Prudential

Group Insurance

The Prudential Insurance Company of America
Disability Management Services

Waiver of Premium Unit
P.O. Box 70183, Philadelphia, PA 19176

Tel 800-524-0542 Fax 877-862-0269

Group Life Claim for Total Disability Benefits—Employee Statement

Instructions to file a Claim for Group Life Insurance Coverage for Total Disability

1. Complete all sections of the **Employee Statement (Form GL.2003.015)**

2. Ask your doctor to complete the **Attending Physician's Statement GL.2002.119)**

3. Submit these completed forms according to the directions you received from your Benefits Office or mail them to:

The Prudential Insurance Company of America
Disability Management Services
Waiver of Premium Unit
P.O. Box 70183
Philadelphia, PA 19176

Or fax the completed forms to:

877-862-0269

If you have any questions, please call our Group Life Claim Division at 800-524-0542 and a customer service representative will assist you.

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 a statement of claim for payment of a loss or benefit commits a fraudulent insurance act, 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.

CALIFORNIA RESIDENTS— For your protection, California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

NEW JERSEY RESIDENTS— Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NEW YORK 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 fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

PENNSYLVANIA 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 fact thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

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.

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Group Insurance Employee's Statement To be completed by Employee. Please complete all five sections.

1 Employer/ Association Information

Employer's Name

Control Number/s

Location/Division

Branch Number/s

2 Employee Information

First Name

MI

Last Name

Social Security Number

Date of Birth (MM DD YYYY)

Gender
☐ Male ☐ Female

Marital Status
☐ Unmarried ☐ Divorced
☐ Married ☐ Widowed

Spouse Date of Birth (MM DD YYYY)

Youngest Child Date of Birth (MM DD YYYY)

Street

Suite

City

State

ZIP Code

Your Mailing Address (if different from home address)

Street

Suite

City

State

ZIP Code

Primary Telephone Number

Work Telephone Number

Education—Highest Level Completed
☐ Elementary ☐ High School ☐ College ☐ Graduate School

List trade schools attended or special training received

Date of Employment (MM DD YYYY)

Date Last Worked (MM DD YYYY)

Date First Treated for This Condition (MM DD YYYY)

Date First Absent (MM DD YYYY)

Date Work Resumed (MM DD YYYY)

Date Expected to Return to Work (MM DD YYYY)

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Employee's Social Security Number

2 Employee Information (Cont'd.)

Are you currently working at another occupation? ☐ Yes ☐ No

If yes, please provide occupation

Date of Hire (MM DD YYYY)

Are you currently seeking vocational assistance or retraining for another occupation? ☐ Yes ☐ No

Have you been approved for Social Security Disability Benefits or Canada/Quebec Pension Benefit because of disability? ☐ Yes ☐ No How many times have you applied?

Do you have Group Long Term Disability coverage with Prudential? ☐ Yes ☐ No

Have you converted your group coverage to an individual policy? ☐ Yes ☐ No

3 Job Information

Occupation

What Job Category best describes the claimant's functional abilities? (Please check the appropriate box)

☐ **Sedentary**	☐ **Light**	☐ **Medium**	☐ **Heavy**	☐ **Very Heavy**
Negligible Weight Mostly Sitting	Up to 10 lbs. frequently Up to 20 lbs. occassionally and/or Frequent Walk/Stand and/or Constant Push/Pull	Up to 25 lbs. frequently Up to 50 lbs. occassionally	25 to 50 lbs. frequently 50 to 100 lbs. occassionally	More than 50 lbs. frequently 100 lbs. occassionally

☐ **Other** (Please describe)

List your previous occupations

Job Title

Employer Name and Address

From (MM DD YYYY)

To (MM DD YYYY)

Job Title

Employer Name and Address

From (MM DD YYYY)

To (MM DD YYYY)

Prudential

Employee's Social Security Number

4 Primary Care Physician

Name of Attending Physician (Please print)

First Name | MI | Last Name

Primary Telephone Number | Fax Number

Office Address | Suite

City | State | ZIP Code

Specialty

5 Medical Information

Other Treating Physicians or Consultants

Name of Attending Physician (Please print)

First Name | Last Name

Specialty | Telephone Number

First Name | Last Name

Specialty | Telephone Number

List any hospital confinement for this disability

Name of Hospital and Address

Period Confined

From (MM DD YYYY)

To (MM DD YYYY)

Name of Hospital and Address

From (MM DD YYYY)

To (MM DD YYYY)

What medical condition is preventing you from working?

What impairment prevents you from performing the essential functions of your occupation or any other occupation?

If you are pregnant: Expected Delivery Date (MM DD YYYY) | Actual Delivery Date (MM DD YYYY)

Prudential

Employee's Social Security Number

5 Medical Information (Cont'd.)

Name of Health Insurance Company

Telephone Number

What are your hobbies and/or other special interests?

I hereby certify that these statements are complete and true:

Employee's Signature X

Date (MM DD YYYY)

The following authorization must also be completed by the employee. When completed by the employee, this form should be returned to the Group Policyholder together with the Attending Physician's Statement of Disability (Form GL.2003.019) completed by the doctor currently treating the employee. Medical proof must be submitted covering the period from date last worked to present. If the employee is being treated by more than one physician for their current disability, it will be beneficial to have each doctor complete an Attending Physician's Statement.

Authorization for Release of Information to Prudential Insurance Company
This Authorization is intended to comply with the HIPAA Privacy Rule

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided treatment, payment, or services to me or on my behalf ("My Providers") to disclose my entire medical record and any other health information concerning me to The Prudential Insurance Company of America (Prudential) and its agents, employees, and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

I authorize my insurance company, employer, the Social Security Administration, or other person or institutions to provide any information, data, or records relating to my Social Security, workers' compensation, credit, financial, earnings, activities, or employment history to Prudential.

Unless limits* are shown below, this form pertains to all of the records listed above.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct My Providers to release and disclose my entire medical record without restriction.

This information is to be disclosed under this Authorization so that Prudential may: 1) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 2) obtain reinsurance; 3) administer coverage; and 4) conduct other legally permissible activities that relate to any coverage I have or have applied for with Prudential.

This authorization shall remain in force for 24 months following the date of my signature below, while the coverage is in force, except to the extent that state law imposes a shorter duration. A copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to Prudential at: P.O. Box 70183, Philadelphia, PA 19176. I understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization or to the extent that Prudential has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that if I refuse to sign this authorization to release the entire medical record, Prudential may not be able to process my claim for benefits and may not be able to make any benefit payments. I understand that I have a right to receive a copy of this authorization.

*Limits, if any:

Signature of Insured/ Patient or Personal Representative X

Date (MM DD YYYY)

Description of Personal Representative's Authority or Relationship to Patient

Notice to Montana residents: You or your authorized representative are entitled to receive a copy of this Authorization, and upon request, a record of any subsequent disclosures of personal or privileged information.

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