The Prudential Insurance Company of America

751 Broad Street, Newark NJ 07102

A Member Benefit of:
STATE BAR of TEXAS
Texas Bar Private Insurance Exchange

State Bar of Texas 47080

AD&D Request for Coverage Form

Return this completed form to:

Application Examiner,Capitol Center,
919 Congress Ave, Suite 720, Austin, Texas 78701.

Please do not include payment now—You will be billed when notified of your coverage effective date.

Questions? Please call 1-800-282-8626
Fax: (904) 396-2091

Please print all answers using black ink.

1 Member Information

First Name | MI | Last Name

Street | Apt.

City | State | ZIP code

Date of Birth (mm/dd/yyyy) | Social Security Number | Daytime Telephone Number

Gender ☐ Male ☐ Female | Height ft. in. | Weight lbs. | Evening Telephone Number

☐ ***Yes,*** I would like to receive important information via email about training opportunities, products, offerings and program-sponsored State Bar of Texas events.

Email

I am employed by a Member's law practice: ☐
State Bar of Texas Member: ☐

[Bar Card Number]

[Date of Full-time employment (mm/dd/yyyy)]

Are You: ☐ A New Applicant ☐ Increasing Present Coverage Current Coverage Amount $ _____

If you are increasing coverage in force, your present amount plus additional amount equals the amount you indicate. (If you do not qualify for the increased amount, your present amount remains in force.)

2 Spouse/ Domestic Partner Information

Complete if you are requesting coverage for your spouse/ domestic partner.

First Name | MI | Last Name

Date of Birth (mm/dd/yyyy) | Social Security Number | Daytime Telephone Number

Gender ☐ Male ☐ Female | Height ft. in. | Weight lbs. | Evening Telephone Number

Dependent Child Information

Child's Name	Date of Birth

3 **Coverage Requested For**

Choose the type of coverage and amounts for which you are requesting.

☐ **Accidental Death & Dismemberment Plan**

Coverage Amounts *(please check one)*:

Optional Coverage(s) Requested:

☐ Member Coverage Amount (in increments of $25,000, up to a maximum of $500,000): $_____

☐ Spouse/Domestic Partner Coverage Amounts* (in increments of $25,000, up to a maximum of $500,000):

*Spouse/Domestic Partner AD&D Coverage may not exceed the Member's AD&D Coverage: $_____

☐ Dependent Child Coverage Amount (in increments of $5,000, up to a maximum of $15,000 each):

$_____

4 **Beneficiary Information**

A. Primary Beneficiary

Name (First, MI, Last)	Address (include city, state, zip)	Relationship	Date of Birth	Social Security#	Phone#	% Share

Total (Must equal 100%) **100%**

B. Contingent Beneficiary

Name (First, MI, Last)	Address (include city, state, zip)	Relationship	Date of Birth	Social Security#	Phone#	% Share

*(If more space is needed, please attach a separate sheet.)

Total (Must equal 100%) **100%**

5 **Contribution Payment Basis**

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

☐ Annual ☐ Monthly Electronic Fund Transfer (EFT)*

*If electing EFT, you must complete the Electronic Fund Transfer Authorization below.

6 **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, enclose a copy of a voided deposit slip. By my signature below I authorize Texas Member Benefits in accordance with the Agreement (included on page 4 of 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.

Type of Account: ☐ Checking ☐ Savings

Account Owner's Name

Bank Name

Bank's Transit Routing Number

Your Account Number

X

Signature of Account Owner

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 (our) request for coverage form, including portions containing health information are submitted to the Plan Administrator, acting for the policy holder, and that the administrator shall forward the request for coverage form to the insurance company. Furthermore I (we) understand that coverage shall be in effect only after all of these conditions have been met: this request for coverage form 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 request for coverage form 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 request for coverage form in no way implies that I (we) will be accepted for insurance coverage.

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.

Please consult Fraud warnings appearing on next page. I have read and understand the terms and requirements of these Fraud warnings.

X _____ _____

Member Signature | Date (mm/dd/yyyy)

X _____ _____

Spouse/Domestic Partner Signature (if applying for Spouse Coverage) | Date (mm/dd/yyyy)

Important Notice: Fraud 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 or 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.

Beneficiary Designation: If more than one beneficiary is desired, please write their name(s) and relationship(s) on a separate sheet and submit to the Plan Administrator. If more than one primary beneficiary is designated, settlement will be made in equal shares to the designated beneficiaries (or beneficiary) who are then still living, unless their shares are specified. If there is no named beneficiary, or no beneficiary survives the insured, settlement will be made in accordance with the terms of your Group Contract.

Electronic Fund Transfer Authorization: Texas Member Benefits 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 first 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. If you are a current participant and would like to change your payment basis, please call 1-800-282-8626.

This request for coverage form is to be attached to and made part of the Group Contract.

Please keep this notice for your records.

State Bar of Texas Accidental Death and Dismemberment coverage is issued by The Prudential Insurance Company of America, a New Jersey company, 751 Broad Street, Newark, NJ 07102. Please refer to the Booklet-Certificate, which is made a part of the Group Contract, for all plan details, including any exclusions, limitations and restrictions which may apply. If there is a discrepancy between this document and the Booklet-Certificate/Group Contract issued by Prudential, the terms of the Group Contract will govern. Contract provisions may vary by state. California COA #1179, NAIC #68241. Contract series: 83500