

# NCPERS PLAN

## ENROLLMENT/CHANGE OF BENEFICIARY FORM

(PLEASE PRINT)

New Member Enrollment  Open Enrollment  Change of Beneficiary

|  |                        |                   |   |                             |                        |
|--|------------------------|-------------------|---|-----------------------------|------------------------|
| Member Last Name   | First Name             | Middle Name       | <input type="checkbox"/> Male <input type="checkbox"/> Female                                   | Date of Birth               | Social Security Number |
| Street   |                        | City              | State   | ZIP Code                    | Home Phone Number      |
| Occupation of Member   | Member's Date Employed | Actively at Work? | <input type="checkbox"/> Yes <input type="checkbox"/> No-You are not eligible for this coverage |                             |                        |
| Beneficiary - Full Name (Example: Mary A. Doe, not Mrs. John A. Doe) |                        |                   |   | Relationship of Beneficiary |                        |
| Address of Beneficiary   |                        | City              | State   | ZIP Code                    |                        |

**FOR EMPLOYER:** Please show date of first deduction \_\_\_\_\_ (Mo. Day Yr.)      **EMPLOYER Unit No.** \_\_\_\_\_

I declare the above statements and answers are complete and true and understand they are the basis for providing life insurance under a plan (or plans) issued by The Prudential Insurance Company of America to the National Conference on Public Employee Retirement Systems, in which I will participate upon becoming insured. I hereby authorize my employer to deduct from my wages amounts equal to the contributions required for me toward the premiums for Group Insurance under the NCPERS plan issued by Prudential. A photographic copy of this authorization shall be as valid as the original. The effective date of coverage will be the first day of the month coincident with or next following payment of my contribution through payroll deductions.

|                  |      |       |          |                     |      |
|------------------|------|-------|----------|---------------------|------|
| Name of Employer | City | State | ZIP Code | Signature of Member | Date |
|------------------|------|-------|----------|---------------------|------|