Prudential

afspa
AMERICAN FOREIGN SERVICE PROTECTIVE ASSOCIATION

GROUP LIFE ENROLLMENT FORM

For use in all states except: MT, UT, NH and WA
Please contact AFSPA for further instructions

The Prudential Insurance Company of America
751 Broad Street, Newark, New Jersey 07102
1-877-232-3619

Company Name	**Control Number**	**Agency**
American Foreign Service Protective Association	42001	

Member General Information	Effective Date of Coverage (for office use only) / /

Last Name	First Name	MI	Email Address	Phone Number

Address	City	State	Zip Code

Social Security Number	Date of Birth (Month/Day/Year)	Date of Hire (Month/Day/Year)
– –	/ /	/ /

Marital Status

☐ Single ☐ Married ☐ Divorced ☐ Widowed

Coverage Election	**Coverage Amount Chosen**
☐ Voluntary Group Term Life Immediate Benefit Plan: Member	$ 15,000

Acceptance or Waiver of Coverage

☐ I am enrolling for coverage and I authorize American Foreign Service Protective Association to deduct from my earnings until further notice my contributions for insurance under a contract issued by The Prudential Insurance Company of America To the best of my knowledge and belief, I declare the statement above is true and understand it is the basis for determining the contribution for coverage. I also understand that for coverage to become effective, I must be actively at work on the effective date of the plan.

☐ I do not wish to enroll for any of the above optional coverages. I certify that I have been given the opportunity by American Foreign Service Protective Association to enroll for coverage. I understand that if I desire to enroll hereafter, I may be required to furnish satisfactory evidence of insurability to The Prudential Insurance Company of America for myself.

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.

The policy/certificate provides limited benefits. Review your certificate carefully.

Member Signature _____ Date Signed (Month/Day/Year) _____

Employees and/or Dependents may be ineligible for group insurance coverage while on active duty in the armed forces

Accelerated Death Benefit Option is a feature that is made available to group life insurance participants. It is not a health, nursing home, or long-term care insurance benefit and is not designed to eliminate the need for those types of insurance coverage. The death benefit is reduced by the amount of the accelerated death benefit paid. There is no administrative fee to accelerate benefits. Receipt of accelerated death benefits may affect eligibility for public assistance and may be taxable. The federal income tax treatment of payments made under this rider depends upon whether the insured is the recipient of the benefits and is considered terminally ill or chronically ill. You may wish to seek professional tax advice before exercising this option.

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Member General Information

Last Name	First Name	Middle Initial	Last 4 digits of Social Security No.
			XXX-XX- _____

Acceptance or Waiver of Coverage

For residents of all states except Alabama, Arkansas, the District of Columbia, Florida, Kentucky, Louisiana, Maine, Maryland, New Jersey, New York, North Carolina, Pennsylvania, Puerto Rico, Rhode Island, 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.

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.

ARKANSAS, DISTRICT OF COLUMBIA, LOUISIANA and RHODE ISLAND 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.

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 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.

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.

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 or misleading information concerning a fact or matter material to the claim may be guilty of a Class H felony.

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.

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.

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, with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

Return completed form to:
American Foreign Service Protective Association
1620 L Street NW Suite 800, Washington, DC 20036-5629
Fax: 202-775-9082

Optional Term Life Insurance coverages are issued by The Prudential Insurance Company of America, 751 Broad Street, Newark, NJ 07102. Life Claims: 1-800-524-0542. The Booklet-Certificate contains all details, including any policy 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.

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AMERICAN FOREIGN SERVICE PROTECTIVE ASSOCIATION

Immediate Benefit Plan

PAYROLL ALLOTMENT FORM

REQUEST BY EMPLOYER FOR ALLOTMENT OF PAY FOR SUBMISSION TO:
AFSPA, 1620 L STREET,N.W. Suite 800• WASHINGTON, DC 20036 • (202) 833-4910 • FAX (202) 775-9082

PRIVACY ACT STATEMENT

The information collected on this form is authorized by 5 U.S.C. 5527, which authorizes disbursing officers to permit employees to make allotments of their pay under regulations issued by the Office of Personnel Management. The information will be used primarily to identify you in your agency's payroll system (by employee number) and to process the payment of the allotment. Other possible disclosures of the information would be to a court or a federal, state or local taxing authority.

Executive Order 9397 permits use of the Social Security Number (SSN) as the means of identifying individuals in personnel record systems. Furnishing your SSN or any other information on this form is voluntary. However, failure to provide your employee identification number (or SSN when it is used by your agency as the employee identification number) or any other requested data may result in your agency not being able to process your request.

COMPLETE THIS SECTION AND SIGN BELOW

☐ Open Enrollment ☐ Apply for Coverage ☐ First Overseas Assignment ☐ New Hire

Employee's Name (As stated on Earnings and Leave Statement) Employee's Identification Number

Employee's Home Address (Number, Street, City, State and Zip Code)

Employee Agency DEPARTMENT OF STATE Payroll Office Location (City, State)

☐ Civil Service ☐ Foreign Service ☐ FMA

Action Requested

☐ New Allotment $ _____

☐ Cancel Allotment

Recipient of Allotment (Name and Mailing Address)

SUNTRUST BANK
1445 New York Avenue NW
Washington, DC 20005-2108
TRN 054000522

Authorization and Certification by Employee

You are hereby authorized under 5 CFR 550.311 to take the action requested above with respect to deductions from salary or wages due me in the amount specified above, which are for remittance to the individual/organization, as designated above.

I understand that this allotment will continue until canceled by me in writing, or until death, retirement, resignation, or involuntary separation from the Dept. of State.

I agree that the agency shall be held harmless for this allotment and that any disputes regarding this allotment shall be a matter between me and the individual/organization designated above to receive the remittance.

I authorize AFSPA to make any adjustments to my AFSPA allotment without receiving prior approval from me in keeping with the provisions of my Immediate Benefit Plan with AFSPA. I also authorize my employing office to disclose any changes in my home address to AFSPA.

It is the member's responsibility to arrange for payment of biweekly premiums directly to AFSPA during any periods of Leave Without Pay (LWOP). LWOP premiums can only be collected for 365 consecutive days. Membership in the Plan will result in termination after 365 consecutive days of LWOP status unless notified in writing that LWOP status is extended. Premiums must be current and received in the AFSPA office prior to the member's death or no death benefit payment will be made.

Signature _____ Date Signed _____

FOR SPECIAL ATTENTION OF EMPLOYEE (AND FOR INFORMATION OF THE FINANCIAL ORGANIZATION)

Agency payroll offices and disbursing offices operate within rigid time schedules to assure timely delivery of salary on the established payday and there will be no change in this emphasis. As requested above, the amount allotted will be deducted from your salary or wages and will be remitted by the disbursing office, as soon as practicable, to the designated financial organization. It should be understood that such remittance may be received in the financial organization later than the regular payday-possibly 3 or 4 business days later.

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Group Insurance Beneficiary Designation/Change

DATE: ____/____/____

1. MEMBER INFORMATION (please print)

Last Name	First Name	MI	Member ID# (if applicable)	Marital Status (check one) ☐ Married ☐ Widowed ☐ Single ☐ Divorced	Gender (check one) ☐ Male ☐ Female

Address	City	State	ZIP Code	Daytime Phone	Home Phone	Date of Birth	Date of Retirement (if applicable)

Name of Association	Group Policy No.	
American Foreign Service Protective Association	**42001**	This form applies only to ☐ Optional Term Life coverage.

2. BENEFICIARY DESIGNATION: I hereby revoke any previous designations of primary benefiiary(ies) and contingent beneficiary(ies), if any, and in the event of my death, designate the following:

A. Primary Beneficiaries

First Name	MI	Last Name	Address (include city, state, ZIP)	Relationship	Date of Birth	SSN/Tax ID Number	Phone	% Share
						TOTAL: (Must equal 100%)		

B. Contingent Beneficiaries

First Name	MI	Last Name	Address (include city, state, ZIP)	Relationship	Date of Birth	SSN/Tax ID Number	Phone	% Share
						TOTAL: (Must equal 100%)		

3. AUTHORIZATION/SIGNATURE: I authorize my plan administrator to record and consider the individuals that I have named on this form as beneficiaries for benefits under the applicable Member benefit plans.

Member's Signature X_____ **Date Signed** _____

The member must sign and date this form. The signature date must be the date the member actually signed the form.

Basic Life, Accidental Death & Dismemberment, Optional Term Life, Dependent Term Life Insurance coverages are issued by The Prudential Insurance Company of America, 751 Broad Street, Newark, NJ 07102. Life Claims: 1-800-524-0542. The Booklet-Certificate contains all details, including any policy 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.

Prudential

GROUP INSURANCE

The Prudential Insurance Company of America

Association:

American Foreign Service Protective Assn

Group Contract No.(s): 0042001

Branch No.: 000001

Mail the completed form to:
American Foreign Service Protective Association
1620 L Street NW Suite 800
Washington, DC 20036-5629

Short Form Health Statement (Submit a separate form for each person whose coverage requires Evidence of Insurability.)

Member

First Name | MI | Last Name

Number and Street | P.O. Box / Apt. Number

City | State | ZIP Code

Social Security Number | Member ID Number | Telephone

Email Address

Name of Person for Whom Insurance is Being Requested

Relationship to Member: ☐ Self ☐ Spouse/Civil Union Partner* or Domestic Partner*

First Name | MI | Last Name | Social Security Number

Coverage that requires Evidence of Insurability: **Member** ☐ Life **Spouse/Civil Union Partner* or Domestic Partner*** ☐ Life

Gender: ☐ Female ☐ Male

Height: ft. in.

Weight: lbs.

Date of Birth: (mm-dd-yyyy)

*Civil Union Partner is a person with whom you have established a civil union relationship which is valid under the laws of the jurisdiction where it was created. Domestic Partner includes a person who satisfies the requirements of being a domestic partner or registered domestic partner under the laws of the jurisdiction where it was created.

Please answer these questions by checking "Yes" or "No". Note: In this section, "you" refers to the person for whom the insurance is being requested.

Yes ☐ No ☐ **Do you currently** have any disorder, condition, or disease or are you currently taking prescription medication for any disorder, condition, or disease (other than: acid reflux; allergies; cold; cough; herniated disc; high cholesterol; nonrheumatoid arthritis; overactive or underactive thyroid; or pregnancy)?

Yes ☐ No ☐ **In the last five years** have you been diagnosed with, treated for, had any symptoms of, or been in a hospital or other facility for any of the following?

- Chest pain, heart disease or disorder, high blood pressure;
- Cancer, tumors;
- Respiratory disease or disorder of the lungs;
- Multiple sclerosis, epilepsy, seizure, stroke;
- Kidney, liver or pancreas disease or disorder;
- AIDS, AIDS-related complex;
- Diabetes;
- Mental or nervous disorder;
- Alcoholism, drug addiction;
- Chronic pain, rheumatoid arthritis, lupus; or
- Colitis, Crohn's disease, gastric bypass.

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

Important Notice: For residents of all states except: Alabama, Arkansas, District of Columbia, Florida, Kentucky, Louisiana, Maine, Maryland, New Jersey, New York, North Carolina, Pennsylvania, Puerto Rico, Rhode Island, 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.

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Group Contract No.(s): 0042001

Branch No.: 000001

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

Print Your First Name

Last Name

Your Social Security Number

Your Signature (unless a minor)

Date Signed (mm-dd-yyyy)

If Person for whom insurance is being requested is a minor, Signature of Parent, Guardian, or Person Liable for Support

Relationship

Date Signed (mm-dd-yyyy)

Please keep a copy of this form for your records.

Group Life and Disability Income Medical Underwriting NOTICE

Thank you for choosing The Prudential Insurance Company of America (Prudential) for your insurance needs. Before we can issue coverage we must review your application/enrollment form. To do this, we need to collect and evaluate personal information about you. This notice is being provided to inform you of certain information practices Prudential engages in, and your rights, with regard to your personal information. We would like you to know that:

- Personal information may be collected from persons other than yourself or other individuals, if applicable, proposed for coverage;
- This personal information as well as other personal or privileged information subsequently collected by us may in certain circumstances be disclosed to third parties without authorization;
- You have a right of access and correction with respect to personal information we collect about you; and
- Upon request from you, we will provide you with a more detailed notice of our information practices and your rights with respect to such information. Should you wish to receive this notice, please contact:

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

Information regarding your insurability will be treated as confidential. We may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life, disability, or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file. In addition, upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901. If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400 Braintree, Massachusetts 02184-8734. Information for consumers about MIB may be obtained on its website at www.mib.com.

Please keep this notice for your records.