Prudential

Group Insurance

Please send the completed form and all attachments to:

The Prudential Insurance Company of America
Group Life Claim Division
P.O. Box 70182
Philadelphia, PA 19176
Tel: 800-524-0542 Fax: 844-625-7807

Accelerated Benefit Option Claim Form

(Use for employee/member and dependent claims.)

How to complete and submit an Accelerated Benefit Option Claim Form:

1. **Disclosure Statement and Tax Certification**
   Employees should first carefully read the Disclosure Statement below and sign and date the Acknowledgment. They should then read the Important Tax Information and Tax Certification (page 11) and complete, sign, and date the Tax Certification.

2. **Accelerated Benefit Option Claim Form**
   Both the "Employee Statement" (page 2) and the "Group Contract Holder Statement" (page 6) attached to these instructions must be completed. Section 1 of the "Group Contract Holder Statement" must be completed if the claim is for an employee/member or for a dependent of an employee. The "Employee Statement" should be completed and returned to the benefits administrator (Group Contract Holder).

3. **Attending Physician Certification**
   Medical evidence of terminal illness should be submitted on the Attending Physician's Certification form. This form should be completed by the physician and certify the nature of the employee's or dependent's illness. It should be mailed to Prudential with the Accelerated Benefit Option Claim Form.

4. **Mail the completed forms to:**
   The Prudential Insurance Company of America
   Group Life Claim Division
   P.O. Box 70182
   Philadelphia, PA 19176

   If you have any questions, please call our Group Life Claim Division at 800-524-0542 and a customer service representative will assist you.

To Be Completed by Employee
Disclosure Statement

The money received from the Accelerated Benefit Option can be used for any purpose. If you exercise this option and accept payment, you should be aware that such payment may adversely affect your eligibility for Medicaid or other government benefits or entitlements. In addition, the Accelerated Benefit Option payment, or a portion thereof, may be considered taxable income. Prudential recommends that assistance be sought from a personal tax advisor and/or an attorney regarding how election of this option may affect your personal situation. Prudential offers this option based on our interpretation of current law, which may change over time.

By electing this option, the total amount of employee or dependents term life insurance otherwise payable at death, including any amount under an extended death benefit, will be reduced by the amount paid under the Accelerated Benefit Option and any required contribution for that insurance will be reduced accordingly. Also, any amount that could otherwise have been converted to an individual contract will be reduced by the amount paid under this option.

Acknowledgment: I have read the disclosure information above.

X ______________________________
Employee's Signature

Date (MM DD YYYY) [ ][ ] [ ][ ] [ ][ ][ ][ ]

X ______________________________
Beneficiary's Signature (Required only if irrevocable.)

Date (MM DD YYYY) [ ][ ] [ ][ ] [ ][ ][ ][ ]

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Accelerated Benefit Option Claim Form

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To Be Completed by Employee

Employee Statement – Pages 2-5 To Be Completed By Employee Please complete in full.

Name

Social Security Number

Date of Birth (MM DD YYYY)

Home Address

Mailing Address (if different)

Last day worked prior to current disability (MM DD YYYY)

Date first treated by physician (MM DD YYYY)

Amount being claimed

$

*If claim is for a dependent, please provide the following information:

Name

Social Security Number

Date of Birth (MM DD YYYY)

List physicians consulted because of this disability

Period Treated

Name

Dr.

From (MM DD YYYY)

To (MM DD YYYY)

Address

Name

Dr.

From (MM DD YYYY)

To (MM DD YYYY)

Address

List any hospital confinements for this disability

Period Confined

Name of hospital

From (MM DD YYYY)

To (MM DD YYYY)

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Accelerated Benefit Option Claim Form

(Use for employee/member and dependent claims.)

To Be Completed by Employee
Employee Statement (continued)

If you have any other Prudential policies, please show policy number(s) (complete as it pertains to employee or dependent):

Has this insurance been assigned? ☐ Yes ☐ No

Has any government agency required that you involuntarily exercise this option as a condition for obtaining or retaining a government benefit or entitlement? ☐ Yes ☐ No

Has any creditor required that you exercise this option? ☐ Yes ☐ No

Optional Payment Election
For cases situated in Connecticut:
Distribution will be lump sum payment only.

☐ **LUMP SUM by Check** ☐ **LUMP SUM by EFT** ☐ **SIX MONTHLY INSTALLMENTS**

If you chose Electronic Funds Transfer, please complete page 4.

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.

X ______________________________
Employee's Signature

Date (MM DD YYYY)

Telephone Number

Prudential

Claimant's Social Security Number

Accelerated Benefit Option Claim Form

Electronic Funds Transfer

If you choose Electronic Funds Transfer, please complete this section:

1. Selection

To select Prudential's Electronic Funds Transfer payment service, please provide the following information. If you elect to have Prudential deposit the funds in your checking account, you must first check with your bank to obtain the correct bank transit routing number and account number for electronic transfer deposit. Please note that a deposit slip does not contain acceptable banking information. If you have any questions, please call us toll-free at 800-524-0542.

2. Beneficiary Information

First name MI Last name

Social Security Number – – Primary Telephone – –

3. Banking Information

Bank name Branch Telephone – –

Bank Transit Routing Number (9 digits)

Type of Account: ☐ Checking ☐ Savings

Bank Account Number Bank Location (City and State)

4. Payment

I authorize The Prudential Insurance Company of America (Prudential) to make electronic deposits of my Group Life Plan Insurance Death Claim proceeds into the above account. I understand that any deposit made to an inactive account agreement will be returned to Prudential and reissued as a manual check. In addition, if any overpayment of such Death Claim proceeds is credited to this account in error, I authorize Prudential to withdraw the difference between the benefit amount paid and the recalculated amount of the benefit actually due under the terms of the insurance coverage.

My eligibility for any such benefits is governed by the terms and conditions of the Group Life Policy and nothing in this Authorization shall be deemed to be an approval of any such benefits.

This authorization is valid indefinitely until such time as I provide written notice of cancellation to Prudential. Any notice hereunder will not be deemed effective until three business days after Prudential has received my written notice.

Account Owner's First Name MI Last Name

Street address

City State ZIP Code –

Telephone – –

Account Owner's signature Date (mm/dd/yyyy)

Return this page with the completed form.

Prudential

Claimant's Social Security Number

Authorization for Release of Information to Prudential Insurance Company

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

Name of Insured:

First Name | MI | Last Name

Date of Birth (MM DD YYYY)

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 pertaining to:

First Name | MI | Last Name

Print Name of Deceased or Patient

or on my (his/her) behalf ("My Providers") to disclose my (his/her) entire medical record for me or my dependents and any other health information concerning me (him/her) 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 all non-health organizations, any insurance company, employer, or other person or institutions to provide any information, data, or records relating to credit, financial, earnings, travel, activities, or employment history to Prudential.

By my signature below, I acknowledge that any agreements I (he/she) have made to restrict my (his/her) protected health information do not apply to this authorization and I instruct My Providers to release and disclose my (his/her) 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 (he/she) have (has) or have (has) 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: PO Box 70182, Philadelphia, PA 19176. I understand that a revocation is not effective to the extent that any of My Providers have relied on this Authorization or to the extent that Prudential has a legal right to contest a claim under an 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 my complete 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 request and receive a copy of this authorization.

Date (MM DD YYYY)

X ______________________________

Signature of Insured/Patient or Personal Representative

Description of Personal Representative's Authority or Relationship to Patient

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Accelerated Benefit Option Claim Form

(Use for employee/member and dependent claims.)

Group Insurance Contract Holder Statement To be completed by Employer/Plan Administrator. Please complete all five sections.

1 Claimant's Information To Be Completed By Employer

First Name MI Last Name

Social Security Number Date of Birth (MM DD YYYY) Date of Disability (MM DD YYYY)

Gender
☐ Male ☐ Female

Relationship to Employee
☐ Employee ☐ Spouse ☐ Child ☐ Other

State of Residence

AKA: First Name Last Name

2 Employee/ Member Information

First Name MI Last Name

Social Security Number Date of Birth (MM DD YYYY)

Date of Employment (MM DD YYYY)

☐ Hourly ☐ Union ☐ Part-Time
☐ Salary ☐ Non–union ☐ Full Time

Date Last Worked (MM DD YYYY)

Occupation Where Employed

If not actively at work immediately prior to disability, what was the reason? (Attach explanation, if applicable.)

☐ Disability ☐ Leave of Absence ☐ Vacation ☐ Discharge
☐ Resigned ☐ Retired ☐ Temporary Layoff ☐ Other

Street Address (where employed)

City State ZIP Code

3 Employer/ Association Information

Employer's Name

Street Suite

City State ZIP Code

Telephone Number

Prudential

Claimant's Social Security Number

4 Insurance Coverages

Complete only the coverage(s) that apply to this claim.

Group Coverage	Control Number	Amount	Effective Date of Coverage (MM DD YYYY)	Branch
Basic Term Life		$.		
Optional Term Life		.		
Dependent Term Life		.		
Dependent Optional Term Life		.		
Group Universal Life		.		
Group Variable Universal Life		.		
Dependent Group Universal Life		.		
Dependent Group Variable Universal Life		.		

Employee/Member Salary Amount on Last Day Worked

$.

per

☐ Hour ☐ Week ☐ Month ☐ Year

Was insurance ever assigned? ☐ Yes ☐ No

Optional Term Life, if applicable, must be supported by proof of enrollment.

Maximum Amount Available Under the Accelerated Benefit Option

$.

Please enter amount being claimed under each applicable coverage.

Group Coverage	Amount to be Distributed
	$.
	$.
	$.

Has insurance percentage increased in last two years? ☐ Yes ☐ No If yes, provide date (MM DD YYYY):

Was evidence of insurability required to secure current coverage? ☐ Yes ☐ No

Is there contributory insurance? ☐ Yes ☐ No

Date Last Premium Paid (MM DD YYYY)

Prudential

Claimant's Social Security Number

5 Payment Information

Mail payment to: ☐ Employer at address listed on previous page ☐ Claimant at address listed below ☐ Other (please specify in cover letter)

Please provide the following information about the claimant.

Name of Claimant

Date of Birth (MM DD YYYY)

Social Security Number

Relationship to Employee

Telephone Number

Residence: Street

Apt.

City

State

ZIP Code

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 warnings.

Completed by (name of representative of the employer or benefit administrator)

Please print or type name

Date (MM DD YYYY)

Signature X

Prudential

Accelerated Benefit Option Claim Form Attending Physician's Certification (Please print.)

To Be Completed by Physician

The patient is responsible for the completion of this form without expense to Prudential.

Name of Patient

Social Security Number

Date of Birth (MM DD YYYY)

Patient's Address

Employer's Name

Control Number

Date (MM DD YYYY)

X

Patient's Signature

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

Date of first visit (MM DD YYYY)

Date of last visit (MM DD YYYY)

Date total disability began (MM DD YYYY)

Diagnosis

ICD Diagnosis

Present Condition

Objective Findings/include any results of current x-rays, E.K.G., or any other special test

Does the patient have the mental capacity to handle his/her financial affairs? ☐ Yes ☐ No

If no, briefly explain:

List any hospital confinements for this disability

Name of hospital

Period Confined

From (MM DD YYYY)

To (MM DD YYYY)

To Be Completed by Physician
To qualify for this benefit, your patient must have a life expectancy of six (6) months or less.

Does your patient meet this requirement? ☐ Yes ☐ No

If "Yes," briefly explain the basis for your opinion of the patient's life expectancy. The patient's most recent clinical records must be provided.

Stage of Cancer (if applicable) ____________ Metastasis? ☐ Yes ☐ No If yes, where? ____________

Hospice? ☐ Yes ☐ No

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 warnings.

Name of Attending Physician (Please print.) ____________ Degree/Specialty ____________ Telephone Number ____________

Physician's Address ____________ Fax Number ____________

X ____________
Signature

Date (MM DD YYYY) ____________

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IMPORTANT TAX INFORMATION

1 Insured/ Dependent's Information

First Name | MI | Last Name

Social Security Number

2 Employee's Information

First Name | MI | Last Name

Street | Suite

City | State | ZIP Code

Telephone Number

Date of Birth (MM DD YYYY)

3 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).**

X______________________________
Signature

Date Signed (MM DD YYYY)

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For residents of all states and jurisdictions except Alabama, Arizona, Arkansas, California, the District of Columbia, Florida, Louisiana, Maine, Kentucky, Maryland, New Hampshire, New Jersey, New York, North Carolina, Pennsylvania, Puerto Rico, Rhode Island, Texas, 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.

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.

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.

CALIFORNIA and TEXAS 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.

ARKANSAS, DISTRICT OF COLUMBIA, LOUISIANA and RHODE ISLAND 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.

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

MAINE and 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.

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.

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

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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, with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

VIRGINIA RESIDENTS — Any person who, with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.