NEA GROUP TERM LIFE ENROLLMENT FORM

Coverage Issued by The Prudential Insurance Company of America

Mail completed form to:
NEA Insurance Operations
P.O. Box 9389, Des Moines, IA 50306-9389

80267-Q 08**8293010606**

Please use blue/black ink only. Do not use correction fluid/tape. ALL FIELDS ARE REQUIRED. An incomplete enrollment form will delay processing.

1. About You

Name: _____ Phone: (____) ____ - _____ Date of Birth: _____/_____/_____
Address: _____ Gender: ☐ Female ☐ Male SSN: _____
City: _____ Email: _____
State: _____ Zip: _____

2. Select Your Coverage Options

	Member	Spouse*	
$25,000	☐	☐	E/C 0H 1/5
$50,000	☐	☐	E/C 0N 1/5
$75,000	☐	☐	E/C 0T 1/5
$100,000	☐	☐	E/C 0Y 1/5
$125,000	☐	☐	E/C YH 1/5
$150,000	☐	☐	E/C YN 1/5
$175,000	☐	☐	E/C YT 1/5
$200,000	☐	☐	E/C 0Z 1/5
$225,000	☐	☐	E/C ZH 1/5
$250,000	☐	☐	E/C ZN 1/5
$275,000	☐	☐	E/C ZT 1/5
$300,000	☐	☐	E/C 03 1/5
$400,000	☐	☐	E/C 04 1/5
$500,000	☐	☐	E/C 05 1/5

	Member	Spouse*	
Waiver of Premium:	☐	☐	W_ _ 1/5
Double Indemnity:	☐	☐	D_ _ 1/5

Member must elect option for spouse to be eligible.
Must be under age 55 for waiver of premium option.

Child(ren) Coverage: ☐ Yes ☐ No E0E7
Coverage amount is $10,000 for each eligible child.
Monthly premium of $0.94 covers all eligible children.
Eligible child coverage begins at 14 days until age 21.

*Includes domestic partner or registered domestic partner

3. About Your Dependents

_____ ☐Female ☐Male Date of Birth: ____/____/____ SSN: _____
Name of Spouse/Domestic Partner

_____ ☐Female ☐Male Date of Birth: ____/____/____
Child**Name

_____ ☐Female ☐Male Date of Birth: ____/____/____
Child**Name

**Eligible child coverage begins at 14 days until age 21, or until age 25 if unmarried and fully dependent on your support. Include additional children on a separate signed and dated sheet of paper.

4. About You and Your Spouse's Health - Note: A "YES" answer to any question does not automatically disqualify you from coverage.

►► Answers are required to ALL questions. If all questions are not answered the form will be returned and will delay processing. ◄◄

1. I am now physically able to perform all the duties of my occupation and I am working in full compliance with the terms of my contract. ❒ Yes ❒ No
   If you answered NO, please select the reason why: I am… ❒ a Student ❒ a Substitute ❒ Retired ❒ on maternity leave
   ❒ on medical disability ❒ an Active member involuntarily terminated by a school board as a result of a reduction in force ❒ other
2. Please provide Primary Physician/Clinic information, including complete name/address/phone. NOTE: Indicate maiden name if needed for medical records.:

Your Primary Physician/Clinic. ❒ none
Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: (____) ____ - _____

Spouse's Primary Physician/Clinic. ❒Same as member's ❒none
Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: (____) ____ - _____

	Member	Spouse
3. Current Height	__ft __in	__ft __in
4. Current Weight	____lbs	____lbs
(Both height and weight is required to process your application.)	Yes No	Yes No
5. Have you or your spouse used tobacco products in the past 24 months? (If not answered you will be billed smoker rates.)	❒ ❒	❒ ❒

(For any "YES" answer to questions 6-11, please give full details on reverse.)

6. Have you or your spouse ever been denied life insurance or had the amount of life insurance reduced due to health reasons?	❒ ❒	❒ ❒
If yes, why? _____		
7. Have you or your spouse ever had, been treated for, been diagnosed with or are currently taking medications prescribed by a doctor or other medical practitioner for any of the following conditions:		

a. Disease or disorder of the heart, blood or circulatory system	❒	❒	❒	❒
b. Cancer or tumor	❒	❒	❒	❒
c. Lung disorder	❒	❒	❒	❒
d. Liver or kidney disorder	❒	❒	❒	❒
e. Stomach or intestine disorder	❒	❒	❒	❒
f. Nervous or mental disorder	❒	❒	❒	❒
g. Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC) or any other immune deficiency disorder (such as Lupus)	❒	❒	❒	❒
8. In the past five years, have you or your spouse ever had, been treated for or been diagnosed by a doctor or medical practitioner as having any of the following conditions:				
a. High blood pressure	❒	❒	❒	❒
b. Diabetes	❒	❒	❒	❒
c. Asthma, pleurisy, ulcers, gallstones or spinal disorder	❒	❒	❒	❒
9. In addition, during the last five months have you or your spouse been confined in a hospital or other institution due to illness?	❒	❒	❒	❒
10. Other than above, have you or your spouse consulted or been attended by a doctor or medical practitioner within the past five years for anything other than a routine physical or a condition not already indicated above with a yes answer?	❒	❒	❒	❒
11. Do you or your spouse have any known physical or mental impairments, deformities or ill health not mentioned in the previous questions?	❒	❒	❒	❒
If yes, do you or your spouse need to see a doctor for this condition?	❒	❒	❒	❒

If you answered 'YES' to any of questions 6-11, please give full details below, including the question number and letter. You must also include the doctor or clinic/hospital name, address and phone number. If you have not seen a doctor, please state "N/A" below. If additional space is needed, please provide your medical details on a separate signed and dated sheet of paper and include it with your enrollment form.

Ques. #/Letter	Name of Condition	Member/ Spouse	Date of Illness	Date of full recovery	Details of nature of illness, number of attacks, duration, severity, treatments and medications prescribed and taken	Names, complete addresses and phone numbers of physicians, if different than Primary Physician listed above.

4. Please read, sign and date:

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 false, incomplete, or misleading information is guilty of a felony of the third degree.

Authorization for the Release of Information. This authorization is intended to comply with the HIPAA Privacy Rule

I/We authorize and instruct any health plan, physician, health care professional, hospital, clinic, laboratory, medical facility, pharmacy benefit manager, retail pharmacy, clearinghouse, data warehouse or other comparable organization that aggregates and maintains pharmacy data, or other health care provider that has provided treatment or services to me within the past 5 years ("My Providers") to disclose my entire medical record and any other health information concerning me to The Prudential Insurance Company of America (Prudential). This includes information on the diagnosis and treatment of Human Immunodeficiency Virus (HIV) infection (In Vermont and Wisconsin, this information is excluded) and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes. By my signature below, I/we acknowledge that any agreements I/we have made to restrict the disclosure of health information do not apply to this Authorization and I/we instruct any of My Providers to release and disclose my entire medical record without restriction, including without limitation any restrictions on health care items or services for which a health care provider has been paid out of pocket in full. This health information is to be disclosed under this Authorization so that Prudential may: 1) underwrite an application for coverage and make risk determinations; 2) administer coverage; and 3) conduct other legally permissible activities that relate to any coverage I have or have applied for with Prudential. This Authorization shall remain in force for 24 months following the date of my signature below, and a copy of this Authorization is as valid as the original. I/We understand that I/we have the right to revoke this Authorization in writing, at any time, by sending a signed request for revocation to The Prudential Insurance Company of America; Group Medical Underwriting, P.O. Box 8796, Philadelphia, PA 19176, Attention: Senior Medical Underwriting Consultant. I understand that such a revocation is not effective to the extent that Prudential has taken action in reliance on this Authorization or to the extent that Prudential has a legal right to contest a claim under the insurance contract or to contest the contract itself. I/We understand that any information that is disclosed pursuant to this authorization may be redisclosed to other parties and will not be protected by the HIPAA Privacy Rule. (In Montana only, I may request a record of any subsequent disclosures of protected health information). I/We understand that if I/we refuse to sign this Authorization to release my entire medical record and any other health information concerning me, Prudential may not be able to process an application for coverage. I/We understand that I/we have the right to request and receive a copy of this Authorization. I/We have received the Group Life and Disability Medical Underwriting Notice, included with this form.

I/We declare by signing this form that all the information I/we have provided is complete and true, and understand that it is the basis of providing insurance under a contract(s) issued by The Prudential Insurance Company of America to the NEA Members Insurance Trust. I/We certify by signing this Enrollment Form that I/we am/are currently an Active, Education Support, Life, Retired, Reserved, Student, Substitute, or Staff member in good standing of the National Education Association. I/We understand that if any statement is found to be inaccurate, it may adversely impact my benefits. I/We

understand that if ineligible for the coverage amount requested, I/we will be issued any amount of coverage for which I/we am/(are) approved. I/We have read and understand the terms and requirement of the fraud warnings included as part of this form.

▶▶ Please STOP and review your form to ensure all information is complete. AN INCOMPLETE FORM WILL DELAY PROCESSING. ◀◀
We cannot process your Enrollment Form without your signature. Please indicate the date the Enrollment Form is signed.

X _____ Member's Signature

X _____ Today's Date (mm/dd/yyyy)

FOR MEMBERS 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 Insurance 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.

X _____ Spouse/Domestic Partner's Signature (only if enrolling)

X _____ Today's Date (mm/dd/yyyy)

X _____ Child's Signature (only if enrolling)

X _____ Today's Date (mm/dd/yyyy)

X _____ Child's Signature (only if enrolling)

X _____ Today's Date (mm/dd/yyyy)

Please Note: You can name your Beneficiary once you receive your issuance materials. Assign your beneficiary online at neamb.com/myaccount, or complete and return the Beneficiary Designation Form included in your issuance packet. Any amount of insurance for which there is no Beneficiary at your death will be payable to the first of the following: (a) surviving spouse or registered domestic partner; (b) surviving child(ren) in equal shares; (c) surviving parents in equal shares; (d) surviving siblings in equal shares; (e) estate. The spouse's beneficiary will always be the member.

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. You may wish to seek professional tax advice before exercising this option.

NEA Group Term Life Insurance is issued by The Prudential Insurance Company of America, Newark, NJ. Plan details, limitations and exclusions are described in your certificate. Contract series 83500.

For residents of all states except Alabama, Arkansas, the District of Columbia, Florida, Kentucky, Louisiana, Maine, Maryland, New Jersey, North Carolina, Pennsylvania, 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. **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 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. **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.

Please keep this notice for your records:

Group Life and Disability Income Medical Underwriting
NOTICE

Thank you for choosing The Prudential Insurance Company of America (Prudential) for your insurance needs. Before we can issue coverage we must review your application/enrollment form. To do this, we need to collect and evaluate personal information about you. This notice is being provided to inform you of certain information practices Prudential engages in, and your rights, with regard to your personal information. We would like you to know that:

- Personal information may be collected from persons other than yourself or other individuals, if applicable, proposed for coverage;
- This personal information as well as other personal or privileged information subsequently collected by us may in certain circumstances be disclosed to third parties without authorization only as permitted by law. Examples of these disclosures would include cases of regulatory audit or subpoena/litigation, or where we employ a third party vendor on our behalf under a written contract requiring them to maintain the information in confidence and only use the information for our business purposes in administering the case. We would not use this information or allow another party to use this information for marketing purposes unless we had your signed authorization;
- You have a right of access and correction with respect to personal information we collect about you; and
- Upon request from you, we will provide you with a more detailed notice of our information practices and your rights with respect to such information. Should you wish to receive this notice, please contact:

The Prudential Insurance Company of America
Group Medical Underwriting
P.O. Box 8796
Philadelphia, PA 19176

Any information we obtain regarding a person's insurability will be treated as confidential.