City | State | ZIP Code | State of Residence

Spouse Social Security Number ___ — ___ — ___ Date of Birth ___ ___ ___ (month day year)

1) 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 salary.

❑ Coverage Amount Chosen $_____

2) Contribution to the Cash Accumulation Fund

In addition to your insurance coverage, GUL provides an optional feature which allows for the building of cash value on a tax-deferred basis. **Complete the following (indicate "0" if you choose not to make optional contributions to the Cash Accumulation Fund for your spouse):**

*Indicate extra **weekly** contribution to the Cash Accumulation Fund: $ _____

If left blank, no optional contribution will be made to the Spouse Cash Accumulation Fund.

3) Is your spouse also employed by your employer? ❑Yes ❑No

Has your Spouse smoked cigarettes or used another tobacco product (including cigars or chewing tobacco) or used any nicotine products (including patches, gum or e-cigarettes) within the past year? ❑Yes ❑No

Section C – Complete if electing Dependent Child coverage (for eligible children).

You may select Dependent Child coverage (term insurance) with your GUL. The employee must be enrolled in order to select Dependent Child coverage. The monthly cost includes all eligible children.

Number of Children

Youngest Child's Date of Birth ___ ___ ___ (month day year)

Select Dependent Child coverage amount.

❑ $10,000

❑ $20,000

3 Important Notice Required by Certain State Regulators

I have read and agree with the below statements. I further understand that my elections and allocations as specified in this enrollment form will be used for future cost of insurance and any additional contribution to the cash accumulation fund, unless changed by me in writing.

I declare that to the best of my knowledge and belief all of the answers to the questions on this form are complete and true. I agree that the insurance being requested shall become effective upon completion of all requirements for coverage, including providing Prudential with any required satisfactory evidence of insurability.

I have read the accompanying information describing the life insurance coverage issued by The Prudential Insurance Company of America.

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.

The policy/certificate provides limited benefits. Review your certificate carefully.

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

X _____ month ____ day ____ year ____

Employee/Assignee Signature (If applying for coverage)

X _____ month ____ day ____ year ____

Spouse/Assignee Signature (If applying for coverage)

*** Employees and/or Dependents may be ineligible for group insurance coverage while on active duty in the armed forces.**

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" or "chronically ill." You may wish to seek professional tax advice before exercising this option.

NOTICE TO CONSUMER: THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMAL ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES. ALSO, THE BENEFITS PROVIDED BY THIS POLICY CANNOT BE COORDINATED WITH THE BENEFITS PROVIDED BY OTHER COVERAGE. PLEASE REVIEW THE BENEFITS PROVIDED BY THIS POLICY CAREFULLY TO AVOID A DUPLICATION OF COVERAGE.

Don't forget to designate your beneficiary(ies) on page 4 and 5.

4 Beneficiary Designations

Designate your beneficiaries for employee and/or spouse coverage below. If more than one primary beneficiary is designated, settlement will be made in equal shares to the designated beneficiaries (or beneficiary) who are then still living, unless their shares are specified. If there is no named beneficiary, or no beneficiary survives the insured, settlement will be made in accordance with the terms of your Group Contract. The employee is automatically the beneficiary for Dependent Child(ren) Coverage. For additional beneficiary designations, please use a separate piece of paper.

Employee

Primary Beneficiary

First Name | MI | Last Name

Street | Apt.

City | State | ZIP Code —

Relationship | Date of Birth (month / day / year) | Social Security Number | Share %

Daytime Telephone — —

Primary Beneficiary

First Name | MI | Last Name

Street | Apt.

City | State | ZIP Code —

Relationship | Date of Birth (month / day / year) | Social Security Number | Share %

Daytime Telephone — —

Contingent Beneficiary (In the event your primary beneficiary is not alive at the time of your death.)

First Name | MI | Last Name

Street | Apt.

City | State | ZIP Code —

Relationship | Date of Birth (month / day / year) | Social Security Number | Share %

Daytime Telephone — —

Contingent Beneficiary (In the event your primary beneficiary is not alive at the time of your death.)

First Name | MI | Last Name

Street | Apt.

City | State | ZIP Code —

Relationship | Date of Birth (month / day / year) | Social Security Number | Share %

Daytime Telephone — —

Spouse

Primary Beneficiary

First Name | MI | Last Name

Street | Apt.

City | State | ZIP Code

Relationship | Date of Birth (month / day / year) | Social Security Number | Share %

Daytime Telephone

Primary Beneficiary

First Name | MI | Last Name

Street | Apt.

City | State | ZIP Code

Relationship | Date of Birth (month / day / year) | Social Security Number | Share %

Daytime Telephone

Contingent Beneficiary (In the event your primary beneficiary is not alive at the time of your death.)

First Name | MI | Last Name

Street | Apt.

City | State | ZIP Code

Relationship | Date of Birth (month / day / year) | Social Security Number | Share %

Daytime Telephone

Contingent Beneficiary (In the event your primary beneficiary is not alive at the time of your death.)

First Name | MI | Last Name

Street | Apt.

City | State | ZIP Code

Relationship | Date of Birth (month / day / year) | Social Security Number | Share %

Daytime Telephone

Group Universal Life, Group Term Life, and Accidental Death and Dismemberment insurance coverages are 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: 83500, 96945