



Enrollment Form – CITY OF CHICAGO Fraternal Order of Police

Return Completed Form to:
The Prudential Insurance Company of America
Record Keeping Services
P. O. Box 13676
Philadelphia, Pennsylvania 19176

Employee General Information		Effective Date of Coverage (for office use only) / /	
Last Name	First Name	MI	Phone
Address		City	State Zip Code
Social Security Number - -	Marital Status Single Married Divorced Widowed	Date of Birth (Month/Day/Year) / /	
Date Employed (Month/Day/Year) / /	Your Annual Earnings \$ _____	(For Prudential Use Only) Control # 44004	
Long Term Disability			
<input type="checkbox"/> I wish to enroll for the Long Term Disability insurance coverage. I authorize my employer to deduct contributions for the cost of the plan from my earnings.			
<input type="checkbox"/> I elect to Opt-Out of Long Term Disability insurance coverage. I understand that in the event I desire such insurance at a later date, I will be required to furnish medical evidence of insurability and the insurance company will have the right to refuse my request.			
Important Notices			
<p>For residents of all states except Alabama, Arkansas, the District of Columbia, Florida, Kentucky, Louisiana, Maine, Maryland, New Jersey, New York, North Carolina, Pennsylvania, Puerto Rico, Rhode Island, Utah, Vermont, Virginia and Washington; WARNING — Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person, or knowing that he 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/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.</p>			
I have read and understand the terms and requirements of the fraud warnings included as part of this form.			
Employee Signature _____		Date Signed (Month/Day/Year) _____	

Long-Term Disability Insurance coverages are issued by The Prudential Insurance Company of America, 751 Broad Street, Newark, NJ 07102. Life Claims: 1-800-524-0542 and Disability Support 1-800-842-1718. The Booklet-Certificate contains all details, including any policy 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.

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