Disability Claim Instructions

1. Notify your employer of your absence, that you will be filing a claim and request they provide Prudential with their Employer’s Statement.
2. Complete all Sections of the Employee’s Statement.
3. Ask your Doctor to complete the Attending Physician’s Statement.
4. Have these statements submitted according to the directions you received from your Benefits Office.
5. If you wish to have voluntary Federal Income Tax withholding from disability benefit payments, read and complete the Tax Notice.

In order for a claim for benefits to be considered filed, Prudential requires an employee’s statement, employer’s statement, and attending physician’s statement to be submitted.

Your Claim Will Be Considered Filed When:

- If you have STD coverage with Prudential, your claim for STD benefits will be considered filed the later of (1) when we receive the employee’s statement, the employer’s statement and the attending physician’s statement, and (2) the start of your STD Elimination Period.
- If you have LTD coverage with Prudential, your claim for LTD benefits will be considered filed the later of (1) when we receive the employee’s statement, the employer’s statement, and the attending physician’s statement, and (2) the date that is 45 days before the end of your LTD Elimination Period.
- If you have both STD and LTD coverages with Prudential and you have filed a claim for STD, there is no need to re-submit the statements noted above for the LTD portion of your claim. However, your claim for LTD benefits will be considered filed in this case the later of (1) when we receive the statements indicated above; and (2) the date that is 45 days before the end of your LTD Elimination period, provided you are receiving STD benefits on that date. If you are approved for STD benefits at a later date, your LTD claim will be considered filed on the date of the STD approval.
For residents of all states except California, Florida, New Jersey, New York, Pennsylvania, Utah, Vermont, Virginia and Washington: 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 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.

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.

FLORIDA RESIDENTS— Any person knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing false, incomplete, or misleading information is guilty of a felony of the third degree.

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 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.

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.

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.

WASHINGTON RESIDENTS— Any person who knowingly provides false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company commits a crime. Penalties include imprisonment, fines, and denial of insurance benefits.
### 1. Employer Information
- Employer Name
- Location / Division

### 2. Employee Information
- **First Name**
- **MI**
- **Last Name**
- **Suffix**
- **Mailing Address - Line 1**
- **Mailing Address - Line 2**
- **City**
- **State**
- **Zip Code**
- **Birth date (MM/DD/Year)**
- **Gender**
- **Marital Status**
- **Email Address**
- **Primary Phone Number**
- **Work Phone Number**
- **Date Last Worked (MM/DD/Year)**
- **Date First Absent**
- **Date First Treated for this Condition**
- **Is Spouse Employed?**
- **Spouses Date of Birth**
- **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**

### 4. Primary Care Physician
- **Physician Name**
- **Street Address**
- **City**
- **State**
- **Zip Code**
- **Primary Phone Number**
- **Fax Number**
Medical Information

All Other Physicians You Have Consulted for this Condition

<table>
<thead>
<tr>
<th>Physician Name</th>
<th>Specialty</th>
<th>Phone Number</th>
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</tbody>
</table>

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 you are pregnant:

Estimated Delivery Date: / / 
Actual Delivery Date: / / 

Name of Your Health Insurance Company: ____________________________
Telephone Number: - - -

Other Income & Workers’ Compensation 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.)

<table>
<thead>
<tr>
<th>Source</th>
<th>Applied For</th>
<th>Amount</th>
<th>Frequency</th>
<th>Date Benefit Begins</th>
<th>Date Benefit Ends</th>
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<tr>
<td>Salary Continuance</td>
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<td>State Disability Benefits</td>
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<td>Workers’ Compensation</td>
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<td>Other:</td>
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<td>Other:</td>
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</table>

Is this condition work related? | Yes | No

If Yes, do you intend to file a Workers’ Compensation claim? | Yes | No

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 ____________________________  Date Signed: / / 

Employee Signature: ____________________________
Employer Statement

1 Employer Information

Employer’s Name

Street

Suite

City

State

ZIP Code

Employer’s Telephone Number

Extension

Email Address

Control Number (required)

STD Branch (required)

LTD Branch (required)

2 Employee Information

First Name

MI

Last Name

Social Security Number

Address 1

Address 2

City

State

Zip

Employer's Name

Street

Suite

City

State

ZIP Code

Employer’s Telephone Number

Extension

Email Address

Control Number (required)

STD Branch (required)

LTD Branch (required)

First Name

MI

Last Name

Social Security Number

Address 1

Address 2

City

State

Zip

Employer's Name

Street

Suite

City

State

ZIP Code

Employer’s Telephone Number

Extension

Email Address

Control Number (required)

STD Branch (required)

LTD Branch (required)

Please check the type of claim you are filing. Check all that apply:

STD Core

LTD Core

TDB (NJ)

STD Supplemental

LTD Supplemental

DBL (NY)

VDI (CA)

Coverage Effective Date (the date the employee became covered under the policy)

LTD:

Date Hired (MM DD YYYY)

Coverage Termination Date (MM DD YYYY)

Last Date Employer Paid Compensation (MM DD YYYY)

Employment Status

Salaried Employee

Hourly Employee

Other

Gender

Male

Female

Normal Earnings Prior to this Absence (exclude bonus, overtime, etc.)

$ Hour Week Bi-Weekly (every two weeks)

Month Year Other

If employee does not work Monday thru Friday, check days worked:

Varies

Wednesday

Saturday

Monday

Thursday

Sunday

Tuesday

Friday

Is the employee subject to FICA Withholding?

Yes

No

If “No” indicate reason


How was the STD premium paid for the plan year in which the disability occurred? ________% paid by employer

How was the LTD premium paid for the plan year in which the disability occurred? ________% paid by employer

Was the premium amount paid by the employer included in the employee’s W-2?

Yes

No

Has either percentage changed within the last 3 years?

Yes

No

Has the employee’s W-2?

Yes

No

Has either percentage changed within the last 3 years?

Yes

No

Has the employee’s W-2?
3 Other Income, Deductions and Workers' Compensation 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.

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<td>Dental Deduction</td>
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<td>Vision Deduction</td>
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<tr>
<td>Life Deduction</td>
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<td>Other</td>
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</table>

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 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

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 Life Insurance

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

If Yes, what is the Face Amount?  
$  

6 Fraud Notice

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Employer Signature X

Date (MM DD YYYY)

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Group Disability Insurance

Attending Physician Statement

1 Employee Information

Employer’s Name
Employee First Name  MI  Last Name
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  

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 is Required  Pregnancy EDC (MM DD YYYY)  Actual Delivery Date (MM DD YYYY)
Primary:
Secondary:
Secondary:

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:

Check all that apply to this disability:

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

Other Treating Physicians or Consultants

First Name  Last Name
Specialty

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

*12301*  *12301*  * 1 2 3 0 1 *
Attending Physician Information (Cont’d.)

Other Treating Physicians or Consultants

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<th>First Name</th>
<th>Last Name</th>
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</table>

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

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

Return to Work Target Date (MM DD YYYY)

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)?

Physician Information

<table>
<thead>
<tr>
<th>First Name</th>
<th>MI</th>
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</tbody>
</table>

Primary Telephone Number

Fax Number

Office Address

Suite

City

State

ZIP Code

Specialty

Physician Information

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Fraud Notice

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Physician Signature

Date (MM DD YYYY)

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Group Disability Insurance Employee Tax Notice

1 Employee Information

First Name   MI   Last Name

Social Security Number   Employee Phone Number

Email Address

Employer’s Name   Control Number

2 Federal and State Withholding

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 ($20 weekly minimum for STD/$88 monthly minimum for LTD) 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:

- or STD $0.00 weekly ($20.00 minimum)
- or LTD $0.00 monthly ($88.00 minimum)

3 Employee Signature

X  

Employee Signature

*Notice to all parties completing this form: It is fraudulent to fill out this form with information you know to be false or to omit important facts. Criminal and/or civil penalties can result from such acts.
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 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.

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 13480, 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 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 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 the right to receive a copy of this authorization.

*Limits, if any:

Date (MM DD YYYY)
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.

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

**Employer’s Name**

**Claimant’s First Name**

**MI**

**Last Name**

**Social Security Number**

**Primary Phone Number**

**Bank Name**

**Branch Phone Number**

**Type of Account**

☐ Savings

☐ Checking

**Bank Transit Routing Number**

**Bank Account Number**

**Account Owner**

**First Name**

**MI**

**Last Name**

**Street**

**Suite**

**City**

**State**

**ZIP Code**

**Date Signed (MM DD YYYY)**

**Signature**
This will help you identify the necessary bank information to initiate electronic withdraws. 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

PAY TO THE ORDER OF

Check No. 1246

Bank XYZ
UXYZ Street
City, State, ZIP

A27202754 006666D66666C 1246

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.

*11302*

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