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 other than those 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.

Section B – Complete if electing Spouse GUL coverage.

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

For residents of all states except, Alabama, Arkansas, District of Columbia, Florida, Kentucky, Louisiana, Maine, Maryland, New Jersey, New York, North Carolina, Pennsylvania, Puerto Rico, Rhode Island, 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.

ALABAMA RESIDENTS – Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

ARKANSAS, DISTRICT OF COLUMBIA, LOUISIANA and RHODE ISLAND RESIDENTS – Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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.

MAINE and 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.

MARYLAND RESIDENTS – Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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.

NORTH CAROLINA RESIDENTS – Any person who, with the intent to injure, defraud, or deceive an insurer or insurance claimant, knowing that the statement contains false or misleading information concerning a fact or matter material to the claim may be guilty of a Class H felony.

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.

PUERTO RICO RESIDENTS – Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances [be] present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

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, with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

I have read and agree with the above 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.

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 5 and 6.

4 Dependent Consent to Insurance Coverage

FOR INSUREDS WHO RESIDE IN MICHIGAN OR MINNESOTA ONLY – If you wish to enroll your spouse, domestic partner, and/or eligible child 18 years of age or older for Dependent Life coverage, your spouse, domestic partner, and/or each of your eligible children age 18 years or older must consent to such coverage by signing and dating this consent in the appropriate space(s) below. Coverage on your spouse and child(ren) age 18 or older will not become effective unless and until the requisite consent is provided.

X _____ *Spouse Signature* — *month* *day* *year*

X _____ *Child Signature* — *month* *day* *year*

X _____ *Child Signature* — *month* *day* *year*

5 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