Group Universal Life

Enrollment Form for Employees of Airborne Express

The Prudential Insurance Company of America

1. Employee data

Employee Name—Last (Please print.) | First | M.I. | Date of Hire Month Day Year

Mailing Address | Date of Birth Month Day Year

City | State | Zip | Area Code | Home Phone | Social Security No.

Check the appropriate box to indicate your employer: ☐ Airborne Freight ☐ ABX Air, Inc. ☐ Sky Courier

2. Coverage elections

Employee Coverage: Based on the following multiple of my annual base salary rounded up to the next higher $10,000 increment, if the multiple of annual base salary cannot be evenly divided by $10,000, not to exceed a coverage amount of $1,000,000.

Check one box:

☐ 1x ☐ 2x ☐ 3x ☐ 4x

Answer the following: Have you smoked or used any tobacco products in the past 12 consecutive months? ☐ Yes ☐ No

Spouse Coverage: In $10,000 units ($20,000 minimum) up to 2 times employee's annual base salary, not to exceed a coverage amount of $100,000.

Name—Last | First | M.I.

Social Security No. | Date of Birth Month Day Year

Check one box:

☐ $20,000 ☐ $30,000 ☐ $40,000 ☐ $50,000
☐ $60,000 ☐ $70,000 ☐ $80,000 ☐ $90,000 ☐ $100,000

Answer the following: Has your spouse smoked or used any tobacco products in the past 12 consecutive months? ☐ Yes ☐ No

Children's Coverage: $10,000 each child, regardless of number. ☐ Yes ☐ No **List children's names and birth dates on the reverse side.**

3. Optional cash contributions

Employee: In addition to the cost of insurance, I elect to contribute a **monthly** dollar amount via payroll deduction to the **cash accumulation account:**

$ _____/month.

Spouse: In addition to the cost of insurance, I elect to contribute a **monthly** dollar amount for my spouse via payroll deduction to the **cash accumulation account:**

$ _____/month.

4. Evidence of good health

If you answer "yes" to any of the following questions, or if employee coverage is more than $500,000, Seabury & Smith will send a Request for Medical Information form to the address shown above for your completion and signature.

Section 4-A: Employee

Section 4-A—Answer #1, #2 and #3 below when employee coverage is either 4 times annual base salary or more than $250,000.

		Yes	Employee	No
#1	Have you been diagnosed with or received medical treatment during the past five years for cancer, tumors, diabetes, or any disorder of the liver, kidneys or heart or any circulatory disorder, including high blood pressure and stroke?	☐		☐
#2	Have you during the past five years, had an application for life or health insurance declined, postponed, rated up, waivered, or issued for a smaller amount than applied for?	☐		☐
#3	Have you in the last 12 months been in any hospital or other institution for observation, test, diagnosis or treatment?	☐		☐

Section 4-B: Spouse

Section 4-B—The following questions must be answered for spouse coverage, regardless of coverage amount.		Yes	Spouse	No
#1	Has your spouse been confined for medical care or treatment at home or elsewhere during the past 90 days?	☐		☐
#2	Is your spouse **unable** to perform normal activities?	☐		☐
	Answer #3, #4 and #5 below when spouse coverage is more than $20,000, or a spouse is age 65-69.			
#3	Has your spouse been diagnosed with or received medical treatment during the past five years for cancer, tumors, diabetes, or any disorder of the liver, kidneys or heart or any circulatory disorder, including high blood pressure and stroke?	☐		☐
#4	Has your spouse during the past five years, had an application for life or health insurance declined, postponed, rated up, waivered, or issued for a smaller amount than applied for?	☐		☐
#5	Has your spouse in the last 12 months been in any hospital or other institution for observation, test, diagnosis or treatment?	☐		☐

Section 4-C: Dependent Children

Section 4-C—The following questions must be answered for dependent children's coverage.		Yes	Children	No
#1	Has any child to be insured been confined for medical care or treatment at home or elsewhere during the past 90 days? Child's name: _____	☐		☐
#2	Is any eligible child ***unable*** to perform normal activities? Child's name: _____	☐		☐

***If you answer "yes" for any child, are there other children eligible for coverage?** ☐ Yes ☐ No

Late entrant

If you enroll after an employer-scheduled enrollment period, or enroll a newly married spouse after 31 days of marriage date, or a firstborn child after 60 days of birth date, Seabury & Smith will send a Request for Medical Information form to the address shown above for your completion and signature.

5. Beneficiary

If you need more space, please use the reverse side of this enrollment form.

Employee

1st Beneficiary (full name) _____ % Share_____ Relationship _____

2nd Beneficiary (if 1st is not living) _____ % Share _____ Relationship _____

Spouse:

1st Beneficiary (full name) _____ % Share_____ Relationship _____

(The beneficiary for a spouse is the employee if not otherwise designated.)

2nd Beneficiary (if 1st is not living) _____ % Share _____ Relationship _____

Children's Coverage: The beneficiary for dependent children's coverage is the employee unless otherwise designated on the reverse side of the enrollment form.

6. Please check the appropriate box, sign and return your enrollment form to Seabury & Smith.

Seabury & Smith
P.O. Box 9122
Des Moines, IA 50306
1-800-447-9381
Printed 7/00

I certify that all of the information on this enrollment is true and complete to the best of my knowledge and belief and that I am actively at work and able to perform normal activities on the date of my signature specified below. If I am not actively at work and able to perform normal activities on such date, coverage will not go into effect until my return to work. If my spouse and/or any dependent child to be insured has been confined for medical care or treatment at home or elsewhere during the 90-day period prior to the date of my signature below, that individual's effective date of coverage will be delayed until approved by The Prudential.

Check only one

☐ **I hereby authorize my employer to deduct the required contribution from my pay for coverage under the Group Universal Life insurance program. I understand the rates are based on age and will change on the program anniversary when the insured enters a new age bracket. This request and authorization applies to this program until rescinded by me in writing.**

☐ **I hereby certify that I have been given the opportunity to enroll for the Group Universal Life program and, after careful consideration, have decided not to enroll.**

Employee Signature _____ **Social Security No.** _____ **Date** _____ (M-D-Y)

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Designating Your Beneficiary

The "1st Beneficiary" is your first choice of the person or persons who would receive the death benefit.

The "2nd Beneficiary" is your second choice of the person or persons who would receive the death benefit (if the first is not living).

Beneficiaries may be changed at any time as long as the change is made in writing to and recorded by Seabury & Smith.

If you wish to designate a trust or other organization as beneficiary, you are encouraged to seek guidance from your personal financial adviser.

Additional space for beneficiary designation. Employee signature required below.

For whose coverage?	Beneficiary's Full Name	% Share	Relationship
_____	1st _____	_____	_____
_____	2nd _____	_____	_____
_____	1st _____	_____	_____
_____	2nd _____	_____	_____
_____	1st _____	_____	_____
_____	2nd _____	_____	_____

Employee Signature _____ Social Security No. _____ Date _____

List each unmarried dependent child under age 21 (or under age 25 if a full-time student):

Child's Name	Child's Birth Date	Age Today
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Note: Seabury & Smith must be notified by you within 90 days when a child ceases to be eligible for Dependent Children's Coverage so that he/she may switch the Dependent Children's Coverage to Group Universal Life coverage.