Prudential Financial

Notice of Continuation of Group Term Life Insurance

Notice is hereby made for continuation of the Group Term Life Insurance through the Insurer.

Employer/Organization: ______________________ Employee Name: ______________________

Employee's Social Security Number: ______________________ Spouse's Social Security Number: ______________________

Employee's Date of Birth (M/D/Y): ______________________ Spouse's Date of Birth (M/D/Y): ______________________

I am applying for continuation of coverage for the following programs under Control Number:____________________

Verification of Coverage

Basic Life Amount: $______________________ Voluntary/Optional Life: $______________________

Do you have dependent coverage? ☐ Yes ☐ No If "Yes," are you applying for continuation of coverage for your dependents? ☐ Yes ☐ No

Spouse's Coverage Amount: $______________________ Dependent Children's Coverage Amount: $______________________

- I currently pay ☐ Smoker Rates ☐ Non-Smoker Rates
- My spouse currently pays ☐ Smoker Rates ☐ Non-Smoker Rates

Reason for request:

☐ Employer Approved Leave of Absence
☐ Termination of Employment/Membership
☐ Other: ______________________

When above event occurred (M/D/Y): ______________

Premium mode elected:

☐ Annual (Current monthly premium x 12 + $10.00 administration fee)
☐ Semi-Annual (Current monthly premium x 6 + $10.00 administration fee)
☐ Quarterly–*This option available only to those employees on an employer approved leave of absence* (Current monthly premium x 3 + $10.00 administration fee)

Beneficiary Designation

Employee's Beneficiary: ______________________ Relationship: ______________________

Is this Beneficiary an Irrevocable Beneficiary? ☐ Yes ☐ No Was there a previous Irrevocable Beneficiary? ☐ Yes ☐ No
(If "Yes," previous Irrevocable Beneficiary MUST sign this form.)

Employee's Contingent Beneficiary:______________________ Relationship: ______________________

Signature of Employee: ______________________ Date Signed: ______________________

Signature of Spouse*: ______________________ Date Signed: ______________________
(*In community property states, the spouse of the Insured must sign this form if the beneficiary is anyone other than the spouse.)

Signature of a Witness (not the beneficiary): ______________________ Date Signed: ______________________

Signature of **Irrevocable** Beneficiary of Assignee: ______________________ Date Signed: ______________________

Irrevocable Beneficiary means a beneficiary designation that cannot be changed by the insured without consent from the beneficiary.
Primary Beneficiary means the person or persons specially designated by the insured as the first in priority to receive policy proceeds.
Contingent Beneficiary means an alternate beneficiary designated to receive payment, usually in the event that the original (Primary) Beneficiary.

(please see reverse side of form)

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Employee Name: ____

Group Control Number: ___________________________

Please send all notices to- Name: ____

Street Address: ____

City, State, Zip: ____

Telephone Number: ____

I hereby request Continuation of Coverage under the above-mentioned Group Master Policy**. I understand that this must be received within 31 days from the date the insurance under the Group Master Policy terminates in order to continue the existing coverage**. I further understand that coverage will continue as long as premiums are paid up-to-date and the Group Master Policy remains in effect, but not to exceed the time limit specified in my Certificate.

Signature of Certificate Holder: ______________________________ Date Signed: ____________________

TO BE COMPLETED BY EMPLOYER

On ____/____/____ the above named insured became ineligible as a benefit-eligible employee. On _____/____/____ the applicant was notified of the right to continue coverage through the Continuation Rider of the Group Master Policy. Prior to that date, the above insured had coverage as follows: Employee Coverage $ ________________; Spouse Coverage (if any) $____________________; Child(ren) Coverage (if any) $______________

Signed: ______________________________ Title: ______________________________

Title: ______________________________ Date: ______________________________

Please submit form to:
Johnson Rooney Welch, Inc.
2250 Douglas Boulevard, Suite 210
Roseville, CA 95661

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