Voluntary 10-Year Level Group Term Life Enrollment Form

Mail completed form to:
Minnesota Benefit Association, Group Level Term Life Administrator
6701 Upper Afton Road, Woodbury, MN 55125

Questions? Email: info@minnesotabenefitassociation.org | Call 800-360-6117

Minnesota Benefit Association | 72209

1 Member Information

Last Name | First Name | Middle Initial | Social Security Number | ☐ Male ☐ Female

Street Address | City | State | Zip Code | Phone Number

Name of Your Public Sector Employer | Email Address | Date of Birth (mm/dd/yyyy)

2 Spouse Information and Dependent Child Information - Complete if you are requesting coverage for your spouse and/or dependent child.

Last Name | First Name | Middle Initial | Date of Birth (mm/dd/yyyy) | ☐ Male ☐ Female

Dependent Child Information

	Full Name	SSN	Date of Birth (mm/dd/yyyy)	
1.				☐ Male ☐ Female
2.				☐ Male ☐ Female
3.				☐ Male ☐ Female
4.				☐ Male ☐ Female

3 Coverage Selection - Please refer to attached rate chart for premium cost.

☐ Member	☐ $50,000	☐ $100,000	☐ $150,000	
☐ Spouse	☐ $50,000	☐ $100,000	☐ $150,000	
☐ Child(ren)*	☐ $10,000			

**Dependent Child(ren) - Each child receives $10,000 in coverage. Eligible child coverage begins from live birth until age 26.*

4 Authorization

I have read and understand the terms and requirements of the fraud warnings included as part of this enrollment. I certify that I am currently a member in good standing of theSAMBA. I declare by signing below that all the information I have provided is complete and true and understand that it is the basis of providing insurance under a contract(s) issued by SAMBA.

X

Member Signature | Date Signed (mm/dd/yyyy)

The Prudential Insurance Company of America
751 Broad Street, Newark, New Jersey 07102

Evidence of Insurability Form: Mail to:

Minnesota Benefit Association, Group Level Term Life Administrator
6701 Upper Afton Road, Woodbury, MN 55125

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Read this Notice before Completing the Health Statement Questionnaire The applicant does not have to disclose any HIV (AIDS Virus) tests which were administered: (1) to a criminal offender or crime victim as a result of a crime that was reported to the police; (2) to a patient who received the services of emergency medical services personnel at a hospital or medical care facility; (3) to emergency medical services personnel who were tested as a result of performing emergency medical services. The term "emergency medical personnel" includes individuals employed to provide pre-hospital emergency services: licensed police officers, firefighters, paramedics, emergency medical technicians, licensed nurses, rescue squad personnel, other individuals who serve as volunteers of an ambulance service who provide emergency medical services, crime lab personnel, correctional guards (including security guards at the Minnesota security hospital who experience a significant exposure to an inmate who is transported to a facility for emergency medical care), and other persons who render emergency care or assistance at the scene of an emergency, or while an injured person is being transported to receive medical care and who would qualify for immunity under the good Samaritan law.

1 Member Information

Please print all answers using black ink.

First Name | Last Name | Middle Initial | Social Security No. optional | Sex Assigned at birth ☐ Male ☐ Female

Street Address | City | State | ZIP Code

Cell Phone Number | Email Address

Birth Date (mm/dd/yyyy) | Birth City | Birth State | Height ft. | Weight lbs.]

2 Spouse/Domestic Partner (DP) Information – Complete if applying for spouse/DP

First Name | Last Name | Middle Initial | Social Security No. optional | Sex Assigned at birth ☐ Male ☐ Female

Street Address | City | State | ZIP Code

Birth Date (mm/dd/yyyy) | Birth City | Birth State | Height ft. | Weight lbs.]

3 Health Questions – Please answer these questions by checking "Yes" or "No"

Member Yes	*Member* No	*Spouse/DP* Yes	*Spouse/DP* No		
☐	☐	☐	☐	1.	**Within the last 12 months,** have you used tobacco or nicotine in any form?
☐	☐	☐	☐	2.	**Are you currently** performing all the duties of your job on a full-time basis?**If no, please explain:**
☐	☐	☐	☐	3.	Do you currently have any known disorder, condition, or disease or are you currently taking prescription medication for any disorder, condition, or disease diagnosed by a member of the medical profession (other than: acid reflux; allergies; cold; cough; herniated disc; high cholesterol; non rheumatoid arthritis; overactive or underactive thyroid; or pregnancy)?
☐	☐	☐	☐	4.	Within the last five years, have you been treated for, had any symptoms of, been in a hospital or health care facility for, or diagnosed with any of the following: • circulatory or respiratory disease or disorder; • asthma, chronic obstructive pulmonary disease (COPD), sleep apnea; • coronary artery or heart disease, chest pain; heart attack, stroke, or high blood pressure; • cancer, leukemia or tumors; • diabetes; disease or disorder of the lungs, kidneys, liver, pancreas, or genitourinary system; • arthritis or other musculoskeletal condition; • alcoholism; drug addiction, mental or nervous disorder; • Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC)? • Multiple sclerosis, epilepsy, seizure, stroke; • Chronic pain, rheumatoid arthritis, lupus; or • Colitis, Crohn's disease, gastric bypass or bariatric surgery.]

If you answered "Yes" to any questions 3-4 please provide full details on the next page.

Health Conditions – Continued from page 2

If you answered "Yes" to any questions 3-4 please provide full details below.

Member Condition	Status	Last Visit	Recovery Date	Physician Name	Address	Phone

Spouse/DP Condition	Status	Last Visit	Recovery Date	Physician Name	Address	Phone

Member Primary Care Physician Information

Full Name | Date Last Seen | Office Phone number

Address | City | State | Zip code

Spouse / DP Primary Care Physician Information

Full Name | Date Last Seen | Office Phone number

Address | City | State | Zip code

Authorization for the Release of Information. This authorization is intended to comply with the HIPAA Privacy Rule. I/Wea uthorize 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/us within the past five years ("My Providers") to disclose my/our entire medical record and any other health information concerning me/us to The Prudential Insurance Company of America ("Prudential") and through it, to its reinsurers, authorized agents and MIB, LLC. 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. I/We also authorize the MIB, LLC. to release any data it may have about me/us for coverage to Prudential. By my/our 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/our Providers to release and disclose my/our 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/ We have or have applied for with Prudential. This Authorization shall remain in force for 24 months following the date of my/our 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/We 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 re-disclosed to other parties and will not be protected by the HIPAA Privacy Rule. I/We understand that if I/ We refuse to sign this Authorization to release my/our 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.

Statement of Understanding: I/We represent that all statements and answers made within or attached to this Request Form are true and complete to the best of my/our knowledge and belief. I /We understand that my application, including portions containing health information are submitted to the Plan Administrator, acting for the policy holder, and that the administrator shall forward the application to the insurance company.

Furthermore, I/we understand that coverage shall be in effect only after all of these conditions have been met: this application has been approved by Prudential; the Certificate has been issued while all persons to be insured thereunder are alive; the answers and statements in this application continue to be true and complete until the Effective Date; and the initial premium contribution has been paid. I/We also understand that coverage will not take effect if the facts have changed. I/We have also read and understand and agree to the additional terms, conditions and requirements as stated in the Authorization for the Release of Information and Important Notice sections. I/We understand that completion of this application in no way implies that I/we will be accepted for insurance coverage.

Please consult Fraud warnings and understand the terms and requirements of these Fraud warnings. I have received the Group Life and Disability Income Medical Underwriting Notice included with this form.

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.

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.**

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

X

Member Signature | Date Signed (mm/dd/yyyy)

By my signature above, I hereby request coverage. I acknowledge that I am a member of the above Association and that I must continue such membership to keep this insurance in force.

X

Spouse or Domestic Partner Signature (if applying for Spouse or Domestic Partner Coverage) | Date Signed (mm/dd/yyyy)

IMPORTANT NOTICES

For residents of all states except Alabama, Alaska, Arkansas, the District of Columbia, Florida, Idaho, Indiana, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Minnesota, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Pennsylvania, Puerto Rico, Rhode Island, Tennessee, Utah, Vermont, West Virginia, 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.

ALASKA RESIDENTS -- A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

ARIZONA RESIDENTS -- For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

ARKANSAS, DISTRICT OF COLUMBIA, LOUISIANA, MASSACHUSETTS, RHODE ISLAND AND WEST VIRGINIA 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.

CALIFORNIA and TEXAS RESIDENTS -- For your protection, California and Texas law requires the following to appear on this form. Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

COLORADO RESIDENTS -- It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

DELAWARE RESIDENTS -- Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

IDAHO RESIDENTS -- Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement containing any false, incomplete, or misleading information is guilty of a felony.

INDIANA RESIENTS -- A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

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, TENNESSEE, VIRGINIA 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.

MINNESOTA RESIDENTS -- A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NEW HAMPSHIRE RESIDENTS -- Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638.20.

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.

NEW MEXICO 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 CIVIL FINES AND CRIMINAL PENALTIES.

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.

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.

OHIO RESIDENTS -- Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

OKLAHOMA RESIDENTS -- WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete, or misleading information is guilty of a felony.

OREGON RESIDENTS -- Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurance company, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

PENNSYLVANIA 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.

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.]

Group Term Life coverage are issued by The Prudential Insurance Company of America, 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 by state. California COA #1179, NAIC #68241 Contract series: 83500