Directions

Please complete, sign and return this form to:

Aon Insurance Services, Plan Agent
AICPA Insurance Trust, 159 E. County Line Rd., Hatboro, PA 19040-1218

or

Fax: 800-242-7248

If you have any questions, please call
one of our representatives at 1-800-223-7473.

The Prudential Insurance Company of America

751 Broad Street, Newark, New Jersey 07102

AICPA Insurance Trust | Aon Benfield Securities, Inc.
Member FINRA/SIPC
159 East County Line Road, Hatboro, PA 19040-1218

Group Variable Universal Life (GVUL) Request for Select Status

Group Variable Universal Life (GVUL) Request for Select Rates

Please return completed form in the enclosed postage-paid envelope. You'll be billed after your new rates are effective.

Member Information *(Please print in black ink)*

First Name ______ MI ______ Last Name ______

Street ______ Apt. ______ City ______ State ______ Zip Code ______

Gender
☐ Male
☐ Female

Date of Birth (mm/dd/yyyy) ______

Social Security Number ______ – ______ – ______

Daytime Telephone Number ______ – ______ – ______

Evening Telephone Number ______ – ______ – ______

☐ ***Yes,*** *I would like to receive the monthly AICPA Insurance Programs e-newsletter and other important information via email about training opportunities, products, offerings, and program-sponsored CPA events.*

E-mail Address ______

Are you a member of the AICPA?
☐ Yes, AICPA #:______ ☐ No*

Are you a member of a State Society of CPAs or other eligible organization?
☐ Yes, the ______ State Society of CPAs ☐ No*

**You are not eligible for GVUL coverage if you're not an AICPA or State Society of CPAs member*

The GVUL coverage is assigned—For any changes in coverage, the assignee must sign below to verify that he or she has knowledge of and has requested such changes.

______ ✗ ______ ______
Name of Assignee (please print) ***Signature of Assignee*** ***Date***

Primary Care Physician Information—Failure to complete this section may delay the processing of your application.

______ ( ) ______
Name of Your Primary Care Physician | Telephone No. of Primary Care Physician

______ ______ ______ ______
Street Address of Primary Care Physician | City | State | Zip

☐ ***I do not have a Primary Care Physician at this time.***

Receipt of Accelerated Death Benefits may affect eligibility for Public Assistance and may be taxable. There is no administrative fee to accelerate death benefits. The accelerated amount is not discounted. The amount of the death benefit may vary under conditions, such as attainment of a specified age, Election of the Accelerated Benefit Option, or overdue contributions.

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 any false, incomplete or misleading information is guilty of a felony of the third degree.

I have read and understand the terms and requirements of the fraud warnings included as part of this form. By my signature below, I hereby request Select Status under the GVUL Plan. I acknowledge that my application, including the portions containing health information, are submitted to the Plan Agent, acting for the Trustee, and that the Plan Agent shall forward the application to the issuing company. I have read the Conditions Applicable to This Subscription, appearing on the Medical Statements Form, and the Beneficiary Designation, appearing on this Form and agree to those statements and conditions. I also hereby subscribe to the AICPA Insurance Trust in accordance with Member's Subscription and agree to the applicable conditions. Insurance and/or rates is to become effective only upon acceptance by the issuing company. The Plan Agent, acting for the Trustee, will inform the person requesting insurance regarding the effective date of coverage.

(All members must sign regardless of state of residence)

Signature of Member ✗ ______ ***Date*** ______

Please complete the reverse side…

The Prudential Insurance Company of America

751 Broad Street, Newark, New Jersey 07102

Group Variable Universal Life (GVUL) Medical Statements Form

Medical Statements—Please print all answers in ink. To be completed by Member requesting Coverage under the AICPA GVUL Life Insurance Plan provided by The Prudential Insurance Company of America (Prudential) pursuant to the AICPA Insurance Trust.

Please print all answers in ink.

1. Name of Member:

Last First MI

2. Residence: Address Change? ☐ Yes ☐ No

Street City State Zip

3. Date of Birth: / /

Month Day Year

4. Birthplace:

City State

5. Gender: ☐ Male ☐ Female **6. Height:**____*ft.*____*in.* **Weight:**_____*lbs.*

7. Within the last 12 months have you used tobacco or nicotine in any form?
☐ Yes ☐ No

Questions must be checked either Yes or No.

Questions should be answered to the best of your knowledge and belief.

8. Have you within the last five years been treated for or had any symptoms of:

Yes* No

☐ ☐ (a) Disease or disorder of the heart, blood or circulatory system?
☐ ☐ (b) High blood pressure, stroke or abnormal pulse?
☐ ☐ (c) Blocked arteries, including arteriosclerosis, atherosclerosis, aneurism or deep vein blood clot?
☐ ☐ (d) Respiratory disease or disorder of the lungs, including chronic obstructive pulmonary disorder (COPD), sleep apnea, emphysema, or asthma?
☐ ☐ (e) Disease or disorder of the stomach, gall bladder, liver, including ulcers?
☐ ☐ (f) Disorder of the kidney, bladder or genitourinary system?
☐ ☐ (g) Musculoskeletal disorders including back, spinal, neck or knee?
☐ ☐ (h) Mental or nervous disorder?
☐ ☐ (i) Diabetes? If "yes" indicate in question 12 whether Type 1 or 2, year of diagnosis, and current treatment.
☐ ☐ (j) Cancer or tumors?
☐ ☐ (k) Arthritis or joint disease or disorder? If arthritis indicate type in question 12.
☐ ☐ (l) Disease or disorder of the intestines, ulcerative colitis, or Crohn's disease?
☐ ☐ (m) Muscular or neurological disease, such as Multiple Sclerosis or Parkinson's disease?
☐ ☐ (n) Fibromyalgia, Chronic Fatigue Syndrome or Chronic Pain Syndrome?
☐ ☐ (o) Disease or disorder of the thyroid or endocrine system?

9. Have you within the last five years:

Yes*No

☐ ☐ (a) Experienced a persistent cough, chronic fatigue, significant weight loss, night sweats, enlarged glands or chronic diarrhea?
☐ ☐ (b) Been advised to have a surgical operation?
☐ ☐ (c) Been a patient in or been advised to enter a hospital or health care facility?
☐ ☐ (d) Consulted or been attended by a doctor or other practitioner, other than for a routine physical, Flu shot, or HIV testing?
☐ ☐ (e) Been diagnosed or treated by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS), or AIDS-Related Complex (ARC)?
☐ ☐ (f) Been diagnosed or treated by a member of the medical profession for any immune deficiency disorder or disease of the lymphatic system or immune system, except HIV?
☐ ☐ (g) Been treated or counseled for alcoholism or drug abuse?
☐ ☐ (h) Regularly used barbiturates, amphetamines, marijuana or other hallucinatory drugs, heroin, opiates, or other narcotics except as prescribed by a doctor?

10. Are you currently taking any medicine prescribed or provided by a doctor? Please provide the name of the medication and reason for taking it in Question 12. ☐ Yes ☐ No

11. Have you, within the last five years, been diagnosed or treated for any physical disorders, impairments or ill health, except HIV, not recorded in answer to Questions 8, 9 or 10? ☐ Yes ☐ No

****If "Yes" is checked, please complete Question 12. When completing information below please be sure to provide physician's name.***

12. What are the complete details of all "Yes" answers to Questions 8, 9, 10 and 11?

Question number & letter	Specify illness,condition and medication	Month/year illness or condition began	Time lost from normal activities	Month/year of full recovery (if applicable)	Print full names, addresses, and telephone number of physicians

☐ *Please check if additional medical information is attached.*

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 to MIB, Inc. This excludes psychotherapy notes and information on the use of alcohol and drugs. I also authorize MIB, Inc. to release any data it may have about me for the proposed coverage with 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.

Further, I declare that to the best of my knowledge and belief all of the above answers to the questions are complete and true. I agree that (1) the coverage and/or rates applied for is subject to the policy terms and shall become effective on the date or dates established by the policy, provided the evidence of insurability is satisfactory, (2) this form supersedes any prior form I may have completed with respect to the coverage and/or rates being applied for.

This information and any information on my application is to be disclosed under this authorization so that Prudential may, in accordance with the AICPA Insurance Trust and its administrator, Aon Insurance Services (Aon), do the following, with respect to the insurance coverage and/or rates I am applying for: underwrite or make rating determinations; evaluate and determine my eligibility for coverage; participate in audits by Prudential, AICPA, Aon or one of the third-party auditors, or conduct other legally permissible activities related to my application. I hereby authorize MIB, Inc. to exchange any medical records or knowledge of my health with The Prudential Insurance Company of America. By signing below, I acknowledge that I have received and read the Medical Information Notice, appearing in the brochure. This authorization is valid until the earliest of: (1) two years after the effective date of any coverage issued in connection with it; or (2) until it is withdrawn in writing; or (3) 24 months after the date it is signed. A photographic copy of this form will be as valid as the original. (If you wish, you may obtain a copy of this authorization).

I understand that I have a right to revoke the authorization in writing at anytime, by sending a signed request for revocation to The Prudential Insurance Company of America, Group Medical Underwriting, PO Box 8796, Philadelphia, PA 19176. Attention: Senior Medical Underwriting Consultant. Any such revocation is subject to the rights of anyone who relied on this authorization before it was revoked. I understand that any information that is disclosed pursuant to this authorization may be redisclosed to other parties and will not be protected by the HIPAA Privacy Rule.

By my signature below, I hereby request coverage under the Plan for the amount selected. I acknowledge that my application, including the portions containing health information, are submitted to the Plan Agent, acting for the Trustee, and that the Plan Agent shall forward the application for coverage to the issuing company.

Member Signature: ✗ ________________ **Date:** __________

You should consider the contract and the underlying Funds Investment Objectives, risks, charges and expenses carefully before investing. Both the contract prospectus and the underlying Fund Prospectuses contain this and other important information. You may contact Aon Benfield Securities, Inc. at 800-223-7473 for the Prospectuses. You should read them carefully before purchasing this coverage.

Member's Subscription—Effective on the date of application, the member (of the AICPA or a State Society of CPAs or other qualifying organization) named herein, a subscriber to the Trust Agreement (hereinafter called the "Agreement") made in the City and State of New York as of January 1, 2012, as amended, by and between the American Institute of Certified Public Accountants, The Bank of New York Mellon, as successor Trustee, and the various Subscribers who from time to time subscribe to the Agreement, hereby amends a previous request for participation in the Insurance Plan of said Trust. Participation in the insurance is requested as indicated herein.

Conditions Applicable to this Subscription—It is understood that the Agreement, among other things, provides that: (1) Subscribers shall make contributions to the Trust in such amounts as may be required for the purpose of providing and maintaining insurance in accordance with the plans of insurance under the Trust and for the purpose of administration; (2) Subscribers shall furnish to the Trustee any information required in connection with the administration of the Trust and the plans of insurance thereunder; and (3) the Trustee may modify the plans from time to time in any respect as may be directed by the Board of Directors of the Institute. It is further understood that: (1) if the Plan Agent, acting for the Trustee, shall determine that the Subscriber is eligible to participate as requested, the Plan Agent shall promptly confirm the effective date; (2) the insurance of an eligible individual shall, as to its effective date and in every other respect, be governed by the provisions of the contracts held and administered by the Trustee pursuant to the Plan (including the requirement that on the effective date the subscriber is actively at work on full-time at any location where his employment requires him to be); and (3) if the Subscriber is determined not to be eligible to participate as requested, this Form shall be considered null and void and the Trustee shall refund to the Subscriber any payment, but in the case of Subscribers currently participating in the Plan, continued participation on the basis existing prior to the date of this Form shall not be affected thereby.

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 in accordance to the terms of the group policy. The beneficiary named herein will be the beneficiary for your total amount of insurance coverage issued pursuant to the Plan of Insurance of the AICPA Insurance Trust which insurance coverage is effective October 1, 1974 or later. If you are a current participant in the Plan and wish to change your Beneficiary election, please call Aon Insurance Services at 1-800-223-7473.

Electronic Fund Transfer Authorization—AICPA Insurance Trust 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 tenth 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 in the Plan and wish to change your Contribution Payment Basis, please call Aon at 1-800-223-7473.**

Special Notice—For residents of all states except **Alabama, the District of Columbia, Florida, Kentucky, Maryland, New Jersey, New York, Pennsylvania, Rhode Island, Utah, Puerto Rico, 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. **District of Columbia 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. **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. **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 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 a statement of claim for payment of a loss or benefit may have violated state law, is 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. **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.

An annual fee is paid by the Trust to the AICPA for administrative services and sponsorship.

If your request for Coverage or rates is denied and you disagree with this determination, you have the right to appeal it. Please contact the AICPA Customer Service Unit at 1-888-257-0412 weekdays from 8:00a.m. to 6:00p.m. Eastern time or write to: The Prudential Insurance Company of America, PO Box 8796, Philadelphia, PA 19176-8796.

Group Variable Universal Life Insurance coverage is issued by The Prudential Insurance Company of America, a New Jersey company, 751 Broad Street, Newark, NJ 07102. GVUL 1-800-562-9874. GVUL is distributed by Prudential Investment Management Services LLC ("PIMS",) Three Gateway Center, 14th Floor, Newark, NJ 07102-4077. GVUL Plan is offered and administered through Aon Benfield Securities, Inc. Member FINRA/SIPC, 159 East County Line Road, Hatboro, PA 19040-1218, 1-800-223-7473. The Plan Agent of the AICPA Insurance Trust is Aon Insurance Services. Aon Benfield Securities, Inc. and Aon Insurance Services are not affiliated with either Prudential or PIMS. 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. Contract provisions may vary by state. California COA #1179, NAIC #68241. Contract series 89759