The Prudential Insurance Company of America

Spouse Level Premium Term (LPT) Life Insurance Request Form

AICPA Insurance Trust | Aon Insurance Services, Plan Agent
159 East County Line Road, Hatboro, PA 19040-1218
Telephone: 1.800.223.7473 | Fax: 1.800.AICPAIT

To request coverage: Return this completed Form in the enclosed postage-paid envelope.

To be completed by the Member for Spouse Level Premium Term Plan coverage.

Member's Name:_____

Street Address:_____

City:_____ **State:**_____ **Zip:**_____

Daytime Phone #:_____ **Date of Birth:**____/____/_____

Evening Phone #:_____ **Gender:** ❑ M ❑ F

E-Mail Address:_____

❑ **Yes,** I would like to receive the monthly AICPA Insurance Programs e-newsletter and other important information about training opportunities, products, offerings, and program-sponsored CPA events.

CPA **Social Security Number** *(required for refund purposes)*: _____

Spouse **Social Security Number:** _____

Is your spouse a CPA and a AICPA member? ❑ No ❑ Yes*
**If Yes, you are not eligible for Spouse LPT coverage. Your spouse may apply for coverage as a member.*

Are you, the CPA, an AICPA member?
❑ No** ❑ Yes, AICPA #:_____
***If No, you are not eligible for coverage.*

Account # for any current CPA, GVUL, LPT or Spouse coverage: _____

Term Period—Please elect the LPT Period most appropriate for you. If your spouse is less than age 56 you may apply for either a 10- or 20-year Term period; ages 56-65 may only apply for a 10-year Term period. **Term Period Requested:** ❑ 10-year ❑ 20-year

Coverage Amount Requested—Select a coverage amount below. Your total amount requested under the Spouse LPT Plan can not be more than the lesser of the maximum coverage schedule for your spouse's age and the maximum coverage schedule you are eligible for less any spouse coverage you may have elected previously under the Spouse LPT Plan or under the Spouse Life Insurance Plan. **To find out if your spouse may qualify for preferred rates, please see item 8 of your Health Statement Questionnaire form.** If your spouse is less than age 45 and answers "yes" to any questions under item 8, he or she will not qualify for LPT Life Insurance; ages 45-65 may continue to complete the Request Form for coverage at Select or Standard rates.

Ages under 50:

❑ CA	$2,500,000*	❑ CG	$400,000
❑ CB	$2,000,000	❑ CH	$350,000
❑ CC	$1,500,000	❑ CI	$300,000
❑ CD	$1,000,000	❑ CJ	$200,000
❑ CE	$750,000	❑ CK	$150,000
❑ CF	$500,000	❑ CL	$100,000

Ages 50-54:

❑ CA	$2,500,000*	❑ CH	$350,000
❑ CB	$2,000,000	❑ CI	$300,000
❑ CC	$1,500,000	❑ CJ	$250,000
❑ CD	$1,000,000	❑ CK	$200,000
❑ CE	$750,000	❑ CL	$150,000
❑ CF	$500,000	❑ CM	$100,000
❑ CG	$400,000		

Ages 55-64:

❑ CA	$2,000,000*	❑ CG	$300,000
❑ CB	$1,500,000	❑ CH	$250,000
❑ CC	$1,000,000	❑ CI	$200,000
❑ CD	$750,000	❑ CJ	$150,000
❑ CE	$500,000	❑ CK	$100,000
❑ CF	$400,000		

Age 65:

❑ CA	$1,500,000*
❑ CB	$1,000,000
❑ CC	$500,000
❑ CD	$350,000
❑ CE	$300,000
❑ CF	$250,000
❑ CG	$200,000
❑ CH	$150,000
❑ CI	$100,000

**Now available to AICPA members only.*

Optional Coverages *(If no election is made, the option will not be provided)*:

❑ **Accidental Death and Dismemberment (AD&D) Coverage**** *(Amount is equal to term life insurance amount.) Cost ranges from $0.20 to $0.30 per $10,000 depending on your spouse's age.*

***Once LPT certificate coverage is issued to you, you may not elect the AD&D option under that certificate of coverage.*

Contribution Payment Basis *(If no election is made, the Annual Basis/Bill me option will apply)*:

Bill Me: ❑ Annually ❑ Semi-Annually*

Electronic Fund Transfer (EFT):** ❑ Annually ❑ Semi-Annually* ❑ Monthly

**The semi-annual contribution must exceed $150 for the semi-annual basis. ** If electing EFT, you must complete the Electronic Fund Transfer Authorization section below.*

Electronic Fund Transfer Authorization—If you wish to use your checking account, **enclose a blank voided check** for that account. If you wish to use your savings account, you must confirm that your bank permits electronic fund withdrawals from savings accounts. By my signature below I authorize the AICPA Insurance Trust in accordance with the Agreement (included further on in this form) to charge my bank account for the amount of my insurance contribution payment until such time as I provide written notice of cancellation, or insurance is terminated.

❑ Checking ❑ Savings

Account Owner's Name | *Bank Name* | *Type of Account*

✘

Bank's Transit Routing Number | ***Your** Savings Account Number* | ***Signature of Account Owner***

Please continue ››

Beneficiary Designation — *Please specify your beneficiary (full name, Example: Jean Lee Doe)*

First Name	*Middle Name*	*Last Name*	*Relationship*	*% Share*

❑ *Please check if attaching additional beneficiary designation information.* **Total** *(Must equal 100%):* **100%**

Spouse's Primary Care Physician Information *(Failure to complete may delay your application process.)*

❑ *My spouse does not have a Primary Care Physician at this time.*

Name of Spouse's Primary Care Physician ( ) *Telephone No. of Primary Care Physician*

Street Address of Primary Care Physician *City* *State* *Zip*

RECEIPT OF ACCELERATED DEATH BENEFITS MAY AFFECT ELIGIBILITY FOR PUBLIC ASSISTANCE AND MAY BE TAXABLE. THERE IS NO ADMINISTRATIVE FEE TO ACCELERATE DEATH BENEFITS. THE ACCELERATED AMOUNT IS NOT DISCOUNTED.

Member's Subscription—Effective on the date of application, the member (of the AICPA named herein, a subscriber to the Agreement and Declaration of Trust (hereinafter called the "Agreement") made in the City and State of New York as of the 25th day of August, 1947, as amended, by and between the American Institute of Certified Public Accountants, The Bank of New York Mellon, as successor Trustee, and the various Subscribers who from time to time subscribe to the Agreement, hereby amends a previous request for participation in the Insurance Plan of said Trust. Participation in the insurance is requested as indicated herein. **Conditions Applicable to this Subscription**—It is understood that the Agreement, among other things, provides that: (1) Subscribers shall make contributions to the Trust in such amounts as may be required for the purpose of providing and maintaining insurance in accordance with the plans of insurance under the Trust and for the purpose of administration; (2) Subscribers shall furnish to the Trustee any information required in connection with the administration of the Trust and the plans of insurance thereunder; and (3) the Trustee may modify the plans from time to time in any respect as may be directed by the Board of Directors of the Institute. It is further understood that: (1) if the Plan Agent, acting for the Trustee, shall determine that the Subscriber is eligible to participate as requested, the Plan Agent shall promptly confirm the effective date; (2) the insurance of an eligible individual shall, as to its effective date and in every other respect, be governed by the provisions of the contracts held and administered by the Trustee pursuant to the Plan; and (3) if the Subscriber is determined not to be eligible to participate as requested, this Request for Coverage/Enrollment Form shall be considered null and void and the Trustee shall refund to the Subscriber any payment, but in the case of Subscribers currently participating in the Plan, continued participation on the basis existing prior to the date of this Form shall not be affected thereby.

Beneficiary Designation—If more than one primary beneficiary is designated, settlement will be made in equal shares to the designated beneficiaries (or beneficiary) that survive the insured, unless their shares are specified. If no named beneficiary survives, settlement will be made in accordance with the terms of the Group Contract.

Electronic Fund Transfer Authorization—AICPA Insurance Trust Automatic Insurance Payment Program Agreement provides for Electronic Fund Transfer for the purpose of making your insurance payment without the use of a check. Your signed authorization is required. The electronic debit will occur on the tenth of each month that the payment is due. If the transfer falls on a weekend or bank holiday, your checking/savings account will be charged the next business day. The amount of the automatic debit may vary due to changes in the amounts of insurance or a premium contribution change. You will be notified in advance of changes to the amount of your debit due to premium contribution changes.

Special Notice—For residents of all states except District of Columbia, Florida, New Jersey, New York, Pennsylvania, 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. **District of Columbia Residents:** It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insured may deny insurance benefits if false information, materially related to a claim, was provided by the applicant. **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. **Pennsylvania:** 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 subjects such person to criminal and civil penalties. **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 criminal offense under state law. **Washington Residents:** Any person who knowingly provides false, incomplete, or misleading information to an insurance company for the purposes of defrauding the company commits a crime. Penalties include imprisonment, fines, and denial of insurance benefits. **If your request for Coverage or rates is denied and you disagree with this determination, you have the right to appeal it. Please contact the AICPA Customer Service Unit at 1-888-257-0412 weekdays from 8:00a.m. to 6:00p.m. Eastern time or write to: The Prudential Insurance Company of America, PO Box 8796, Philadelphia, PA 19176-8796.**

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Spouse Level Premium Term (LPT) Life Insurance Health Statement Questionnaire

Medical Statements—*Please print all answers in ink.* *To be completed by the eligible spouse of the member requesting coverage under the Spouse Level Premium Term Life Insurance Plan with coverage issued by The Prudential Insurance Company of America (Prudential) pursuant to the AICPA Insurance Trust.*

1. Name of Spouse:

Last *First* *Middle Initial*

2. Residence: *Address Change?* ❑ *Yes* ❑ *No*

No. *Street*

City *State* *Zip*

3. Date of Birth: ☐☐ ☐☐ ☐☐☐☐ *Month Day Year*

4. Birthplace: _____ *City* *State*

5. Gender: ❑ *Male* ❑ *Female*

6. Height: ☐ *ft.* ☐☐ *in.* **Weight?** ☐☐☐ *lbs.*

7. Have you smoked cigarettes, cigars or a pipe within the last year: ❑ *Yes* ❑ *No*

Questions 8-13 should be answered to the best of your knowledge and belief.

Please read before continuing to Item 8. If you answer "Yes" to any question in Item 8, you are not eligible for Preferred Rates.

8. Please respond to the following questions.

	Yes	No
(a) Has your mother, father, sister(s) or brother(s) died prior to age 60 as a result of heart disease, stroke, diabetes or cancer (does not include stepparent(s), stepsister(s) or stepbrother(s), adoptive parents, adopted sister(s) or adopted brother(s))?	❑	❑
(b) Have you, in the last three years, flown in an aircraft, glider or balloon in which you operated or had duties aboard, or do you anticipate flying in an aircraft, glider or balloon in which you will operate or have duties aboard? Or, are you participating in ultra light flying, ballooning, parachuting, mountaineering, rodeo riding, any type of motorized racing, hang gliding, parasailing or bungee jumping?	❑	❑
(c) In the last three years, has your driver's license been revoked or suspended for, or have you been convicted of, driving under the influence of alcohol or drugs?	❑	❑
(d) In the past five years have you received treatment, counseling or participated in a rehabilitation program for drug or alcohol abuse?	❑	❑
(e) Have you used any tobacco products in the last 12 months?	❑	❑

9. Have you within the last five years been treated for or had any symptoms of:

	*Yes**	*No*
(a) Heart trouble?	❑	❑
(b) High blood pressure?	❑	❑
(c) Abnormal pulse?	❑	❑
(d) Lung or respiratory trouble?	❑	❑
(e) Stomach or intestinal trouble?	❑	❑
(f) Disorder of the kidney, bladder or urinary system?	❑	❑
(g) Spine or back disorder?	❑	❑
(h) Nervous or mental disorder?	❑	❑
(i) Diabetes or sugar in urine?	❑	❑
(j) Cancer or tumors?	❑	❑
(k) Arthritis or rheumatism?	❑	❑
(l) Liver or gall bladder disorder?	❑	❑
(m) Neuritis or sciatica?	❑	❑

10. Have you within the last five years:

	*Yes**	*No*
(a) Experienced a persistent cough, chronic fatigue, night sweats, significant weight loss, enlarged glands or chronic diarrhea?	❑	❑
(b) Been advised to have a surgical operation?	❑	❑
(c) Been a patient in or been advised to enter a hospital or health care facility?	❑	❑
(d) Consulted, been attended or examined by a doctor or other practitioner, except for HIV testing?	❑	❑
(e) Been diagnosed or treated by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS), or AIDS-Related Complex (ARC)?	❑	❑
(f) Been diagnosed or treated by a member of the medical profession for any immune deficiency disorder or disease of the lymphatic system or immune system, except HIV?	❑	❑
(g) Been treated or counseled for alcoholism or drug abuse?	❑	❑
(h) Regularly used barbiturates, amphetamines, marijuana or other hallucinatory drugs, heroin, opiates, or other narcotics except as prescribed by a doctor?	❑	❑

11. Are you currently taking any medicine prescribed or provided by a doctor? Please provide the name of the medication and reason for taking it in Question 13	❑	❑
12. Have you, within the last five years, been diagnosed or treated for any physical disorders, impairments or ill health, except HIV, not recorded in answer to Questions 9, 10 or 11?	❑	❑

If "Yes" is checked, please complete Question 13. When completing information below please be sure to provide Physician's Name, address and Telephone Number

13. What are the complete details of all "Yes" answers to Questions 9, 10, 11 and 12?

Question and Item Number	Conditions, Details and Number of Attacks (if operated, so state)	Time Lost from Normal Activities	Complete Recovery Month	Year	List Physician's name, address and telephone as well as Hospital name
☐☐☐			☐☐	☐☐	
☐☐☐			☐☐	☐☐	

❑ ***Please check if additional information is attached.***

Please complete the reverse side ››

Continued from Request Form on previous page

I declare that to the best of my knowledge and belief all of the above answers to the questions are complete and true. I agree that: (1) the coverage and rates applied for are subject to the policy terms and shall become effective on the date or dates established by the policy, provided the evidence of insurability is satisfactory; (2) this form supersedes any prior form I may have completed with respect to the coverage and rates being applied for.

So that eligibility for coverage and rates may be determined, I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, or insurance company that has any medical records or knowledge of my health to provide such information to The Prudential Insurance Company of America. This excludes information on the diagnosis and treatment of mental illness and the use of alcohol and or drugs.

This information, and any information on my application, is to be disclosed under this authorization so that Prudential may, in accordance with the AICPA Insurance Trust and its administrator, Aon Insurance Services (Aon), do the following, with respect to the insurance coverage I am applying for: underwrite or make rating determinations; evaluate and determine my eligibility for coverage; participate in audits by Prudential, AICPA, Aon or one of their third-party auditors; or conduct other legally permissible activities related to my application.

I hereby authorize the Medical Information Bureau to exchange any medical records or knowledge of my health with The Prudential Insurance Company of America. **By signing below, I acknowledge that I have received and read the NOTICE appearing on the letter.** This authorization is valid until the earliest of: (1) two years after the effective date of any coverage issued in connection with it; or (2) until it is withdrawn in writing; or (3) 24 months after the date it is signed. A photographic copy of this form will be as valid as the original. (If you wish, you may obtain a copy of this authorization.)

I understand that I have the right to revoke the authorization in writing at anytime, 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. Any such revocation is subject to the rights of anyone who relied on this authorization before it was revoked.

Special Notice—New York Residents: This notice ONLY applies to applications for accident and disability income coverage. 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.

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.

Please consult Fraud Warnings appearing on prior page.

By my signature below, I consent to this coverage and acknowledge that portions of this Health Statement Questionnaire Form containing my health information is being submitted to the Plan Agent, acting for the Trustee, and that the Plan Agent shall forward the form to the issuing company. **ATTENTION MEMBERS: Michigan and Minnesota Residents Only—**If you wish to enroll your spouse for dependent insurance your spouse must acknowledge consent for coverage below.

Signature of Spouse or Domestic Partner ✗_____ ***Date***_____

By my signature below, I hereby request coverage under the life insurance plan for the amount selected. I acknowledge that my application, including the portions containing health information, are submitted to the Plan Agent, acting for the Trustee, and that the Plan Agent shall forward the application to the issuing company. I have read the Conditions Applicable to This Subscription and the Beneficiary Designation appearing on the enclosed enrollment form, and agree to those statements and conditions. I also hereby subscribe to the AICPA Insurance Trust in accordance with Member's Subscription and agree to the applicable conditions. Insurance is to become effective only upon acceptance by the issuing company. The Plan Agent, acting for the Trustee, will inform the person requesting insurance regarding the effective date of coverage.

Signature of Member ✗_____ ***Date***_____

All members and spouses regardless of where they reside must sign this form.