Instructions to File a Claim for Disability Benefits

1. Complete all Sections of the Employee Statement.
2. Read the Tax Notice and complete it for voluntary Federal Income Tax withholding from disability benefit payments.
3. Ask your Doctor to complete an Attending Physician's Statement.
4. Submit these completed forms according to the directions you received from your Benefits Office.

The Prudential Insurance Company of America
Disability Management Services
P0 Box 13480, Philadelphia, PA 19101
Voice: 1-800-842-1718
Facsimile: 1-877-889-4885

For your protection, certain state laws require the following to appear on this form:

California Residents Notice - Section 1879.2 of the California Statutes regarding Insurance Fraud requires us to inform you of the following law: "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."

Colorado Residents Notice - Section 10-1 -1 27(7)(a) of the Colorado Statutes regarding Insurance Fraud requires us to inform you of the following law: "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, civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regards to a settlement of award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies."

Delaware Residents Notice - Section 11.913(b) of the Delaware Statutes regarding Insurance Fraud requires us to inform you of the following law: "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."

Florida Residents Notice - Section 81 7.234(1)b of the Florida Statutes regarding "False and Fraudulent Insurance Claims" requires us to inform you of the following law: "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."

Idaho Residents Notice - Section 41 -1 331 of the Idaho Statutes regarding Insurance Fraud requires us to inform you of the following law: "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 Notice - Section 27-2-16-3 of the Indiana Statutes regarding Insurance Fraud requires us to inform you of the following law: "Any 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."

New York Residents Notice - Section 28:4-403(d) of the New York Statute regarding Insurance Fraud requires us to inform you of the following law: "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."

Oklahoma Residents Notice - Section 36 3613.1 of the Oklahoma Statute regarding Insurance Fraud requires us to inform you of the following law: "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."

Pennsylvania Residents Notice - Section 18 Pa. C.S. 411 7(k)(l) of the Pennsylvania Statute regarding Insurance Fraud requires us to inform you of the following law: "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 subjects such person to criminal and civil penalties."

Prudential Financial

Group Disability Insurance
Employee Statement

1 Employer Information

Employer Name

Control Number

Location / Division

Branch Number

2 Employee Information

First Name

MI

Social Security Number

Last Name

Suffix

Mailing Address - Line 1

Mailing Address - Line 2

Birth date (MM/DD/Year)

City

State

Zip Code

Gender

- Male
- Female

Marital Status

- Unmarried
- Married
- Divorced
- Widowed

Primary Phone Number

Work Phone Number

Email Address

Date Last Worked (MM/DD/Year)

Date First Absent

Date First Treated for this Condition

Date Expected to Return to Work

Spouses Date of Birth

Is Spouse Employed? Yes No

EDUCATION:
Highest Grade Completed:

Number of Children Under 18:

Age of Youngest Child:

3 Job Information

Occupation

What Job Category best describes your required job duties? (Please check appropriate box)

Sedentary	Light	Medium	Heavy	Very Heavy	Other
Negligible Weight Mostly Sitting	Up to 10 lbs. frequently Up to 20 lbs. occasionally and / or Frequent Walk/Stand and / or Constant Push/Pull	10 to 25 lbs. freq. Up to 50 lbs. occ.	25 to 50 lbs. freq. 50 to 100 lbs. occ.	More than 50 lbs. freq. 100 lbs. occasionally	(Please describe below)

4 Primary Care Physician

Physician Name

Primary Phone Number

Street Address

Fax Number

City

State

Zip Code

For Internal Use Only

Claim Number

* 1 0 1 A 0 1 *

The Prudential Insurance Company of America
Disability Management Services
PO Box 13480, Philadelphia, PA 19101
Tel: 1-800-842-1718 Fax: 1-877-889-4885

Prudential Financial

Group Disability Insurance
Employee Statement

Employee Last Name

Social Security Number ___ - ___ - ____

5 Medical Information

All Other Physicians You Have Consulted for this Condition

Physician Name	Specialty	Phone Number

What medical condition is preventing you from working? _____

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

Have you been hospitalized for this condition? ☐ Yes ☐ No ☐ In-Patient ☐ Out-Patient

If hospitalized, give dates:
From: __ / __ / ____
To: __ / __ / ____

If you are pregnant: Estimated Delivery Date __ / __ / ____ Actual Delivery Date __ / __ / ____

Name of Your Health Insurance Company

Telephone Number ___ - ___ - ____

6 Other Income & Workers' Comp. Information

What other income are you entitled to receive as a result of your disability? (Examples: Social Security Disability or Retirement Benefits, Workers' Compensation, State Disability, Pension Disability or Retirement, No-Fault Auto Insurance, Salary Continuance, Group Life or Disability Plan, Health or Welfare Plan, Individual Disability Benefits.) **Please send copies of any letters or notices approving or denying benefits.**

Source	Applied For Yes	Applied For No	Amount	Frequency	Date Benefit Begins	Date Benefit Ends
Salary Continuance						
State Disability Benefits	☐	☐				
Workers' Compensation	☐	☐				
Other: _____	☐	☐				
Other: _____	☐	☐				

Is this condition work related? ☐ Yes ☐ No If Yes, do you intend to file a Workers' Compensation claim? ☐ Yes ☐ No

7 Fraud Notice

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. This includes Employer and Attending Physician portions of the claim form. (Please see state specific fraud warnings attached.)

X _____ __ / __ / ____

Employee Signature Date Signed

Prudential Financial

Group Disability Insurance Medical Authorization and Tax Notice

First Name | MI | *Social Security Number*

Last Name | Suffix

1 Authorization To Release Medical Information

PERSONS OR INSTITUTIONS: This authorizes you to give The Prudential Insurance Company of America, its affiliates and representatives, any information, data or records you have regarding my medical history and treatment (including records pertaining to psychiatric, drug or alcohol use, and any medical condition I may now have or have had), and any information, data or records regarding my activities (including records relating to my Social Security, Workers' Compensation, credit, financial, earnings and employment history) needed to evaluate my claim for benefits. I understand that any such information obtained may be provided to a person or agency requested by Prudential to assist with this purpose. This authorization is valid during the dependency of my claim. I understand that I have the right to request and receive a copy of this authorization. A photocopy of this authorization is as valid as the original.

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

This information is for the sole use of Prudential or the group contract holder which will process the claim. Unless the law requires it, information will not be given in an identifiable form to any other persons unless I agree to its release in writing.

I can revoke this authorization by giving notice to Prudential. The notice will not apply to information released before the date Prudential has the notice. If not revoked, this authorization will be valid while the claim is pending, but not more than one year from the date it is signed.

I agree that a photocopy of this form will be valid as the original.

*Limits, if any: _____

_____

X _____ / /

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

2 Tax Notice

Benefits provided under your Group Disability Income Plan may be subject to federal, state and local taxation. Contact your employee benefits representative or disability plan trustee for details on your rights and obligations under the various tax codes. If you wish to have Federal Income Tax (FIT) withheld from any payments you may receive, indicate the amount to be withheld below and sign the authorization. Withholding requests may also be submitted on IRS Form W-4S. Withholding requests must be stated in whole dollar amounts. FIT will not be withheld if the disability benefit is not taxable.

I request voluntary Federal Income Tax withholding from each payment, as authorized under section 3402(c) of the Internal Revenue Code, in the amount(s) of:

For STD .00 weekly ($20.00 minimum)

For LTD .00 monthly ($88.00 minimum)

X _____ / /

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

For Internal Use Only

Claim Number

* 1 0 4 A 0 1 *

The Prudential Insurance Company of America
Disability Management Services
PO Box 13480, Philadelphia, PA 19101
Tel: 1-800-842-1718 Fax: 1-877-889-4885

Prudential Financial

Group Disability Insurance Employer Statement

1 Employer Information

Employer Name

Control Number

Address

Branch Number

City

State

Zip Code

Employer Phone Number

Email Address

2 Employee Information

First Name

MI

Social Security Number

Last Name

Suffix

Coverage in force when absence began (check all that apply): ☐ STD ☐ LTD

Employee Phone Number

Gender ☐ Male ☐ Female

STD Coverage Selected ☐ Core ☐ Optional _____

LTD Coverage Selected ☐ Core ☐ Optional _____

Date employee became a covered individual for the applicable Coverages:

STD: / /

LTD: / /

Date Hired (MM/DD/Year) / /

Coverage Termination Date / /

Date Last Worked / /

Date First Absent / /

Date Work Was Resumed / /

Normal Earnings Prior To This Absence (exclude bonus, overtime, etc.)

$, .

Frequency of Normal Earnings

☐ Hourly ☐ Monthly
☐ Weekly ☐ Annually
☐ Bi-Weekly ☐ Other _____

Last Date Employer Paid Any Compensation / /

Work Hours

Is the employee's work week Monday thru Friday? ☐ Yes ☐ No

Number of hours worked per normal work week:

If not Mon thru Fri, Check Days Worked

☐ Varies ☐ Wednesday ☐ Saturday
☐ Monday ☐ Thursday ☐ Sunday
☐ Tuesday ☐ Friday

Employment Status

☐ Salary
☐ Hourly
☐ Other _____

Does employee contribute toward the **STD** Premium? ☐ Yes ☐ No

If Yes: ☐ Pre Tax ☐ Post Tax

If Post Tax:

_____ % paid by employer

_____ % paid by employee

Does employee contribute toward the **LTD** Premium? ☐ Yes ☐ No

If Yes: ☐ Pre Tax ☐ Post Tax

If Post Tax:

_____ % paid by employer

_____ % paid by employee

For Internal Use Only

Claim Number

* 1 0 2 A 0 1 *

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Disability Management Services
PO Box 13480, Philadelphia, PA 19101
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Prudential Financial

Group Disability Insurance Employer Statement

Employee Last Name ________________________ Social Security Number ___ - __ - ____

2 Employee Information (Continued)

Is employee covered under a Prudential Group Life Insurance Policy? ☐ Yes ☐ No

If Yes, what is the Face Amount? $ _ , ___ , ___ .00

3 Other Income, Deductions & Workers' Comp. Information

Please indicate any applicable deductions, such as Local Tax, State Income Tax, Medical, Dental, Life, 401K, that should be withheld from the employee's benefits, if approved. Please also indicate if the employee is receiving, or is eligible to receive, benefits from any other sources because of this absence, such as Salary Continuance, Workers' Compensation, Social Security Disability or Retirement Benefits, Statutory Benefits, No Fault Auto Insurance, Retirement or Pension Plan. Please send copies of any letters or notices approving or denying benefits.

Source	Applied For Yes	Applied For No	Amount	Frequency	Date Benefit Begins	Date Benefit Ends
Salary Continuance						
State Disability Benefits	☐	☐				
Workers' Compensation	☐	☐				
Other: ______________	☐	☐				
Other: ______________	☐	☐				

Has the employee indicated that the absence is work related? ☐ Yes ☐ No

Has a Workers' Compensation claim been filed? ☐ Yes ☐ No

4 Job Information

Occupation ________________________ DOT Job Code: ____________

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

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

____

____

As the employer, would you be able to accommodate modified duty to facilitate early return to work? ☐ **Yes** ☐ **No**

If Yes, please explain (reduced hours, job modification, etc):______________________________

____

5 Fraud Notice

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. This includes the Employee and Attending Physician portions of the claim form.

X ______________________________ __ / __ / ____

Employer Signature Date Signed

* 1 0 2 A 0 2 *

Prudential Financial

Group Disability Insurance
Attending Physician's Statement

1 To Be Completed By Employee

Employer/Association Name

Control Number

Employee First Name | MI | ***Social Security Number*** ___ - __ - ____

Employee Last Name | Suffix

Employee Address - Line 1 | Birth date (MM/DD/Year) __ / __ / ____

Employee Address - Line 2 | Gender ☐ Male ☐ Female

City | State | Zip Code ____ - ____

Occupation

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

X _____ __ / __ / ____

Employee Signature | Date Signed

2 To Be Completed By Attending Physician

Clinical Diagnosis | ICD-9 Code | Pregnancy EDC __ / __ / ____

Primary: _____ ___ . __

Secondary: _____ ___ . __

Secondary: _____ ___ . __

Relevant test procedures performed (Please provide results) _____

Surgical procedure(s) performed (Please be specific): Date of Procedure: __ / __ / ____

Current Medications: _____

For Internal Use Only

Claim Number

* 1 0 3 A 0 1 *

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Prudential Financial

Group Disability Insurance
Attending Physician's Statement

Employee Last Name

Social Security Number ___ - ___ - ____

2 Attending Physician Information (Cont'd)

Was Claimant hospital confined? ☐ Yes ☐ No

If Yes, please provide name and address of hospital:

_____

_____

If hospitalized, give dates:
From: __ / __ / ____
To: __ / __ / ____

Other Treating Physicians or Consultants

Physician Name	Specialty	Phone 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) _____

Date when significant loss of function occurred: __ / __ / ____

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

Prognosis for Return to Function / Return to Work: _____

Return to Work Plan (Please describe): Target Date: __ / __ / ____

Prudential Financial

Group Disability Insurance
Attending Physician's Statement

Employee Last Name

Social Security Number ___ - ___ - ____

2 Attending Physician Information (Cont'd)

Describe Medical Obstacles to Return to Work: _____

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

Work related illness or injury? ☐ Yes ☐ No

Was Condition caused by a MVA? ☐ Yes ☐ No

If MVA, in what state did it occur? ☐☐

First Visit ☐☐ / ☐☐ / ☐☐☐☐

Last Visit ☐☐ / ☐☐ / ☐☐☐☐

Frequency of Visits: _____

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

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

3 Physician Information

Physician Name

Primary Phone Number ___ - ___ - ____

Office Address

Fax Number ___ - ___ - ____

City

State ☐☐ Zip Code ☐☐☐☐☐ - ☐☐☐☐

Specialty

4 Fraud Notice

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

X _____ ☐☐ / ☐☐ / ☐☐☐☐

Physician Signature — Date Completed

103A03

Prudential Financial

Group Disability 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 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**.

2 Claimant Information

Employer Name

Claimant First Name

Last Name

Social Security Number ___ - __ - ____

Primary Phone Number ___ - ___ - ____

3 Banking Information

Bank Name

Branch Telephone Number ___ - ___ - ____

Type of Account (Select One)

☐ Savings ☐ Checking

Bank Transit Routing Number

(Nine digit bank transit routing)

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 disability 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 disability 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 Name

Street Address

City

State

Zip Code ____ - ____

X _____ __ / __ / ____

Account Owner Signature *Date Signed*

For Internal Use Only

Claim Number

* 1 1 3 A 0 1 *

The Prudential Insurance Company of America
Disability Management Services
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Prudential Financial

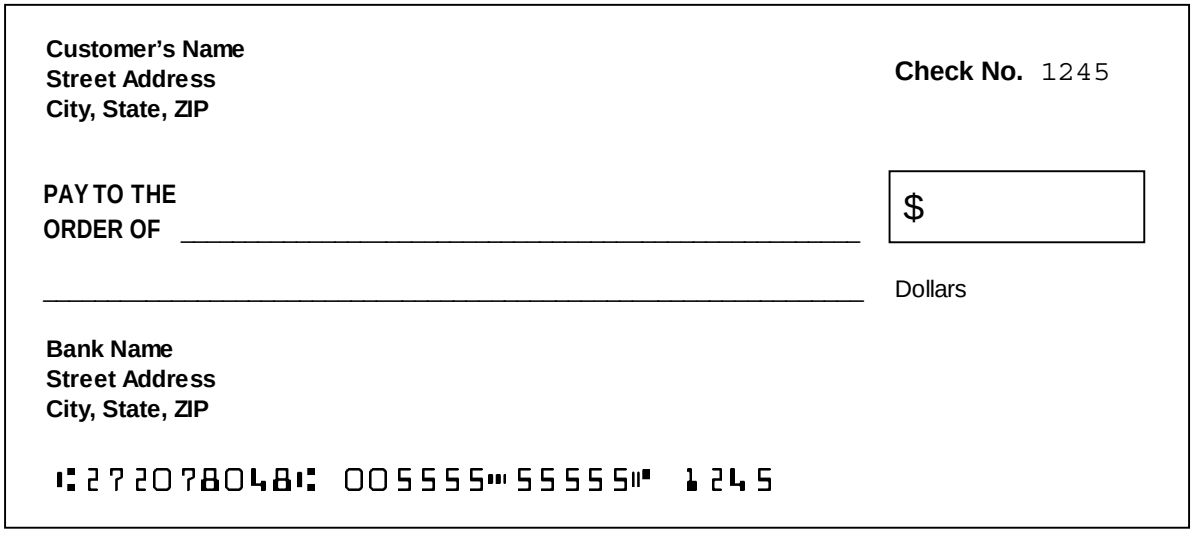
Group Disability Insurance
Electronic Funds Transfer Authorization

Instructions Only: It is not necessary to return this page with your EFT Authorization.

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.



This is the bank transit routing number.

It is always 9 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.