ESSENTIAL TERM LIFE

Providing for your family's future doesn't have to be complicated or expensive. That's why we are excited about this affordable group life benefit package that can help put you and your family at ease and keep you protected should the unexpected occur.

Issued by The Prudential Insurance Company of America

Affordable monthly rates to fit your budget · Get up to $250,000 of life coverage · Coverage for your spouse or dependent children

1st Community Federal Credit Union

Prudential is rated A+ by A.M. Best Company and ranks fourth on FORTUNE "World's Most Admired Companies" as well as first on "The Life/Health Insurance Companies" list.

4. Coverage Amounts

Choose the type of coverage and amounts for which you are applying.

Member Term Life Coverage [please check one]

- ☐ $ 50,000 ☐ $125,000 ☐ $200,000
- ☐ $ 75,000 ☐ $150,000 ☐ $225,000
- ☐ $100,000 ☐ $175,000 ☐ $250,000

Spouse Coverage [please check one]

- ☐ $ 50,000 ☐ $125,000 ☐ $200,000
- ☐ $ 75,000 ☐ $150,000 ☐ $225,000
- ☐ $100,000 ☐ $175,000 ☐ $250,000

Dependent Child Coverage

☐ $20,000 [14 days to age 19, 25 if full-time student]

Child's Name	Date of Birth

5. Beneficiary Designation

Please specify your beneficiary. [Full name, Example: Jean Lee Doe]

First Name	Middle Name	Last Name	Relationship	% Share

☐ Please check if additional information regarding your beneficiary designation is attached.

TOTAL [must equal 100%] 100%

6. Billing Selection

IMPORTANT NOTE- Please write in your account number and check the appropriate account designation:

Account Number | | | | | | | | | | | | | | | | |

☐ Savings ☐ Checking

AUTHORIZATION For the Release of Information. This authorization is intended to comply with the HIPAA Privacy Rule. I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, medical facility or other health care provider that has provided payment, treatment or services to me on my behalf within the past five (5) years ["My Providers"] to disclose the entire medical record and any other health information concerning me and/or any dependent proposed for coverage in the application to The Prudential Insurance Company of America ["Prudential"] and through it, to its reinsurers, authorized agents and the Medical Information Bureau, Inc. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol and/or drugs, but excludes psychotherapy notes. I also authorize the Medical Information Bureau, Inc. to release any data it may have about me and/or any dependent proposed for coverage to Prudential. By my signature below, I acknowledge that any agreements I or my dependents have made to restrict my health information do not apply to the Authorization and I instruct My Providers to release and disclose the entire medial record for me and/or my dependent without restriction. This health information is to be disclosed under the Authorization so that Prudential may: 1) underwrite an application for coverage and make risk determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provisions of benefits; 4) administer coverage; and 5) 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 the Authorization is as valid as the original. I understand that any information that is disclosed pursuant to this Authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information. I understand that if I refuse to sign this Authorization to release the entire medical record for me and/or my dependent, Prudential may not be able to process an application for coverage, or if coverage has been issued, may not be able to make any benefit payments. I understand that I 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 coverage shall be in effect only after all of these conditions have been met: this application has been approved by Prudential; the Contract has been issued while all persons to be insured thereunder are alive, and; the answers and statements in this application continue to be true and complete until the Effective Date. 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.

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.

✘ _____ Date [mm/dd/year] __-__-____

Member Signature

✘ _____ Date [mm/dd/year] __-__-____

Spouse Signature [if applying for Spouse Coverage]

Calculate Your Monthly Premium

1. Find the appropriate unit rate for you.
2. Multiply that rate by the number of $10,000 units of coverage you need [Example: $100,000 of life insurance = 10 units]

The rates shown are available to eligible members and spouses under age 70, subject to evidence of insurability acceptable to the insurer.

Non-Smoker Rate per $10,000			Smoker Rate per $10,000		
AGE	MALE	FEMALE	AGE	MALE	FEMALE
Under 30	$ 1.17	$ .72	Under 30	$ 2.05	$ 1.23
30-34	1.14	.89	30-34	2.00	1.56
35-39	1.41	1.16	35-39	2.47	2.03
40-44	2.12	1.54	40-44	3.71	2.70
45-49	3.06	2.49	45-49	5.36	4.36
50-54	4.83	4.23	50-54	8.45	7.40
55-59	8.11	5.77	55-59	14.19	10.97
60-64	14.20	9.44	60-64	24.85	16.74
65**-69	24.85	13.62	65**-69	43.49	23.56
70**-74*	39.80	19.28	70**-74*	62.78	29.93

CHILDREN: Additional $2.50/month for all dependent children - $20,000 benefit each child

*Renewal rates only **Coverage reduces by 50% at ages 65 & 70, and terminates at age 75.
Note: The male rates apply for both members and spouses in MT.

Information about this group Term Life insurance coverage is available through Financial Solutions Association. It is written in non-technical language and is not intended to be a detailed description. This information is controlled by and does not modify the group policy issued by The Prudential Insurance Company of America.

ISI's Privacy Policy – Institution Solutions I, LLC (ISI) is required and agrees to maintain the confidentiality of any information provided or obtained by the Financial Institution or its accountholders. ISI warrants that all such information will be used solely for the administration of the program(s). ISI further agrees that it will not solicit the Financial Institution's accountholders to participate in any other programs sponsored by ISI without the prior written consent and approval of the Financial Institution through an executed contract.

ACCELERATED DEATH BENEFITS – Receipt of accelerated death benefits may affect eligibility for public assistance programs and may be taxable. There is no administrative fee to accelerate death benefits. The accelerated amount is not discounted.

BENEFICIARY DESIGNATION – If you name more than one beneficiary, settlement will be made in equal shares to the designated beneficiaries (or beneficiary) that survive you, unless otherwise provided in the designation. If no named beneficiary survives you, settlement will be made to the first of the following: your (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 beneficiary named herein will be the beneficiary for your total amount of insurance coverage issued.

SPECIAL NOTICE – For residents of all states except Florida, Kentucky, New Jersey, Pennsylvania, 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. 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. 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. 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 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 a statement of claim for payment of a loss or benefit may have violated state law, is 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. 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.

ELECTRONIC FUND TRANSFER AUTHORIZATION - Automatic Insurance Payment Program Agreement provides for Electronic Fund Transfer for the purpose of making your insurance payment without the use of a check. Your signed authorization is required. The electronic debit will occur each month on the date elected by your Financial Institution. If the transfer falls on a weekend or bank holiday your checking/savings account will be charged the next business day. The amount of the automatic debit may vary due to changes in the amounts of insurance or a premium contribution change. You will be notified in advance of changes to the amount of your debit due to premium contribution changes.

PLEASE KEEP THIS NOTICE FOR YOUR RECORDS.

REQUEST FOR TERM LIFE COVERAGE FORM

1. Member Information

Please complete Sections 1-6 and mail form to Institution Solutions, P.O. Box 851795, Richardson, TX 75085-1795 or fax to 866/301-5827. DO NOT INCLUDE PAYMENT NOW. You will be billed on a monthly basis and notified of your coverage effective date. IF YOU HAVE ANY QUESTIONS, PLEASE CALL INSTITUTION SOLUTIONS AT 800/272-3057.

First Name | MI | Last Name

Address | Apt.#

City | State | Zip

Social Security Number | Date of Birth [mm/dd/year] | Phone Number

Gender ☐ Male ☐ Female | Height ft. in. | Weight [lbs.]

☐ YES, I would like to receive important information via email about products, offerings and program -sponsored events.

Email Address

2. Spouse Information

Complete if you are requesting coverage for your spouse.

First Name | MI | Last Name

Gender ☐ Male ☐ Female | Height ft. in. | Weight [lbs.] | Social Security Number | Daytime Phone Number

Date of Birth [mm/dd/year] | Evening Phone Number

3. Health Questions

Please answer the following questions, by checking "YES" or "NO."

MEMBER (YES NO) | SPOUSE [if applicable] (YES NO)

☐ ☐ ☐ ☐ 1. Within the last 12 months, have you smoked cigarettes?

☐ ☐ ☐ ☐ 2. Are you currently performing all the duties of your job for the number of hours required? If no, explain:

3. Within the last five (5) years, have you been evaluated for, medically treated for, diagnosed with, taken medications for or experienced symptoms of any of the following conditions:

☐ ☐ ☐ ☐ a. Disease or disorder of the heart, blood or circulatory system

☐ ☐ ☐ ☐ b. High blood pressure

☐ ☐ ☐ ☐ c. Cancer or tumors

☐ ☐ ☐ ☐ d. Lung, respiratory or breathing disorders

☐ ☐ ☐ ☐ e. Diabetes

☐ ☐ ☐ ☐ f. Liver or kidney disorders

☐ ☐ ☐ ☐ g. Gastrointestinal, stomach or intestine disorders, including ulcers or gallstones

☐ ☐ ☐ ☐ h. Mental or nervous illness or disorder, alcoholism or drug addiction

☐ ☐ ☐ ☐ i. Chronic pain or fatigue syndromes

☐ ☐ ☐ ☐ j. Neurological disorders such as Multiple Sclerosis or Parkinson's Disease

☐ ☐ ☐ ☐ k. Musculoskeletal disorders including arthritis, fractures or carpal tunnel syndrome

☐ ☐ ☐ ☐ 4. Within the last five (5) years, have you been diagnosed with or treated by a physician for, Human Immunodeficiency Virus (HIV), AIDS-Related Complex (ARC) or Acquired Immune Deficiency Syndrome (AIDS)?

☐ ☐ ☐ ☐ 5. Within the last five (5) years, have you been in a hospital or other institution for observation, rest, diagnosis or treatment?

☐ ☐ ☐ ☐ 6. Within the last five (5) years, have you been attended by a doctor or licensed practitioner for anything other than a routine physical?

☐ ☐ ☐ ☐ 7. Do you have any known symptoms, physical or mental impairments not mentioned in the previous questions?

☐ ☐ ☐ ☐ 8. Are you taking any medication or being treated for any condition, including pregnancy or disease not mentioned in the previous questions?

If you answered "YES" to any of the questions 3-8, please provide full details below. [If more space is needed, attach an additional sheet]

Member	Spouse	Question Number	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
☐	☐					
☐	☐					
☐	☐					

PRIMARY CARE PHYSICIAN INFORMATION [MEMBER]

Name | Date Last Seen

Address | Phone Number

PRIMARY CARE PHYSICIAN INFORMATION [SPOUSE]

Name | Date Last Seen

Address | Phone Number

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