Prudential

Group Disability Insurance

The fastest way to file a claim is through our website.
After registration, you can file your claim and easily check on status in one place.
Visit **www.prudential.com/mybenefits** to get started.

The Prudential Insurance Company of America
Disability Management Services
P.O. Box 13480, Philadelphia, PA 19176
Tel: 800-842-1718 Fax: 877-889-4885
www.prudential.com/mybenefits

Employee Statement

1 Employer Information

Employer Name

Control Number

Location/Division

Branch Number

2 Employee Information

First Name

MI

Last Name

Address 1

Social Security Number

Address 2

City

State

Zip Code

Mobile/Cell Telephone Number

Home Telephone Number

Work Telephone Number

Birth Date (MM DD YYYY)

Sex assigned at birth

☐ Male ☐ Female

Marital Status

☐ Unmarried ☐ Married ☐ Divorced ☐ Widowed

Email Address

Date Last Worked (MM DD YYYY)

Date First Absent (MM DD YYYY)

Date First Treated for this Condition (MM DD YYYY)

Date Expected to Return to Work (MM DD YYYY)

Spouse's Date of Birth (MM DD YYYY)

Is Spouse Employed?

☐ Yes ☐ No

Education: Highest Grade Completed

Number of Children Under 18

Youngest Child's Date of Birth (MM DD YYYY)

3 Job Information

Occupation

Work State

What Job Category best describes the claimant's essential job duties? (Please check the appropriate box)

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

☐ **Other** (Please describe)

Prudential

Employee Social Security Number

4 Primary Care Physician (required)

Physician First Name | MI | Physician Last Name

Primary Telephone Number | Fax Number

Office Address | Suite

City | State | Zip Code

Specialty

5 Medical Information

All Other Physicians You Have Consulted for this Condition (Attach an additional sheet if necessary)

Physician First Name | Physician Last Name

Specialty | Telephone Number

Physician First Name | Physician Last Name

Specialty | Telephone Number

Physician First Name | Physician Last Name

Specialty | Telephone Number

What medical condition is preventing you from working?

How does this condition interfere with your ability to perform your job?

Have you ever been hospitalized for this condition? ☐ Yes ☐ No ☐ Inpatient ☐ Outpatient

If Hospitalized Give Dates (MM DD YYYY)
From | To

If You are Pregnant:
Estimated Delivery Date (MM DD YYYY) | Actual Delivery Date (MM DD YYYY)

Name of Your Health Insurance Company | Telephone Number

Dates of coverage

Prudential

Employee Social Security Number

6 Other Income and Workers' Compensation Information

What other income are you entitled to receive as a result of your disability? Please complete the chart below. Other Income type examples include but are not limited to: Individual Disability Benefits, Paid Family Leave, Third Party Liability payments, Unemployment Benefits, any other income.

Please send copies of any letters or notices approving or denying benefits.
Please respond "Yes" or "No" to each income source listed below.

Source	Applied for Yes	Applied for No	Amount	Frequency	Date Benefit Begins	Date Benefit Ends
Salary Continuance/ Sick Pay	☐	☐	.	☐ Weekly ☐ Monthly		
State Disability Benefits	☐	☐	.	☐ Weekly ☐ Monthly		
Social Security	☐	☐	.	☐ Weekly ☐ Monthly		
Workers' Compensation	☐	☐	.	☐ Weekly ☐ Monthly		
Automobile Liability Insurance	☐	☐	.	☐ Weekly ☐ Monthly		
Disability Paid by another carrier	☐	☐	.	☐ Weekly ☐ Monthly		
Pension/Retirement	☐	☐	.	☐ Weekly ☐ Monthly		
Other Income	☐	☐	.	☐ Weekly ☐ Monthly		

Have you received or are you pursuing a lump sum payment from any of the sources listed above? ☐ Yes ☐ No
If so, please provide the name, address, phone number of the parties involved (i.e., workers' compensation or auto insurance carrier, pension plan administrator or attorney)

_____

Are you currently working in any capacity? ☐ Yes ☐ No If yes, please explain _____

Is your disability a result of (check all that apply): ☐ Sickness ☐ Maternity ☐ MVA ☐ Other Accident ☐ Slip/trip/fall ☐ Work Related Injury/Illness

7 Go Paperless!

The Prudential website is a quick, secure way to review the status of your claim and view/print all claim-related correspondence. It also means less paper in your mailbox!

We highly recommend going paperless as it is good for your mailbox and it is good for the environment too! When you do that, you'll be able to easily view your documents on the web and you will stop receiving paper mail. You'll be notified via email when new documents are available. You can change your mind any time on the website. Please select your preference below:

☐ **Yes, email me the link for going paperless.**
Alternatively, you can also go to **www.prudential.com/mybenefits** yourself. After Registration, sign in to your account, go to "My Profile," scroll down to e-Delivery Consent Section, and select the "I agree" check box to go paperless.

☐ No, I prefer my correspondence to be mailed to me

Prudential

Employee Social Security Number

8 **Taxpayer Identification Number And Certification**

Prudential requires your Taxpayer Identification Number. The Taxpayer Identification Number is either the Social Security Number or the Employer Identification Number. If you:

- Are an individual, your Taxpayer Identification Number is the Social Security Number.
- Represent a trust or estate, the Taxpayer Identification Number is its Employer Identification Number.
- Represent a minor, please provide the minor's Social Security Number.
- Are applying for a Taxpayer Identification Number, please write "applied for" in the space provided.

TAXPAYER IDENTIFICATION NUMBER/FORM W-9 CERTIFICATION:
Under penalties of perjury, I certify that the number shown on this form is my correct Taxpayer Identification Number (Social Security Number). I further certify that the citizen/residency status I have listed on this form is my correct citizen/residency status. I am not subject to backup withholding because (a) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding, (b) the IRS has told me that I am no longer subject to a backup withholding order, or (c) I am exempt from backup withholding. I am exempt from FATCA reporting.

Social Security Number or Taxpayer Identification Number of beneficiary

Check all applicable boxes.

☐ **I have been notified by the Internal Revenue Service that I am subject to backup withholding due to underreporting of interest or dividends.**

☐ **I am subject to FATCA reporting.**

☐ **If not a U.S. person (including resident alien), submit the applicable Form W-8 (BEN, BEN-E, ECI, EXP or IMY).**

Date Signed (MM DD YYYY)

X_____
Signature

Prudential

Employee Social Security Number

9 Fraud Notice

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 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.

I have read and understand the terms and requirements of the fraud warnings included as part of this form. I certify that the above statements are true.

Claimant Signature X _____

Date (MM DD YYYY)

For residents of all states and jurisdictions except Alabama, Alaska, Arizona, Arkansas, California, Colorado, Delaware, the District of Columbia, Florida, Idaho, Indiana, Kentucky, Louisiana, Maine, Maryland, Minnesota, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Puerto Rico, Rhode Island, Tennessee, Texas, Utah, Vermont, Virginia, Washington and West Virginia; WARNING — Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person, or knowing that he or she 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.

ALABAMA RESIDENTS —Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

ALASKA RESIDENTS—A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

ARIZONA RESIDENTS—For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

ARKANSAS, DISTRICT OF COLUMBIA, LOUISIANA, MASSACHUSETTS, RHODE ISLAND and WEST VIRGINIA RESIDENTS—Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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

COLORADO RESIDENTS—It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

DELAWARE RESIDENTS—Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

IDAHO RESIDENTS—Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement containing any false, incomplete, or misleading information is guilty of a felony.

INDIANA RESIDENTS—A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

KENTUCKY RESIDENTS—Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

MAINE, TENNESSEE, VIRGINIA, and WASHINGTON RESIDENTS - It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

MARYLAND RESIDENTS—Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

MINNESOTA RESIDENTS—A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NEW HAMPSHIRE RESIDENTS—Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638.20.

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.

NEW MEXICO RESIDENTS–ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

NORTH CAROLINA RESIDENTS—Any person who, with the intent to injure, defraud, or deceive an insurer or insurance claimant, knowing that the statement contains false information concerning a fact or matter material to the claim may be guilty of a class H felony.

OHIO RESIDENTS—Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

OKLAHOMA RESIDENTS—WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete, or misleading information is guilty of a felony.

OREGON RESIDENTS—Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurance company, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

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.

PUERTO RICO RESIDENTS—Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances [be] present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

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.

Prudential

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Group Disability Insurance Authorization

1 Claimant's Information

First Name | MI | Last Name

Claim Number | Social Security Number (Last four digits) | Employee Phone Number

Date of Birth (mm yyyy) | Control Number

2 Authorization for Release of Information to The Prudential Insurance Company

This authorization is intended to comply with the HIPAA Privacy Rule.

I authorize and instruct any health plan, physician, health care professional, medical professional, hospital, clinic, laboratory, pharmacy, clearinghouse, data warehouse, or other organization that aggregates and maintains pharmacy data, MIB, Inc. (formerly known as the Medical Information Bureau), medical facility, or other health care provider or insurance company or producer that has provided treatment, payment, or services to me or on my behalf ("My Providers") to disclose my entire medical record and any other information concerning me or my mental or physical health 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 any 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.

For purposes of this Authorization, I acknowledge that any agreements I have made with My Providers that restricts the disclosure of my protected health information as described above do not apply to this Authorization and I instruct My Providers to release and disclose my entire medical record without restriction, including any restrictions on health care items or services for which a healthcare provider has been paid out of pocket in full.

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Group Disability Insurance Authorization

First Name | MI | Last Name | Claim Number

2

Authorization for Release of Information to The Prudential Insurance Company

This authorization is intended to comply with the HIPAA Privacy Rule.

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 or benefits 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 13480, Philadelphia, PA 19176. I understand that a revocation is not effective to the extent that any of My Providers or Prudential has relied on this Authorization or to the extent that Prudential has a legal right to contest a claim under any insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and will no longer be protected by the HIPAA Privacy Rule 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 the right to receive a copy of this Authorization.

Authorization for Release of Information to The Prudential Insurance Company.

Date (mm dd yyyy)

X _____

Employee Signature (indicate how related if signed by other than claimant)

Prudential

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www.prudential.com/forphysicians

Attending Physician Statement

1 Employee Information

Employer's Name

Control Number (required)

Employee First Name

MI

Last Name

Claim Number

Social Security Number

Date of Birth (MM DD YYYY)

Gender ☐ Male ☐ Female

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

Employee Signature X

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 Code is Required**

Primary:

Secondary:

Secondary:

Pregnancy EDC (MM DD YYYY)

Actual Delivery Date (MM DD YYYY)

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

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

Return to Work Target Date (MM DD YYYY)

☐ Full-Time ☐ Part-Time ☐ With Limitations (functions lost)

Please describe Return to Work Plan and provide any corresponding Limitations:

Please describe any Medical Obstacles to Return to Work:

Nature of Medical Impairment (i.e., loss of function):

Are there any Non-Medical Factors which have a significant impact on Functional Abilities (i.e., interpersonal, financial, family)?

Check all that apply to this disability:

Work Related	Accident	Sickness	Maternity	Motor Vehicle Accident	If MVA, in what State did it occur?
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	

Other Treating Physicians or Consultants:

First Name

Last Name

Specialty

Telephone Number

Prudential

Employee First Name | MI | Last Name

Claim Number | Date of Birth (MM DD YYYY) | Employee's Social Security Number

2 Attending Physician Information (Cont'd)

Other Treating Physicians or Consultants

First Name | Last Name

Specialty | Telephone Number

Date of Surgical Procedure (MM DD YYYY)

Relevant tests and surgical procedure (s) performed (please be specific):

Current Medications, Treatment, and Prognosis:

First Visit (MM DD YYYY) | Last Visit (MM DD YYYY) | Next Visit (MM DD YYYY) | Was Claimant hospital confined? ☐ Yes ☐ No

If yes, please provide name and address of hospital:

From (MM DD YYYY)

To (MM DD YYYY)

3 Physician Information

First Name | MI | Last Name

Primary Telephone Number | Fax Number

Office Address | Suite

City | State | ZIP Code

Specialty

4 Fraud Notice

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.

I have read and understand the terms and requirements of the fraud warning and I certify the above statements are true.

Physician Signature X

Date (MM DD YYYY)

Prudential

Group Insurance

The Prudential Insurance Company of America
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Tel: 800-842-1718 Fax: 877-889-4885
www.prudential.com/mybenefits

Group Insurance
Electronic Funds Transfer Authorization

1 Enrollment

To enroll in Prudential's Electronic Funds Transfer (EFT) payment service, please provide the following information. If you elect to have Prudential deposit the funds in your savings or checking account, you must first check with your bank to obtain the correct bank transit routing number and account number for electronic deposit. Please note that a deposit slip does not contain acceptable banking information. If you have any questions, please call us toll free at 800-842-1718.

***Please note that not all policies are designed to participate in the Electronic Funds Transfer option. Contact your employee benefits representative or plan trustee for details.**

2

Employer's Name

Control Number (required)

Claimant's First Name

MI

Last Name

Claim Number

Social Security Number

Primary Phone Number

3 Banking Information

Bank Name

Branch Phone Number

Type of Account (Select One)

☐ Savings ☐ Checking

Bank Transit Routing Number

(NINE-DIGIT BANK TRANSIT ROUTING NUMBER)

Bank Account Number

(BANK ACCOUNT NUMBER)

4 Payment Plan Agreement

I authorize the Prudential Insurance Company of America to make electronic fund deposits of my benefit payment to my account. I understand that any deposit made to an inactive account will be returned to Prudential and reissued as a manual check. In addition, if any overpayment of such benefits is credited to my account in error, I authorize Prudential to withdraw any payments necessary in order to assure the accuracy of my claim payments.

I can cancel this authorization at any time by giving Prudential written notice. Any notice hereunder will not be deemed effective until Prudential has received my written notice.

Account Owner

First Name

MI

Last Name

Street

Apartment

City

State

ZIP Code

Date Signed (MM DD YYYY)

X

Signature

Prudential

5

Instructions for Completing Section 3, "Banking Information"

This will help you identify the necessary bank information to initiate electronic withdrawals. The nine-digit transit routing number is how we recognize the bank you do business with.

Record all banking information on page 1 of the form in Section 3, "Banking Information". Please call your bank to confirm that the information you are supplying is correct.

Customer XYZ
XYZ Street
City, State, ZIP

Check No. 1246

PAY TO THE ORDER OF _____ $ _____

Dollars

_____

Bank XYZ
UXYZ Street
City, State, ZIP

A27202754 006666D66666C 1246

This is the bank transit routing number.

It is always nine digits and appears between the ":" symbols.

Record this number in the boxes provided in Section 3, "nine-digit bank transit routing number."

This is your bank account number. It varies in number of digits and may include dashes or spaces.

The "<" symbol indicates the end of the account number.

Record the account number in the boxes provided in Section 3, "Bank Account Number" and include any dashes and spaces that are within the account number.

If there are any digits to the right of the "<" symbol (which do not represent the check sequence number), record them in the boxes provided.

This is the check sequence number. It may be on either end of your check. Please do **not** include this on the authorization form.

*This page consists only of **Instructions**: It is not necessary to return this page with your EFT Authorization.*