Member Term Life (Immediate Benefit Plan) Enrollment Form

Mail or fax your completed form to:

Mail: Attention: Life Insurance 1620 L Street NW,
Suite 800 Washington, DC 20036-5629 Fax: 202-775-9082

afspa
AMERICAN FOREIGN SERVICE PROTECTIVE ASSOCIATION

American Foreign Service Protective Association
Questions? Phone: 202-833-4910 Email: life@AFSPA.org
Website: www.AFSPA.org/life

1 Member Information

Please print all answers using black ink.

Last Name | First | Middle Initial | Social Security Number | Sex: ☐ Male ☐ Female

Home Address | City | State | Zip Code | Phone Number

Agency Name | Email Address | Date of Birth (mm/dd/yyyy)

Are you enrolling during any of the following qualifying events?

New Hire (within 60 days of start date) ☐ Yes ☐ No — Date of Hire (mm/dd/yyyy)

Receipt of first overseas assignment: ☐ Yes ☐ No

Open Enrollment ☐ Yes ☐ No

If you did not answer "yes' to any of the qualifying events, please complete the health questionnaire below.

2 Coverage Applied For:

IBP Coverage Amount Requested:

Member	**Bi-Weekly Payroll deduction**
☐ $15,000	☐ $2.00 per pay Period
☐ $20,000	☐ $2.55 per pay Period

3 Beneficiary Information (If more space is needed please attach an additional sheet with date and signature.)

A. Primary Beneficiary

Name (First, MI, Last)	Address (include city, state, zip)	Relationship	Date of Birth	Social Security#	Phone#	% Share

Total (Must equal 100%) **100%**

B. Contingent Beneficiary

Name (First, MI, Last)	Address (include city, state, zip)	Relationship	Date of Birth	Social Security#	Phone#	% Share

Total (Must equal 100%) **100%**

The Prudential Insurance Company of America

751 Broad Street, Newark, NJ 07102

Mail or fax your completed form to:

Mail: Attention: Life Insurance 1620 L Street NW,
Suite 800 Washington, DC 20036-5629 Fax: 202-775-9082

American Foreign Service Protective Association

Control Number 42001

1 Member Information

Please print all answers using black ink.

Last Name _____ First _____ Middle Initial _____ Social Security Number _____ Sex: ☐ Male ☐ Female

Home Address _____ City _____ State _____ Zip Code _____ Phone Number _____

Email Address _____ Date of Birth (mm/dd/yyyy) ____/____/____ Height _____ft. ____in. Weight _____ lbs.

Place of Birth: City _____ State _____ Country _____

2 Health Questions—Please answer these questions by checking "Yes" or "No".

Member

Yes No

☐ ☐ **1. Within the last 12 months,** have you used tobacco or nicotine in any form?

☐ ☐ **2. Within the last five years,** have you been treated for or diagnosed with any of the following: circulatory or respiratory disease or disorder; chest pain; high blood pressure; cancer or tumors; diabetes; disease or disorder of the heart, lungs, kidneys, liver, genitourinary system; arthritis or other musculoskeletal condition; 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)?

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

☐ ☐ **4. Within the last five years,** have you been counseled, treated, or hospitalized for the use of alcohol or drugs?

If you answered "Yes" to any questions 2–4, please provide full details below. *(If more space is needed please attach an additional sheet with date and signature.)*

Member	Question #	Condition	Dates	Physician's Name, Address, and Phone Number	Current Status
☐					
☐					
☐					

Authorization for the Release of Information. This authorization is intended to comply with the HIPAA Privacy Rule. I authorize and instruct any health plan, physician, health-care professional, hospital, clinic, laboratory, medical facility, pharmacy benefit manager, retail pharmacy, clearinghouse, data warehouse or other comparable organization that aggregates and maintains pharmacy data, or other health-care provider that has provided treatment or services to me within the past 5 years ("My Providers") to disclose my entire medical record and any other health information concerning me to The Prudential Insurance Company of America ("Prudential") and through it, to its reinsurers, authorized agents and MIB, Inc. This includes information on the diagnosis and treatment of Human Immunodeficiency Virus (HIV) infection (In Vermont and Wisconsin, this information is excluded) and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes. I also authorize the MIB, Inc. to release any data it may have about me for coverage to Prudential. By my signature below, I acknowledge that any agreements I have made to restrict the disclosure of health information do not apply to this Authorization and I instruct any of My Providers to release and disclose my entire medical record without restriction, including without limitation any restrictions on health-care items or services for which a health-care provider has been paid out of pocket in full. This health information is to be disclosed under this Authorization so that Prudential may: 1) underwrite an application for coverage and make risk determinations; 2) administer coverage; and 3) 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 this Authorization is as valid as the original. I understand that I have the right to revoke this Authorization in writing, at any time, by sending a signed request for revocation to The Prudential Insurance Company of America; Group Medical Underwriting, P.O. Box 8796, Philadelphia, PA 19176, Attention: Senior Medical Underwriting Consultant. I understand that such a revocation is not effective to the extent that Prudential has taken action in reliance on this Authorization or to the extent that Prudential has a legal right to contest a claim under the insurance contract or to contest the contract itself. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed to other parties and will not be protected by the HIPAA Privacy Rule. (In Montana only, I may request a record of any subsequent disclosures of protected health information). I understand that if I refuse to sign this Authorization to release my entire medical record and any other health information concerning me, Prudential may not be able to process an application for coverage. I understand that I have the right to request and receive a copy of this Authorization.

Statement of Understanding: I represent that all statements and answers made within or attached to this Request Form are true and complete to the best of my knowledge and belief. I understand that my application, including portions containing health information are submitted to the Plan Administrator, acting for the policy holder, and that the administrator shall forward the application to the insurance company. Furthermore I understand that coverage shall be in effect only after all of these conditions have been met: this application has been approved by Prudential; the Certificate has been issued while all persons to be insured thereunder are alive; the answers and statements in this application continue to be true and complete until the Effective Date; and the initial premium contribution has been paid. I also understand that coverage will not take effect if the facts have changed. I 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 understand that completion of this application in no way implies that I 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 any false, incomplete, or misleading information is guilty of a felony of the third degree.

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.

Please consult Fraud warnings appearing on next page. I have read and understand the terms and requirements of these Fraud warnings.

I have received the Group Life and Disability Income Medical Underwriting Notice included with this form.

I, the undersigned member, certify that I have read, or have had read to me, the completed request for coverage form and I realize that any false statement or misrepresentation in the request for coverage form may result in loss of coverage under the Group Contract. By my signature below, I hereby request coverage. I acknowledge that I am a member of the above Association and that I must continue such membership to keep this insurance in force.

X _____ / /

Member Signature Date (mm/dd/yyyy)

For residents of all states and jurisdictions except Alabama, Arizona, Arkansas, California, the District of Columbia, Florida, Kentucky, Louisiana, Maine, Maryland, New Hampshire, 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.

ARIZONA RESIDENTS – For your protection, Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

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.

CALIFORNIA RESIDENTS – For your protection, California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

KENTUCKY RESIDENTS – Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

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 HAMPSHIRE RESIDENTS – Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

NEW JERSEY RESIDENTS – Any person who knowingly files a statement of claim containing any false or misleading information 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 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.

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 $2.00

☐ New Allotment $2.55

☐ 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.

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.