

### Group Life Disability Benefit Attending Physician's Statement

**1**  
**To Be Completed By Employee**

Employer's Name  Control Number

First Name  MI  Last Name

Social Security Number  Date of Birth (MM DD YYYY)  Gender  Male  Female

Street  Suite

City  State  ZIP Code

Occupation

I hereby authorize the release of information requested on this form by the below named physician for the purpose of claim processing.

Employee Signature  \_\_\_\_\_ Date (MM DD YYYY)

**The employee is responsible for the completion of this form without expense to Prudential.**

**2**  
**To Be Completed By Attending Physician**

Clinical Diagnosis  ICD-9 Code  Pregnancy EDC (MM DD YYYY)

Primary

Secondary

Secondary

Pregnancy Actual Delivery Date (MM DD YYYY)

Relevant test procedures performed (Please provide results)

Date of Procedure (MM DD YYYY)

Surgical Procedure(s) Performed (Please be specific)

Current Medications





