# The Prudential Insurance Company of America

751 Broad Street, Newark NJ 07102

A Member Benefit of:
STATE BAR *of* TEXAS

State Bar of Texas | 47080

## OOE Request for Coverage Form

Return this completed form to:

Application Examiner, Capitol Center,
10739 Deerwood Park Blvd #200-B, Jacksonville, FL 32256-4838.

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

**Please print all answers using black ink.**

**Questions? Please call 1-800-282-8626 Fax: (904) 212-2058**

**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

**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 Health Questions**

Please answer these questions by checking "Yes" or "No."

| Yes | No | |
|---|---|---|
| ☐ | ☐ | **1. Are you currently** performing all the duties of your job on a fulltime basis? If no, please explain: _____ You may attach additional sheets of paper if needed. |
| | | **2. Within the last five years,** have you been evaluated for, medically treated for, diagnosed with, taken medications for, or experienced symptoms of any of the following conditions: |
| ☐ | ☐ | a. Disease or disorder of the heart, blood or circulatory system, coronary artery disease, heart attack, or stroke |
| ☐ | ☐ | b. High blood pressure |
| ☐ | ☐ | c. Cancer, leukemia or tumors |
| ☐ | ☐ | d. Lung, respiratory or breathing disease or disorder, asthma, chronic obstructive pulmonary disease (COPD) or sleep apnea |
| ☐ | ☐ | e. Diabetes |
| ☐ | ☐ | f. Liver or kidney disorders |
| ☐ | ☐ | g. Gastrointestinal, stomach, intestine, or genitourinary system disease or disorder, including ulcers or gallstones, ulcerative colitis, or Crohn's disease |
| ☐ | ☐ | h. Mental or nervous illness or disorder, alcoholism or drug addiction |
| ☐ | ☐ | i. Chronic pain or fatigue syndromes |
| ☐ | ☐ | j. Neurological disorders such as multiple sclerosis or Parkinson's disease |
| ☐ | ☐ | k. Musculoskeletal disorders including arthritis, back disorder, fractures, or carpal tunnel syndrome |
| ☐ | ☐ | l. HIV, acquired immune deficiency syndrome (AIDS) or AIDS-related complex (ARC) or any other immune deficiency disorder (such as lupus)? |

## 2 Health Questions

continued from page 1

Yes No

- ☐ ☐ **3. Within the last five years,** have you been in a hospital or other institution for observation, rest, diagnosis or treatment?
- ☐ ☐ **4. Within the last five years,** have you been treated or counseled by a doctor, psychiatrist, psychologist, or licensed practitioner for anything other than a routine physical?
- ☐ ☐ **5. Do you have** any known symptoms, physical or mental impairments not mentioned in the previous questions?
- ☐ ☐ **6. Are you taking** any medication or being treated for any condition, including pregnancy, or disease not mentioned in the previous questions?

**If you answered "Yes" to any of questions 2-6, please provide full details below.**
(If more space is needed, please attach an additional sheet.)

| Question Number | Date of Illness | Date of Full Recovery | Details of nature of illness, number of attacks, duration, severity, treatments and medications prescribed and taken | Names, complete addresses and phone numbers of physicians |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

**Primary Care Physician Information**

Name | Date last seen | Telephone

Address

## 3 Coverage Requested For

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

☐ **Office Overhead Expense Disability Plan:**

What was your average monthly amount of eligible overhead expenses in the past six months? $ _____ per month

Type of Practice: ☐ Sole Proprietorship ☐ Corporation ☐ Partnership

Are you insured for Office Overhead Expense Disability coverage with any other company? ☐ Yes ☐ No

If "Yes", what is the monthly benefit? $ _____ per month

Maximum Monthly Benefit applying for? $ _____ (available in $100 increments from $300 to $10,000)*

*If you have partners, share office facilities, or are a member of a professional corporation, request a Monthly Benefit Amount equal to only your share of expenses.

## 4 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.

## 5 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

**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 the 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 proposed 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 represent that all statements and answers made within or attached to this Request Form are true and complete to the best of my knowledge and belief. I understand that my 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 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 also understand that coverage will not take effect if the facts have changed. I 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 understand that completion of this request for coverage form in no way implies that I will be accepted for insurance coverage.

**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.

**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)

**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.

**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 Office Overhead Expense Disability 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