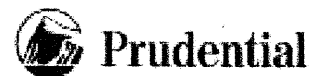


THE PRUDENTIAL INSURANCE COMPANY OF AMERICA

751 Broad Street, Newark, New Jersey 07102

1. Employee Information - Please enter your information in the spaces provided below.

(For Office use only) Effective Date of Coverage: Control No:											
Last Name	First Name										
MI											
Street Address											
City	State										
Zip Code											
Social Security Number:											
<table border="1" style="margin: auto; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table>											
Date of Birth ____/____/____ (mm/dd/yyyy)	Date of Employment ____/____/____ (mm/dd/yyyy)										
Annual Earnings: \$ _____	Occupation: _____										
Daytime Phone: _____	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female										
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed											



Client Name : ADMINISTRATIVE RESOURCES

Control No :

2. Coverage Elections - Please make your optional selections below. Check each applicable box.

Optional Employee Term Life

<input type="checkbox"/> Max without Medical Questions, the lesser of \$150,000 and 5 times my annual salary	<input type="checkbox"/> \$ _____	<input type="checkbox"/> None
--	-----------------------------------	-------------------------------

Optional Dependent Term Life - Spouse

<input type="checkbox"/> Max without Medical Questions, \$20,000	<input type="checkbox"/> \$ _____ (not to exceed 50% of your Optional Life amount)	<input type="checkbox"/> None
--	--	-------------------------------

Optional Dependent Term Life - Child

<input type="checkbox"/> \$ _____ (not to exceed 50% of your Optional Life amount)	<input type="checkbox"/> None
--	-------------------------------

Eligible children are unmarried from 14 days, up to age 19, or up to age 25 if a full-time student at an accredited college/university.

Optional Accidental Death and Dismemberment

<input type="checkbox"/> \$ _____ (Not to Exceed 5 times earnings)	<input checked="" type="checkbox"/> None
--	--

Short Term Disability

<input type="checkbox"/> Elect Coverage	<input type="checkbox"/> Do Not Elect Coverage
---	--

Long Term Disability

<input type="checkbox"/> Elect Coverage	<input type="checkbox"/> Do Not Elect Coverage
---	--

For coverage to become effective, you must be actively at work during the enrollment period and on the effective date of the plan. If you apply for an amount that requires evidence of good health, you must be actively at work on the date of approval for the amount requiring evidence of good health. In the future, if you wish to enroll for employee-paid insurance, increase coverage amounts, or add dependent coverage, you may be required to furnish evidence of insurability for yourself and/or your spouse. If your dependents are confined for medical treatment at home or elsewhere, coverage will begin when confinement ends.

Employee Name : _____



Client Name : ADMINISTRATIVE RESOURCES

Control No :

3. Authorization - Please review the Important Notes that follow before completing this step. Then, indicate your acceptance or waiver of coverage below, sign and date this form, and return to your Benefits Administrator. You will receive a Booklet-Certificate with complete plan information for any coverages you have elected.

Acceptance or Waiver of Coverage

- I am enrolling for coverage and I authorize my employer to deduct from my earnings until further notice my contributions for insurance under a contract issued by Prudential. I understand that, if I desire to increase the amount of my insurance or my dependent insurance coverage hereafter, I may be required to furnish evidence of good health satisfactory to Prudential for myself and/or my dependent. I declare the statements above are true, accurate and complete and understand they are the basis for determining my insurability and contribution for coverage.
- I do not wish to enroll for coverage. I certify that I have been given the opportunity by my employer to enroll for coverage. I understand that, if I desire to enroll hereafter, I may be required to furnish evidence of good health satisfactory to Prudential for myself and/or my dependent.

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 warning **ONLY** applies to accident and disability income 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.

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

X _____
Employee Signature **Date**

Print Employee Name

MICHIGAN RESIDENTS ONLY: When enrolling for Spouse Dependent Term Life coverage and/or Child coverage (\$10,000 or more), the spouse and children must sign below to acknowledge consent for the coverage.

X _____ X _____
Spouse's Signature **and/or Children age 18 and over** **Date**

This brochure is intended to be a summary of your benefits and does not include all plan provisions, exclusions and limitations. 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 The Prudential Insurance Company of America, the Group Contract will govern. Contract provisions may vary by state. Contract Series: 83500. Group Term Life coverage is issued by The Prudential Insurance Company of America, 751 Broad Street, Newark, NJ 07102. Life Claims: 1-800-524-0542. Prudential and the Rock logo are registered service marks of The Prudential Insurance Company of America and its affiliates. **Please also read the Important Notes that follow.**



Client Name : ADMINISTRATIVE RESOURCES
Control No :

4. Indicate your beneficiary(ies) - Do not name a beneficiary for spouse and/or child Dependent Term Life Coverage; these benefits are paid to you if you survive them. If more than one primary beneficiary is designated, settlement will be made in equal shares to the designated beneficiaries (or beneficiary) who are then still living, unless their shares are specified. If there is no named beneficiary or no beneficiary survives the insured, settlement will be made in accordance with the terms of your Group Contract. Use a separate piece of paper for additional beneficiary designations. I understand that, unless otherwise indicated, this designation applies to all coverages offered by Prudential under my employer's group plan and I expressly revoke all prior designations. All of the fields listed below are mandatory and must be completed in full if you have elected coverage.

Employee Primary Beneficiary Designation (must equal 100%)

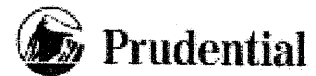
Full Name	Address	Social Security Number	Percentage	Relationship to Insured

Employee Contingent Beneficiary Designation (must equal 100%)

A contingent beneficiary is the person(s) or entity you choose to receive your life insurance proceeds if the primary beneficiary(ies) die (or the entity dissolves) before you die.

Full Name	Address	Social Security Number	Percentage	Relationship to Insured

Employee Name : _____



Client Name : ADMINISTRATIVE RESOURCES

Control No :