

NATIONAL AUTOMOBILE DEALERS
INSURANCE TRUST

COVERAGE REQUEST FORM (Please print in black ink)

Group Contract No. 34371

Please complete the Request Form below and the Short Health Questionnaire on page 2. Upon completion, please mail these Forms to NADA Insurance at 8400 Westpark Drive, McLean, VA, 22101. Do not include payment now. You will be billed on a monthly basis when notified of your effective coverage date.

Please complete the sections below:

Applicant's Name: _____

Dealership Name: _____

Dealership Address: _____

Gender: M F

Date of Birth: ____/____/____

Social Security No.: ____ - ____ - ____

Dealer Account No.: _____

Percentage of Stock Owned: _____%

Home Phone: (____) _____

Business Phone: (____) _____

Are you actively working 20 hours per week or 1,000 hours per year?

Yes No

Amount of Dealer Life Insurance Requested:

(Please check one)

Coverage Amounts

- \$2,000,000
- \$1,500,000
- \$1,000,000
- \$750,000
- \$500,000
- \$300,000
- \$100,000
- \$50,000

-OR-

Other Amount Requested: \$ _____

(In \$50,000 increments up to a maximum of \$2,000,000).

Please note: You will be billed for your coverage on a monthly basis.

Beneficiary Designation Please note: If you are a current participant, any designation listed below will replace what is currently on file. Please specify your beneficiary (full name, Example: Jean Lee Doe)

First Name	Middle Name	Last Name	Social Security No.	Relationship	% Share
_____	_____	_____	_____	_____	_____
Address _____					

Please check if additional beneficiary designation is attached.

Total (Must equal 100%): 100%

In order to be eligible to maintain the insurance indicated above, I acknowledge: (a) that I am a member of the National Automobile Dealers 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 National Automobile Dealers 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: **X** _____

Date: _____

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.

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 National Automobile Dealers Insurance Trust.

IMPORTANT NOTICE:

For residents of all states except Florida, New Jersey, Pennsylvania, 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.

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.

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.

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—It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.