

GROUP INSURANCE ENROLLMENT CARD

Prudential Life Insurance
Company of America

Organization of Staff Analysts Welfare Fund • 220 East 23rd Street • Suite 707 • New York NY • 10010

Employee's Name	Date of Birth	<input type="checkbox"/> Male
Last	Mo	<input type="checkbox"/> Female
First	Day	<input type="checkbox"/> Married
Initial	Year	<input type="checkbox"/> Single
Home Address (No & Street)	City/State	Zip
Phone Number		

Beneficiary #1 Full Given Name	<input type="checkbox"/> Primary Beneficiary <input type="checkbox"/> Contingent Beneficiary	Beneficiary #2 (if any) Full Given Name	<input type="checkbox"/> Primary Beneficiary <input type="checkbox"/> Contingent Beneficiary
Street Address	City/State/Zip	Street Address	City/State/Zip
Social Security Number	Benefit Percentage	Social Security Number	Benefit Percentage
	%		%
Birth Date (mo/day/yr)		Birth Date (mo/day/yr)	
Beneficiary Phone No.:		Beneficiary Phone No.:	

Need space for additional beneficiaries? Please use the boxes on the other side of this form.

I hereby enroll for that group life/AD&D insurance for which I am or may be eligible. I declare that all information is correct as shown above.

DATE SOCIAL SECURITY NUMBER EMPLOYEE'S SIGNATURE (DO NOT PRINT)

Please note: If any of the information above is missing, this form will be returned to you for completion.

Beneficiary #3 (if any) Full Given Name	<input type="checkbox"/> Primary Beneficiary <input type="checkbox"/> Contingent Beneficiary <input type="checkbox"/> Secondary Contingent Beneficiary	Beneficiary #4 (if any) Full Given Name	<input type="checkbox"/> Primary Beneficiary <input type="checkbox"/> Contingent Beneficiary <input type="checkbox"/> Secondary Contingent Beneficiary
Street Address	City/State/Zip	Street Address	City/State/Zip
Social Security Number	Benefit Percentage	Social Security Number	Benefit Percentage
	%		%
Birth Date(mo/day/yr)		Birth Date (mo/day/yr)	
Beneficiary Phone No.		Beneficiary Phone No.	

Beneficiary #5 (if any) Full Given Name	<input type="checkbox"/> Primary Beneficiary <input type="checkbox"/> Contingent Beneficiary <input type="checkbox"/> Secondary Contingent Beneficiary	Beneficiary #6 (if any) Full Given Name	<input type="checkbox"/> Primary Beneficiary <input type="checkbox"/> Contingent Beneficiary <input type="checkbox"/> Secondary Contingent Beneficiary
Street Address	City/State/Zip	Street Address	City/State/Zip
Social Security Number	Benefit Percentage	Social Security Number	Benefit Percentage
	%		%
Birth Date (mo/day/yr)		Birth Date (mo/day/yr)	
Beneficiary Phone No.		Beneficiary Phone No.	