

Member Term Life Coverage Request Form *(Please print in black ink)*

Group Contract No: 82750

Please mail your completed Form to TMAIT, P.O. Box 1707, Austin, TX 78767-1707.

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

Member Information *(Please print in black ink)*

First Name	MI	Last Name
<input type="text"/>	<input type="text"/>	<input type="text"/>
Street	Apt.	City
<input type="text"/>	<input type="text"/>	<input type="text"/>
State	ZIP Code	Date of Birth (mm/dd/yyyy)
<input type="text"/>	<input type="text"/>	<input type="text"/>
Height	Weight	Email Address
<input type="text"/> ft. <input type="text"/> in.	<input type="text"/> lbs.	<input type="text"/>
Gender	Social Security Number	Daytime Telephone Number
<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="text"/>	<input type="text"/>
		Evening Telephone Number
		<input type="text"/>
TMA Member Number	Texas Medical License	Specialty
<input type="text"/>	<input type="text"/>	<input type="text"/>
		Current Coverage Amount <i>(if applicable)</i>
		\$ <input type="text"/>

Term Life Insurance Amount Now Requested *(Please check one):*

- \$2,000,000
 \$1,000,000
 \$200,000
 \$1,500,000
 \$500,000
 Other Amount Requested: \$ _____
(In \$10,000 increments up to a maximum of \$2,000,000.)

Beneficiary Designation *Please specify your beneficiary (full name, Example: Jean Lee Doe)*

First Name	Middle Name	Last Name	Social Security No.	Relationship	% Share
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> <i>Please check if additional information regarding your beneficiary designation is attached.</i>				Total (Must equal 100%):	100%

Payment Basis—Please note: All your TMAIT insurance coverage(s) will be billed per your election below. *(Please check one):*

- Bill Me Quarterly
 Monthly Electronic Funds Transfer (EFT) *

***Monthly Electronic Funds Transfer Authorization**—If you wish to use your checking account, **enclose a blank voided check** for that account. If you wish to use your credit union or savings account, you must confirm that your bank permits electronic funds withdrawals. By my signature below I authorize the Texas Medical Association Insurance Trust in accordance with the Agreement (see the back of the attached letter) 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.

- Checking
 Savings
 Credit Union

<input type="text"/>	<input type="text"/>	<input type="text"/>
<i>Account Owner's Name</i>	<i>Bank or Credit Union Name</i>	<i>Type of Account</i>
<input type="text"/>	<input type="text"/>	<input checked="" type="checkbox"/> Signature of Account Owner
<i>Bank's Transit Routing Number (9 digits required)</i>	<i>Your Account Number</i>	

In order to be eligible to maintain the insurance indicated above, I acknowledge: (a) that I am a member of the Texas Medical Association, (b) that I must continue such membership to keep this insurance in force, (c) that I must be actively at work on a full-time basis on the effective date of coverage, (d) I hereby request participation in the Texas Medical Association Insurance Trust and agree to be bound by its terms, and (e) I will remit required contributions for such insurance when due.

Signature of Member: _____ **Date:** _____

Accelerated Death Benefits: Receipt of accelerated death benefits may affect eligibility for public assistance programs and may be taxable. There is no administrative fee to accelerate death benefits. The accelerated amount is not discounted.

Beneficiary Designation—If you name more than one beneficiary, settlement will be made in equal shares to the designated beneficiaries (or beneficiary) that survive you, unless otherwise provided in the designation. If no named beneficiary survives you, settlement will be made to your estate. The beneficiary named herein will be the beneficiary for your total amount of insurance coverage issued pursuant to the Plan of Insurance of the TMA Insurance Trust.

Electronic Funds Transfer Authorization—Texas Medical Association Insurance Trust Automatic Insurance Payment Program Agreement provides for Electronic Funds Transfer for the purpose of making your insurance payment without the use of a check. Your signed authorization is required. Your monthly insurance payments will be debited from your bank/credit union account on the first business day of each month. Your first electronic payment will be debited on the first business day of the following month as long as TMAIT receives this authorization form by the 10th of the current month. Signing up for EFT does not guarantee that your future premiums will not change. Premiums can change because of age, increases or decreases in coverage, adding or deleting dependents, rate increases, as well as other unforeseen factors. You will receive written confirmation if the amount of your debit due to premium contribution changes. You will not receive a monthly bill or statement.

A quarterly fee is paid by Prudential to Texas Medical Association for administrative services and sponsorship.

Term Life Coverage under the TMA Insurance Trust is issued by The Prudential Insurance Company of America, a New Jersey Company, 751 Broad Street, Newark, N.J. 07102. Life Claims: 1-800-524-0542. 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, California COA #1179, NAIC #68241. Contract series 83500.

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.

Any information we obtain regarding a person's insurability will be treated as confidential. We may, however, make a brief report of it to the Medical Information Bureau (the Bureau), a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. When you apply for life, disability, or health insurance to any company, including Prudential, which is a member of the Bureau, or submit a claim for benefits to such a company, the Bureau will, on request, give the company the information in its files. In addition, upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If the information came from the Bureau and you question the accuracy of the information in the Bureau's files, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is: P.O. Box 105, Essex Station, Boston, MA, 02112, (617) 426-3660.

Please keep this notice for your records.