Prudential Financial

NJEA Endorsed Disability Insurance Program

Issued by The Prudential Insurance Company of America

Questions? Please call 1-800-727-3414

Enrollment Form

Please print all information clearly in the sections below and return in the enclosed postage-paid envelope. Coverage will begin on the first day of the month after collection of one full monthly payroll deduction, provided you are actively at work. A disability that begins during the first 12 months of coverage and is due to a pre-existing condition is excluded. Your monthly deduction will be based on the benefit amount you elect.

NJEA Member Information

Last Name	First Name	Middle I.	Date of Birth (Mo, Day, Yr) / /	Social Security Number – –
Home Address–Street		City	State	Zip Code
Home Phone Number ( )	Employment Date (Mo, Day, Yr) / /	Annual Salary $	Occupation	Sex ❑ M ❑ F
Present School District Name	County	Name of School	District Last Year	County Last Year

Are you employed at least 15 hours per week? ❑ Yes ❑ No

Are you actively at work on the date of this enrollment? ❑ Yes ❑ No

Are you an active NJEA member? ❑ Yes ❑ No If no, please call 609-599-4561 for membership information.

Are you returning from a leave of absence? ❑ Yes ❑ No If yes, please explain:

Plan Information

The maximum Monthly Benefit Amount must be in $100 increments from $500 to $6,500 but not more than 66⅔% of your salary (from the Board of Education, or from NJEA if a NJEA employee). If the Monthly Benefit Amount you indicate below exceeds your allowable maximum, your Monthly Benefit Amount will be limited to your maximum. Please note that the monthly benefit amount may be reduced by other sources.

❑ **New Enrollment** ❑ **Plan Change**

❑ **PruProtect** (disability coverage up to 6 months)
Monthly Benefit Amount: $_____

❑ **PruProtect Two-Year** (disability coverage up to 2 years)
Monthly Benefit Amount: $_____

❑ **PruProtect Plus** (disability coverage up to age 65)
Elimination Period: ❑ 14 Days ❑ 30 Days ❑ 90 Days ❑ 180 Days
Monthly Benefit Amount: $_____

Authorization

I am enrolling for coverage and authorize my employer to deduct my contributions for the NJEA Endorsed Disability Insurance Program from my earnings until further notice. I understand that if I desire to increase the amount of my insurance, I may be required to furnish evidence of good health. A disability that begins during the first 12 months of coverage and is due to a pre-existing condition is excluded. I declare the statements above are true and understand they are the basis for determining my monthly contribution for coverage.

✘ _____ / / _____

NJEA Member Signature *Date (Mo, Day, Yr)*

For Company Use Only:

School District ID#	School Meeting Date (Mo/Day/Yr)	Effective Date (Mo/Day/Yr)	Initial Monthly Deduction	Representative Number
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