

# Optional Long Term Disability Insurance Enrollment Form



Mail this completed form to:

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

Phone: 202-833-4910 Fax: 202-775-9082

Email: [disability@AFSPA.org](mailto:disability@AFSPA.org) | Website: [www.AFSPA.org/aip/disability](http://www.AFSPA.org/aip/disability)

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: <input type="checkbox"/> Male <input type="checkbox"/> Female
Home Address	City	State	Zip Code \$ / /	Phone Number
Agency Name	Email Address	Salary	Date of Birth (mm/dd/yyyy)	

**2 Coverage Requested For:** Choose a monthly coverage amount in increments of \$100 up to the maximum monthly coverage amount you are eligible for (Lesser of \$7,500 or 60% monthly earnings). Both plan options have a 90 day Elimination Period.

- ❖ 2 Year Plan: Maximum Benefit Period for under age 68 is 2 years, for age 68 is until age 70, Ages 69 and above is for 12 months.
- ❖ 5 Year Plan: Maximum Benefit Period for under age 65 is 5 years, for ages 65 to 68 is until age 70, and Age 69 and above is for 12 months.

Monthly Benefit Amount: \$ \_\_\_\_\_

Benefit Duration:  2 Year Plan  5 Year Plan

**Other Coverage**—Do you now have or are you now applying for other disability insurance which provides benefits if you are unable to work because of disability?  Yes  No

If you answered "yes" please provide full details below (If more space is needed, please attach an additional sheet).

Company	Plan	Monthly Benefit	Benefit Period

## 3 Payment Basis

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

## 4 Member Signature

X  
\_\_\_\_\_  
Member Signature Line

\_\_\_\_\_  
Date (MM/DD/YYYY)

**This coverage is not health insurance coverage (often referred to as "Major Medical Coverage").**

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.

**Please keep a copy of this form for your records.**



**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/We represent that all statements and answers made within or attached to this Request Form are true and complete to the best of my/our knowledge and belief. I/We understand that my application, including portions containing health information are submitted to the Plan Administrator, acting for the policyholder, and that the administrator shall forward the application to the insurance company. Furthermore I/we 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/We also understand that coverage will not take effect if the facts have changed.

I/We 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/We understand that completion of this application in no way implies that I/we 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)

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**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.

## 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](http://www.mib.com).

**Please keep this notice for your records.**