



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





Grid for Social Security Number

2 Attending Physician Information (Cont'd.)

Was Claimant hospitalized? [] Yes [] No

If yes, please provide name and address of hospital

Three stacked text boxes for hospital name and address

If hospitalized, give dates:

From (MM DD YYYY)

Grid for start date

To (MM DD YYYY)

Grid for end date

Other Treating Physicians or Consultants

Name of Attending Physician (Please print)

First Name

Grid for first name

Last Name

Grid for last name

Specialty

Grid for specialty

Telephone Number

Grid for telephone number

First Name

Grid for first name

Last Name

Grid for last name

Specialty

Grid for specialty

Telephone Number

Grid for telephone number

Do you feel the claimant is competent to endorse checks and direct the use of proceeds? [] Yes [] No

Nature of Medical Impairment/Limitation (Please specify nature of corresponding loss of function)

Two stacked text boxes for medical impairment

Date when significant loss of function occurred: (MM DD YYYY)

Grid for date of loss of function

Are there corresponding medical restrictions? (i.e., What activities should the claimant not perform because of a significant risk to self or others?)

Two stacked text boxes for medical restrictions

Target Date (MM DD YYYY)

Grid for target date

Prognosis for Return to Function/Return to Work

Two stacked text boxes for prognosis

Return to Work Plan (Please describe)

Two stacked text boxes for return to work plan



