Enrollment Form - CUMMINS CONSTRUCTION COMPANY

The Prudential Insurance Company of America

751 Broad Street, Newark, New Jersey 07102

1-877-232-3619

Employee General Information				Effective Date of Coverage (for office use only) _____/_____/_____
Last Name	First Name	Middle Initial	Email	Phone
Address		City	State	Zip Code

Social Security Number	Marital Status		Date of Birth
_____ – _____ – _____	☐ Single ☐ Divorced	☐ Married ☐ Widowed	Month Day Year _____/_____/_____
Date Employed Month Day Year _____/_____/_____	Your Annual Earnings $_____	Spouse or Domestic Partner Date of Birth Month Day Year _____/_____/_____	(For Prudential Use Only) Control # 19865

Basic Term Life and Accidental Death & Dismemberment (AD&D)

CUMMINS CONSTRUCTION COMPANY Company offers you Basic Term Life and AD&D Insurance coverages at no cost to you. You will automatically be enrolled in these plans.

Basic Dependent Term Life

CUMMINS CONSTRUCTION COMPANY Company offers your Spouse or Domestic Partner and Child Basic Dependent Term Life at no cost to you. You will automatically be enrolled in these plans.

Optional Term Life

☐ Coverage amount chosen: $_____ Payroll Deduction: $_____

☐ No coverage chosen ☐ Continue current coverage amount

Optional Dependent Term Life

You must be enrolled for Optional Term Life to elect coverage for your dependents. Spouse or Domestic Partner coverage cannot exceed 50% of your Optional Term Life coverage amount. Child(ren) coverage cannot exceed 50% of your Optional Term Life coverage amount.

Spouse or Domestic Partner ☐ No coverage chosen

☐ Coverage amount chosen:$_____

☐ Continue current coverage amount

Payroll Deduction: $_____

Children ☐ No coverage chosen

☐ Coverage amount chosen:$_____

☐ Continue current coverage amount

Payroll Deduction: $_____

Optional Accidental Death & Dismemberment (Optional AD&D)

Employee, Spouse or Domestic Partner, Child(ren)

☐ Employee & Family Coverage ☐ No coverage chosen	☐ Continue current coverage amount Coverage amount:$_____	Payroll Deduction: $_____
Spouse or Domestic Partner ☐ Coverage ☐ No coverage chosen	☐ Continue current coverage amount Coverage amount:$_____	Payroll Deduction: $_____
☐ Child(ren) Coverage ☐ No coverage chosen	☐ Continue current coverage amount Coverage amount:$_____	Payroll Deduction:$_____

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Employee General Information			
Last Name	First Name	Middle Initial	Last 4 digits of Social Security No. XXX – XX – _____

Voluntary Short Term Disability

☐ I wish to enroll for the Short Term Disability insurance coverage.

☐ No Short Term Disability insurance coverage chosen.

Accelerated Death Benefit Option is a feature that is made available to group life insurance participants. It is not a health, nursing home, or long-term care insurance benefit and is not designed to eliminate the need for those types of insurance coverage. The death benefit is reduced by the amount of the accelerated death benefit paid. There is no administrative fee to accelerate benefits. Receipt of accelerated death benefits may affect eligibility for public assistance and may be taxable. The federal income tax treatment of payments made under this rider depends upon whether the insured is the recipient of the benefits and is considered terminally ill or chronically ill. You may wish to seek professional tax advice before exercising this option.

NOTICE TO CONSUMER: THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMAL ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES. ALSO, THE BENEFITS PROVIDED BY THIS POLICY CANNOT BE COORDINATED WITH THE BENEFITS PROVIDED BY OTHER COVERAGE. PLEASE REVIEW THE BENEFITS PROVIDED BY THIS POLICY CAREFULLY TO AVOID A DUPLICATION OF COVERAGE.

Basic Life, Accidental Death & Dismemberment, Optional Term Life, Dependent Term Life, Short-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.

Enrollment Form - CUMMINS CONSTRUCTION COMPANY

Employee General Information

Last Name	First Name	Middle Initial	Last 4 digits of Social Security No.
			XXX – XX – _____

Acceptance or Waiver of Coverage

☐ I am enrolling for coverage and I authorize my employer to deduct from my earnings until further notice my contributions for insurance under a contract issued by The Prudential Insurance Company of America. I understand that if I desire to increase the amount of my insurance or add dependent coverage hereafter, I may be required to furnish evidence of insurability for myself and/or my dependents. To the best of my knowledge and belief, I declare the statement above is true and understand it is the basis for determining the monthly contribution for coverage. I also understand that for coverage to become effective, I must be actively at work during the enrollment period and on the effective date of the plan. If I apply for an amount that requires evidence of insurability satisfactory to The Prudential Insurance Company of America, I must be actively at work on the date of approval for the amount requiring satisfactory evidence of insurability.

☐ I do not wish to enroll for any of the above optional coverages. To the best of my knowledge and belief, I have been given the opportunity by my above named employer to enroll for coverage. I understand that if I desire to enroll hereafter, I may be required to furnish satisfactory evidence of insurability to The Prudential Insurance Company of America for myself and/or my dependents.

FLORIDA RESIDENTS—Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing false, incomplete, or misleading information is guilty of a felony of the third degree.

NEW YORK RESIDENTS—Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.**This warning ONLY applies to accident and disability coverage.**

I have read and understand the terms and requirements of the fraud warnings included as part of this form.

Employee Signature _____ Date (Month/Day/Year) ____/____/_____

Enrollment Form - CUMMINS CONSTRUCTION COMPANY

Employee General Information

Last Name	First Name	Middle Initial	Last 4 digits of Social Security No.
			XXX – XX – _____

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.

ALABAMA RESIDENTS – Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

ARKANSAS, DISTRICT OF COLUMBIA, LOUISIANA AND RHODE ISLAND RESIDENTS – Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

KENTUCKY RESIDENTS – Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

MAINE AND WASHINGTON RESIDENTS – Any person who knowingly provides false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company commits a crime. Penalties include imprisonment, fines, and denial of insurance benefits.

MARYLAND RESIDENTS – Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NEW JERSEY RESIDENTS – Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NORTH CAROLINA RESIDENTS – Any person who, with the intent to injure, defraud, or deceive an insurer or insurance claimant, knowing that the statement contains false or misleading information concerning a fact or matter material to the claim may be guilty of a Class H felony.

PENNSYLVANIA AND UTAH RESIDENTS – Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any material fact thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

PUERTO RICO RESIDENTS – Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances [be] present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

VERMONT RESIDENTS – Any person who knowingly presents a false or fraudulent claim for payment of a loss or knowingly makes a false statement in an application for insurance may be guilty of a criminal offense under state law.

VIRGINIA RESIDENTS – Any person who, with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

You must also complete a separate beneficiary designation form.

If you have any questions, please see Human Resources for details.

Beneficiary Designation - CUMMINS CONSTRUCTION COMPANY

Control # 19865

Employee General Information

Last Name	First Name	Middle Initial	Social Security No.
			_ _ _

Employee/Applicant Beneficiary Designations (to be completed by employee/applicant or assignee, if assigned)

Please designate at least one primary beneficiary. Use a separate sheet if you want to name more than two primary beneficiaries. If designating a Trust, Estate, or Corporation, please complete the corresponding fields. Do not name a beneficiary for Dependent Term Life Coverage; these benefits are paid to you while living. 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.

Basic Life, Basic ADD, Optional Life and OADD — Primary beneficiaries:

Last Name	First Name	MI	Telephone Number
Social Security Number	Date of Birth	Relationship	Percentage
Street Address	City	State	Zip

Check one, if applicable:	☐ **Trust** ☐ **Estate** ☐ **Corporation**	**Entity Name:**	
Tax ID #/Tax Exempt #	Creation/Incorporation/Formation Date	Telephone Number	Percentage
Street Address	City	State	Zip

Last Name	First Name	MI	Telephone Number
Social Security Number	Date of Birth	Relationship	Percentage
Street Address	City	State	Zip

Check one, if applicable:	☐ **Trust** ☐ **Estate** ☐ **Corporation**	**Entity Name:**	
Tax ID #/Tax Exempt #	Creation/Incorporation/Formation Date	Telephone Number	Percentage
Street Address	City	State	Zip

Basic Life, Basic ADD, Optional Life and OADD — Contingent Beneficiary Designation -

Death benefits will be paid to the contingent beneficiaries if the primary beneficiary(ies) is not alive. Use a separate sheet if you want to name more than two contingent beneficiaries. If designating a Trust, Estate, or Corporation, please complete the corresponding fields.

Last Name	First Name	MI	Telephone Number
Social Security Number	Date of Birth	Relationship	Percentage
Street Address	City	State	Zip

Check one, if applicable:	☐ **Trust** ☐ **Estate** ☐ **Corporation**	**Entity Name:**	
Tax ID #/Tax Exempt #	Creation/Incorporation/Formation Date	Telephone Number	Percentage
Street Address	City	State	Zip

Beneficiary Designation - CUMMINS CONSTRUCTION COMPANY

Control # 19865

Last Name	First Name	MI	Telephone Number
Social Security Number	Date of Birth	Relationship	Percentage
Street Address	City	State	Zip

Check one, if applicable:	☐ **Trust** ☐ **Estate** ☐ **Corporation**	**Entity Name:**	
Tax ID #/Tax Exempt #	Creation/Incorporation/Formation Date	Telephone Number	Percentage
Street Address	City	State	Zip

The above beneficiary designation only applies to: ☐ Basic Term Life/AD&D ☐ Optional Term Life ☐ Optional AD&D

Employee Signature _____ **Date (Month/Day/Year)** ____/____/_____

If you have any questions, please see Human Resources for details.

Group Dependent Life,Optional DependentLife,Basic AD&D,Optional AD&D,Short Term Disability,Optional Life,Basic Life,Long Term Disability coverages are issued by The Prudential Insurance Company of America, 751 Broad Street, Newark, NJ 07102.

Life Claims: 800-524-0542 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. Contract series: {83500} . Prudential, the Prudential logo and the Rock symbol are service marks of Prudential Financial, Inc. and its related entities, registered in many jurisdictions worldwide.

Prudential

GROUP INSURANCE

The Prudential Insurance Company of America

Employer:

CUMMINS CONSTRUCTION COMPANY

Group Contract No.(s): 00 19865

Branch No.: 000001

Mail the completed form to:

The Prudential Insurance Company of America
Group Medical Underwriting, P.O. Box 8796
Philadelphia, PA 19176

Or fax the completed form to:
877-605-6671

Short Form Health Statement

(Submit a separate form for each person whose coverage requires Evidence of Insurability.)

Employee

First Name | MI | Last Name

Number and Street | P.O. Box / Apt. Number

City | State | ZIP Code

Social Security Number | Employee ID Number | Telephone

Email Address

Name of Person for Whom Insurance is Being Requested

Relationship to Employee: ☐ Self ☐ Spouse or Domestic Partner

First Name | MI | Last Name | Social Security Number

Coverage that requires Evidence of Insurability: **Employee** ☐ Life ☐ Long Term Disability ☐ Short Term Disability
Spouse or Domestic Partner ☐ Life

Gender: ☐ Female ☐ Male

Height: ft. in.

Weight: lbs.

Date of Birth: (mm-dd-yyyy)

Please answer these questions by checking "Yes" or "No". Note: In this section, "you" refers to the person for whom the insurance is being requested.

Yes ☐ No ☐ **Do you currently** have any disorder, condition, or disease or are you currently taking prescription medication for any disorder, condition, or disease (other than: allergies; cold; or cough)?

Yes ☐ No ☐ **In the last five years** have you been diagnosed with, treated for, had any symptoms of, or been in a hospital or other facility for any of the following?

- Chest pain, heart disease or disorder, high blood pressure;
- Cancer, tumors;
- Respiratory disease or disorder of the lungs;
- Multiple sclerosis, epilepsy, seizure, stroke;
- Kidney, liver or pancreas disease or disorder;
- AIDS, AIDS-related complex;
- Diabetes;
- Mental or nervous disorder;
- Alcoholism, drug addiction;
- Chronic pain, rheumatoid arthritis, lupus; or
- Colitis, Crohn's disease, gastric bypass.

Yes ☐ No ☐ **In the last five years**, have you been diagnosed with or treated by a medical or other practitioner for neurological disease or disorder or musculoskeletal disease or disorder or **are you currently pregnant**?

Prudential reserves the right to request additional health information on the basis of the responses given to the above questions.

Important Notice: For residents of all states except: Alabama, Arkansas, 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.

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Group Contract No.(s): 0019865

Branch No.: 000001

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I have read and understand the terms and requirements of the fraud warnings included as part of this form.

I declare that, to the best of my knowledge and belief, the statements made in this application are complete and true. I agree that the coverage applied for is subject to the terms of the plan and shall become effective on the date or dates established by the plan, provided the evidence of good health is satisfactory.

Print Your First Name | Last Name | Your Social Security Number (___ – ___ – ____)

Your Signature (unless a minor) | Date Signed (mm-dd-yyyy) (__ – __ – ____)

If Person for whom insurance is being requested is a minor, Signature of Parent, Guardian, or Person Liable for Support | Relationship | Date Signed (mm-dd-yyyy) (__ – __ – ____)

Please keep a copy of this form for your records.

Group Life and Disability Income Medical Underwriting NOTICE

Thank you for choosing The Prudential Insurance Company of America (Prudential) for your insurance needs. Before we can issue coverage we must review your application/enrollment form. To do this, we need to collect and evaluate personal information about you. This notice is being provided to inform you of certain information practices Prudential engages in, and your rights, with regard to your personal information. We would like you to know that:

- Personal information may be collected from persons other than yourself or other individuals, if applicable, proposed for coverage;
- This personal information as well as other personal or privileged information subsequently collected by us may in certain circumstances be disclosed to third parties without authorization;
- You have a right of access and correction with respect to personal information we collect about you; and
- Upon request from you, we will provide you with a more detailed notice of our information practices and your rights with respect to such information. Should you wish to receive this notice, please contact:

The Prudential Insurance Company of America
Group Medical Underwriting
P.O. Box 8796
Philadelphia, PA 19176

Information regarding your insurability will be treated as confidential. We may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life, disability, or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file. In addition, upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901. If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400 Braintree, Massachusetts 02184-8734. Information for consumers about MIB may be obtained on its website at www.mib.com.

Please keep this notice for your records.