Request for AFSPA Member Critical Illness Insurance Coverage Form

Mail this completed form to:

AFSPA Attention: AIP Dept. 1620 L Street NW, Suite 800 Washington, DC 20036-5629

Questions? 202-833-4910 Fax: 202-775-9082

American Foreign Protective Association | Control Number 42001

1 Member Information

Please print all answers using black ink.

Last Name | First | Middle Initial | Social Security Number

Home Address | City | State | ZIP Code

Primary Phone Number | Fax Number | Date of Birth (mm/dd/yyyy) | Sex ☐ Male ☐ Female

Email Address | Agency

**Member and Spouse must be under age 65 and be enrolled in a major medical plan to be eligible for coverage*

2 Spouse Information/Civil Union Partner

Complete if you are requesting coverage for your spouse/civil union partner or dependent child.

Last Name | First | Middle Initial

Home Address | City | State | ZIP Code

Primary Phone Number | Social Security Number | Date of Birth (mm/dd/yyyy) | Sex ☐ Male ☐ Female

3 Plan Selection

Select the coverage amount and who you are applying for below. If applying for dependent coverage, the coverage amount cannot exceed 50% of the member amount.

Member: $_____
Maximum: $100,000, increments of $10,000

***Spouse**: $_____
Maximum: $50,000, increments of $5,000

***Children**: $_____
Maximum: $15,000, increments of $2,500

Applying For:

☐ Member Only ☐ Member and Child(ren) ☐ Member and Spouse/Civil Union Partner ☐ Member, Spouse/Civil Union Partner and Child(ren)

4 Contribution Payment Basis

I request the following payment basis (please check one): ☐ Quarterly ☐ Annually

5 Member Signature

X_____
Member Signature Line | Date Signed (mm/dd/yyyy)

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 the applicant conceals, for the purpose of misleading, information concerning any fact material thereto. This type of plan is NOT considered "minimum essential coverage" under the Affordable Care Act and therefore does NOT satisfy the individual mandate that you have health insurance coverage. If you do not have other health insurance coverage, you may be subject to a federal tax penalty.

Please keep this notice for your records.

Prudential

GROUP INSURANCE

The Prudential Insurance Company of America

Critical Illness Health Statement Questionnaire

(A separate form must be completed for each person requiring Evidence of Insurability)

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

Association Name:

Group Contract No.(s) **Branch No.**

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Member Information

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

Applicant Information

Relationship to Member: ☐ Self ☐ Spouse/Civil Union Partner

First Name | MI | Last Name | Social Security number

Gender
☐ Female ☐ Male

[Date of Birth (mm-dd-yyyy)

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

1. **Do you have other medical coverage that meets Minimum Essential Coverage standards that will provide benefits for hospital, surgical, and medical services, and supplies? IF THE ANSWER IS NO, THE APPLICANT IS NOT ELIGIBLE TO APPLY FOR THIS COVERAGE.]** Yes ☐ No ☐

2. **Question on general health:** Has the Applicant ever been diagnosed with or treated for any of the following conditions: chest pain, heart attack, cancer, malignant tumor, stroke, diabetes, kidney disease, prostate trouble, elevated prostate-specific antigen (PSA), cirrhosis, liver disorder, thyroid trouble, Human Immuno-deficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), or AIDS Related Complex (ARC), or has the Applicant changed medication for high blood pressure in the past three months? Yes ☐ No ☐

3. **Question on hospital/facility confinement:** In the past 24 months, has the Applicant received care, or been advised to receive care, as an inpatient in a hospital (excluding hospitalization due to an accident, pregnancy and/or childbirth, and routine procedures unrelated to any of the conditions mentioned in Question #1), immediate care facility, long-term care facility, or hospice; or been advised to receive chemotherapy, radiation therapy, or dialysis? Yes ☐ No ☐

4. **Additional Health Question:** Has the Applicant ever had, or been advised to have, an organ transplant, including a bone marrow or stem cell transplant? Yes ☐ No ☐

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

I declare that, to the best of my knowledge and belief, the statements made in this questionnaire 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 to Prudential.

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. **This notice ONLY applies to accident and health insurance.**

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

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) ☐☐ – ☐☐ – ☐☐☐☐

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/she 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 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.

Please keep a copy of this form for your records.

Group Critical Illness coverage is issued by The Prudential Insurance Company of America, a New Jersey company, 751 Broad Street, Newark, NJ 07102.