



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/disability>

Disability Claim Instructions

Submitting a Claim

The first three steps are required.

1. Notify your employer of your absence. Inform your employer that you'll be filing a disability claim. Ask your employer to complete the **Employer's Statement** and submit it to Prudential.
2. Complete all sections of the **Employee's Statement** and submit it to Prudential.
(If you prefer, you may complete and submit the Employee's Statement online. Go to www.prudential.com/disability. Your online submission will save time at the beginning of your claim-filing process.)
3. Ask your doctor to complete the **Attending Physician's Statement** and submit it to Prudential. Check with your Benefits Office to see if there are any additional requirements.

Steps 4 through 6 are voluntary.

4. Complete all sections of the **Group Disability Insurance Authorization**.
(If additional medical information is needed to review your claim, submitting this form now may reduce the time needed to reach a decision.)
5. If you want voluntary Federal Income Tax withheld from your disability benefit payments — read and complete the **Group Disability Insurance Tax Notice**.
6. If you want electronic fund deposits of your disability benefit payments — read and complete the **Group Disability Insurance Electronic Funds Authorization**.

Prudential considers a claim to be filed when the **Employer's Statement, Employee's Statement, and Attending Physician's Statement** have been submitted, and specific elimination period requirements have been met — as specified below.

- **If you have Short-Term Disability (STD) coverage** with Prudential, your claim for STD benefits will be considered filed, when you meet **both** of these two criteria. **1** We receive the Employee's Statement, the Employer's Statement, and the Attending Physician's Statement. **2** Your STD elimination period has started.
- **If you have Long-Term Disability (LTD) coverage** with Prudential, your claim for LTD benefits will be considered filed, when you meet **both** of these two criteria. **1** We receive the Employee's Statement, the Employer's Statement, and the Attending Physician's Statement. **2** The date 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 resubmit the statements noted above for the LTD portion of your claim.

Your claim for LTD benefits, in this case, will be considered filed, when you meet **both** of these two criteria. **1** We receive the Employee's Statement, the Employer's Statement, and the Attending Physician's Statement. **2** The date is 45 days before the end of your LTD elimination period.

Note: 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.

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For residents of all states except California, District of Columbia, 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.

DISTRICT OF COLUMBIA 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.

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 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.

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4 Primary Care Physician

Physician First Name	MI	Physician Last Name
<input type="text"/>	<input type="text"/>	<input type="text"/>
Primary Telephone Number	Fax Number	
<input type="text"/>	<input type="text"/>	<input type="text"/>
Office Address	Suite	
<input type="text"/>	<input type="text"/>	
City	State	ZIP Code
<input type="text"/>	<input type="text"/>	<input type="text"/>
Specialty		
<input type="text"/>		

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

Physician First Name	Physician Last Name
<input type="text"/>	<input type="text"/>
Specialty	Telephone Number
<input type="text"/>	<input type="text"/>
Physician First Name	Physician Last Name
<input type="text"/>	<input type="text"/>
Specialty	Telephone Number
<input type="text"/>	<input type="text"/>
Physician First Name	Physician Last Name
<input type="text"/>	<input type="text"/>
Specialty	Telephone Number
<input type="text"/>	<input type="text"/>

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)	Return to Work Target Date (MM DD YYYY)
From	To
<input type="text"/>	<input type="text"/>

If You are Pregnant:	
Estimated Delivery Date: (MM DD YYYY)	Actual Delivery Date (MM DD YYYY)
<input type="text"/>	<input type="text"/>

Name of Your Health Insurance company	Telephone Number
<input type="text"/>	<input type="text"/>



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6 Other Income and 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.)

Please send copies of any letters or notices approving or denying benefits.

Source	Applied for		Amount	Frequency		Date Benefit Begins			Date Benefit Ends		
	Yes	No		Weekly	Monthly						
Salary Continuance	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>						
State Disability Benefits	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>						
Social Security	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>						
Workers' Compensation	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>						
Medical Deduction	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>						
Dental Deduction	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>						
Vision Deduction	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>						
Life Deduction	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>						
Other	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>						

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 the Employer and Attending Physician portions of the claim form.

Claimant
Signature

X

Date (MM DD YYYY)

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Employer Statement

1 Employer Information

Employer's Name, Control Number, Street, Suite, STD Branch, City, State, ZIP Code, LTD Branch, Employer's Telephone Number, Extension, E-mail Address

2 Employee Information

First Name, MI, Last Name, Address 1, Social Security Number, Address 2, Telephone Number, City, State, ZIP Code, Gender, Employment Status, Coverage Effective Date, Date Hired, Coverage Termination Date, Last Date Employer Paid Compensation, Date First Absent, Date Last Worked, Date Work Was Resumed

Normal Earnings Prior to this Absence (exclude bonus, overtime, etc.)
\$ PER
Hour, Week, Bi-Weekly, Month, Year, Other

If employee does not work Monday through 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?
Was the premium amount paid by the employer included in the employee's W-2?
Has either percentage changed within the last 3 years?

How was the LTD premium paid for the plan year in which the disability occurred?
Was the premium amount paid by the employer included in the employee's W-2?
Has either percentage changed within the last 3 years?





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Attending Physician Statement

1 Employee Information

Employer's Name, Control Number (required), 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, 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 is Required, Pregnancy EDC (MM DD YYYY), Actual Delivery Date (MM DD YYYY), Primary, Secondary, 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)

Check all that apply to this disability: Work Related, Accident, Sickness, Maternity, Motor Vehicle Accident, If MVA, in what State did it occur?

Other Treating Physicians or Consultants: First Name, Last Name, Specialty, Telephone Number





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2 Attending Physician Information (Cont'd.)

Other Treating Physicians or Consultants

First Name	Last Name

Specialty	Telephone Number

First Name	Last Name

Specialty	Telephone Number

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)	Full-Time <input type="checkbox"/>
		Part-Time <input type="checkbox"/>

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)?

--

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 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.)

Physician Signature _____

Date (MM DD YYYY)

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Group Disability Insurance Authorization

1 Claimant's Information

Form fields for First Name, MI, Last Name, Social Security Number, Employee Phone Number, and Control Number.

2 Authorization for Release of Information to Prudential Insurance Company

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.

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

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 is 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:

Empty box for limits, if any.

Date (MM DD YYYY)

Date input fields (MM DD YYYY)

X

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

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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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.

*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.

2 Claimant Information

Employer's Name
Claimant's First Name MI Last Name
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 Bank Account Number
(NINE-DIGIT BANK TRANSIT ROUTING 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
First Name MI Last Name
Street Apartment
City State ZIP Code

Date Signed (MM DD YYYY)
X
Signature





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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.

<p>Customer XYZ XYZ Street City, State, ZIP</p>	<p>Check No. 1246</p>	
<p>PAY TO THE ORDER OF _____</p>	<table border="1" style="margin-left: auto; margin-right: auto;"> <tr> <td style="text-align: center; width: 40px;">\$</td> </tr> </table> <p>Dollars</p>	\$
\$		
<p>Bank XYZ UXYZ Street City, State, ZIP</p>		
<p>A27202754 006666D66666C 1246</p>		

↑ 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.*

