Tennessee Board of Regents

Prudential Long Term Disability Insurance Plan

Non-Exempt Enrollment Form (please complete front and back)

☐ **New Hire**

☐ ***Change** (**IMPORTANT)** *If you fail to enroll when eligible or increasing coverage, you are required to furnish evidence of insurability (EOI) to Prudential Insurance. Coverage subject to (EOI) is not effective until approved by Prudential.*

☐ ***Reclassification (IMPORTANT)** Employees have 31 days from the date of reclassification to move into any level of the non-exempt plan without having to furnish EOI.

Important information concerning Pre-existing Conditions:

You have a pre-existing condition if both 1. and 2. are true:

1. (a) You received medical treatment, consultation, care or services, including diagnostic measures, or took prescribed drugs or medicines, or followed treatment recommendation in the 6 months just prior to your effective date of coverage.

(b) You had symptoms for which an ordinarily prudent person would have consulted a health care provider in the 6 months just prior to your effective date of coverage.

2. Your disability begins within 12 months of the date your coverage under the plan becomes effective.

*If a claim is incurred during the Pre-Existing Condition period, Prudential will conduct a review to determine if your condition is pre-existing. *If an applicant increases coverage and a condition is determined to be Pre-existing, Prudential may pay benefits based on the applicants prior plan level.*

For additional information please see your Human Resource Representative.

1. Please complete the following information:

Social Security Number - -	Name (last, first, middle initial)	
Street		
City	State	Zip
Date of Birth / /	Date of Hire / /	Gender ❑ Male ❑ Female
Change Date / /		Reclassification Date / /
Company/Location	Annual Salary $	Occupation

2. Please read, mark one of the boxes below, then sign and return this form to your Benefits Office:

❑ I REQUEST COVERAGE under the Long Term Disability Insurance Plan through my employer's group insurance contract, as now or hereafter applicable to me, and authorize the appropriate deductions from my wages. **PLEASE CHOOSE AN OPTION BELOW:** ***(Options 1 through 3 pay a maximum benefit of $6,000 per month)***

- ❑ Plan 1 – 50% with 6 month Elimination
- ❑ Plan 2 – 60% with 4 month Elimination
- ❑ Plan 3 – 60% with 3 month Elimination

❑ I DECLINE COVERAGE under the Long Term Disability Insurance Plan. I understand that if I desire to apply at a later date for the benefits that I have declined, I will have to furnish evidence of insurability and be approved by Prudential.

_____ _____

Employee Signature Date

3. To be completed by the Employer:

Effective Date of Coverage: _____ Benefit Administrator's Signature: _____

Important: If a change is due to reclassification and the employee wishes to remain in their original plan, they must complete **Reclassification Form B** indicating their intent not to change plans.