



ONLY TO BE FOLLOWT
IF EXCEEDING
GUARANTEED ISSUE
LIMITS

GROUP INSURANCE

The Prudential Insurance Company of America

Employer/Association Name:

ADMINISTRATIVE RESOURCES

Group Contract No.(s):

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Branch No.:

000001

Mail the completed form to:

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

Or fax the completed form to:

877-605-6671

Short Form Health Statement Questionnaire (A separate form must be completed for each person requiring Evidence of Insurability)

Employee/Member Information

First Name MI Last Name
Number and Street P.O. Box / Apt. Number
City State ZIP Code
Social Security Number Employee/Member ID Number Telephone
E-Mail Address

Applicant Information Relationship to Employee/Member: Self Spouse

First Name MI Last Name Social Security Number

Applicant Coverage requiring Evidence of Insurability: **Employee/Member** Life Long Term Disability Short Term Disability
Spouse Life

Gender: Female Male Height: ft. in. Weight: lbs. Date of Birth: (mm-dd-yyyy)

Please answer these questions by checking "Yes" or "No."

- Yes No Do you currently have any disorder, condition (including pregnancy), or disease or are you currently taking medication prescribed or provided by a medical or other practitioner for any disorder, condition (including pregnancy), or disease other than a cold, cough, or allergies?
- Yes No During the last five years, have you been in a hospital or other institution for observation, rest, diagnosis, or treatment?
- Yes No During the last five years, have you had life, disability, or health insurance declined, postponed, changed, rated-up, cancelled, or withdrawn by an insurer?
- Yes No Within the last five years, have you been treated for or had any trouble with any of the following: heart; chest pain; high blood pressure; cancer or tumors; diabetes; lungs; kidneys; liver; alcoholism; mental, or nervous disorder or have you been diagnosed with, or treated by a member of the medical profession for, Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC)?
- Yes No Within the last five years, have you been diagnosed with, or treated by a member of the medical profession for, drug addiction, chronic pain, neurological, musculoskeletal, or respiratory disorder?

Prudential reserves the right to request additional health information on the basis of the responses given to the above questions.

I have read and understand the terms and requirements of the Important Notice included as page 2 of this form. I declare that, to the best of my knowledge and belief, the statements made in this application are complete and true. I agree that the coverage applied for is subject to the terms of the plan and shall become effective on the date or dates established by the plan, provided the evidence of good health is satisfactory.

Applicant's Signature (unless a minor) Date Signed (mm-dd-yyyy)
If applicant is a minor, Signature of Parent, Guardian or Person Liable for Support of Applicant Relationship Date Signed (mm-dd-yyyy)



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