Prudential

Group Disability Insurance

Return completed form to:
Insurance Specialists, Inc.
305 Carteret Street
Beaufort, SC 29902
Tel: 800-241-7753 Fax: 866-336-9449

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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Employee Statement

1 Employer Information

Employer Name

Control Number

Location/Division

Branch Number

2 Employee Information

First Name

MI

Last Name

Address 1

Social Security Number

Address 2

Telephone Number

City

State

Zip

Birth Date (MM DD YYYY)

Gender

☐ Male ☐ Female

Marital Status

☐ Unmarried ☐ Married ☐ Divorced ☐ Widowed

Email Address

Work Telephone Number

Date Last Worked (MM DD YYYY)

Date First Absent (MM DD YYYY)

Date First Treated for this Condition (MM DD YYYY)

Date Expected to Return to Work (MM DD YYYY)

Spouses Date of Birth (MM DD YYYY)

Is Spouse Employed?

☐ Yes ☐ No

Education: Highest Grade Completed

Number of Children Under 18

Age of Youngest Child

3 Job Information

Occupation

DOT Job Code_____

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

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

☐ **Other** (Please describe)

Prudential

Employee Social Security Number

4 Primary Care Physician

Physician First Name | MI | Physician Last Name

Primary Telephone Number | Fax Number

Office Address | Suite

City | State | ZIP Code

Specialty

5 Medical Information

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

Physician First Name | Physician Last Name

Specialty | Telephone Number

Physician First Name | Physician Last Name

Specialty | Telephone Number

Physician First Name | Physician Last Name

Specialty | Telephone Number

What medical condition is preventing you from working?

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

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

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

Return to Work Target Date (MM DD YYYY)

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

Name of Your Health Insurance company | Telephone Number

Prudential

Employee Social Security Number

6 Other Income and Workers' Compensation Information

What other income are you entitled to receive as a result of your disability? (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	☐	☐	.	☐ Weekly ☐ Monthly		
State Disability Benefits	☐	☐	.	☐ Weekly ☐ Monthly		
Social Security	☐	☐	.	☐ Weekly ☐ Monthly		
Workers' Compensation	☐	☐	.	☐ Weekly ☐ Monthly		
Medical Deduction	☐	☐	.	☐ Weekly ☐ Monthly		
Dental Deduction	☐	☐	.	☐ Weekly ☐ Monthly		
Vision Deduction	☐	☐	.	☐ Weekly ☐ Monthly		
Life Deduction	☐	☐	.	☐ Weekly ☐ Monthly		
Other	☐	☐	.	☐ Weekly ☐ Monthly		

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

7 Fraud Notice

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Claimant Signature X _____ Date (MM DD YYYY)

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Employer Statement

1 Employer Information

Employer's Name | Control Number (required)

Street | Suite | STD Branch (required)

City | State | ZIP Code | LTD Branch (required)

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 ☐ Male ☐ Female

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

☐ STD Core ☐ STD Supplemental _____
☐ LTD Core ☐ LTD Supplemental _____
☐ TDB (NJ) ☐ DBL (NY) ☐ VDI (CA)

Employment Status

☐ Salaried Employee
☐ Hourly Employee
☐ Other_____

Coverage Effective Date (date the employee became covered under group disability policy regardless of carrier).

STD:
LTD:

Date Hired (MM DD YYYY)

Coverage Termination Date (MM DD YYYY)

Last Date Employer Paid Compensation (MM DD YYYY)

Date First Absent (MM DD YYYY)

Date Last Worked (MM DD YYYY)

Date Work Was Resumed (MM DD YYYY)

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

$ ___,___.___ **PER**

☐ Hour ___# of hrs worked ☐ Week ☐ Bi-Weekly (every two weeks)
☐ 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? _____% 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

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

Prudential

Employee's Social Security Number

3 Other Income, Deductions, and Workers' Compensation Information

Please indicate any applicable deductions such as Local Tax, State Income Tax, Medical, Dental, Life and/or 401(k), 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	☐	☐	.	☐ Weekly ☐ Monthly		
State Disability Benefits	☐	☐	.	☐ Weekly ☐ Monthly		
Social Security	☐	☐	.	☐ Weekly ☐ Monthly		
Workers' Compensation	☐	☐	.	☐ Weekly ☐ Monthly		
Medical Deduction	☐	☐	.	☐ Weekly ☐ Monthly		
Dental Deduction	☐	☐	.	☐ Weekly ☐ Monthly		
Vision Deduction	☐	☐	.	☐ Weekly ☐ Monthly		
Life Deduction	☐	☐	.	☐ Weekly ☐ Monthly		
Other	☐	☐	.	☐ Weekly ☐ Monthly		

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	Up to 25 lbs. frequently, Up to 50 lbs. occasionally	25 to 50 lbs. frequently, 50 to 100 lbs. occasionally	More than 50 lbs. frequently, 100 lbs. occasionally

☐ **Other** (Please describe)

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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Attending Physician Statement

1 Employee Information

Employer's Name

Control Number (required)

Employee First Name

MI

Last Name

Claim Number

Social Security Number

Date of Birth (MM DD YYYY)

Gender
☐ Female
☐ Male

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

Employee Signature X

Date (MM DD YYYY)

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

2 To Be Completed by Attending Physician

Clinical Diagnosis **ICD-9 Code is Required**

Primary:

Secondary:

Secondary:

Pregnancy EDC (MM DD YYYY)

Actual Delivery Date (MM DD YYYY)

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

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

Return to Work Target Date (MM DD YYYY)

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

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

Please describe any Medical Obstacles to Return to Work:

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

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

Check all that apply to this disability:

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

Other Treating Physicians or Consultants:

First Name

Last Name

Specialty

Telephone Number

Prudential

Employee First Name | MI | Last Name

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

2 Attending Physician Information (Cont'd.)

Other Treating Physicians or Consultants

First Name | Last Name

Specialty | Telephone Number

Date of Surgical Procedure (MM DD YYYY)

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

Current Medications, Treatment, and Prognosis:

First Visit (MM DD YYYY) | Last Visit (MM DD YYYY) | Next Visit (MM DD YYYY)

Was Claimant hospital confined? ☐ Yes ☐ No

If yes, please provide name and address of hospital:

From (MM DD YYYY)

To (MM DD YYYY)

3 Physician Information

First Name | MI | Last Name

Primary Telephone Number | Fax Number

Office Address | Suite

City | State | ZIP Code

Specialty

4 Fraud Notice

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Physician Signature X _____ Date (MM DD YYYY)

* 6 9 2 0 4 B 0 2 *

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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
(NINE-DIGIT BANK TRANSIT ROUTING NUMBER)

Bank Account Number
(BANK ACCOUNT NUMBER)

4 Payment Plan Agreement

I authorize the Prudential Insurance Company of America to make electronic fund deposits of my 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

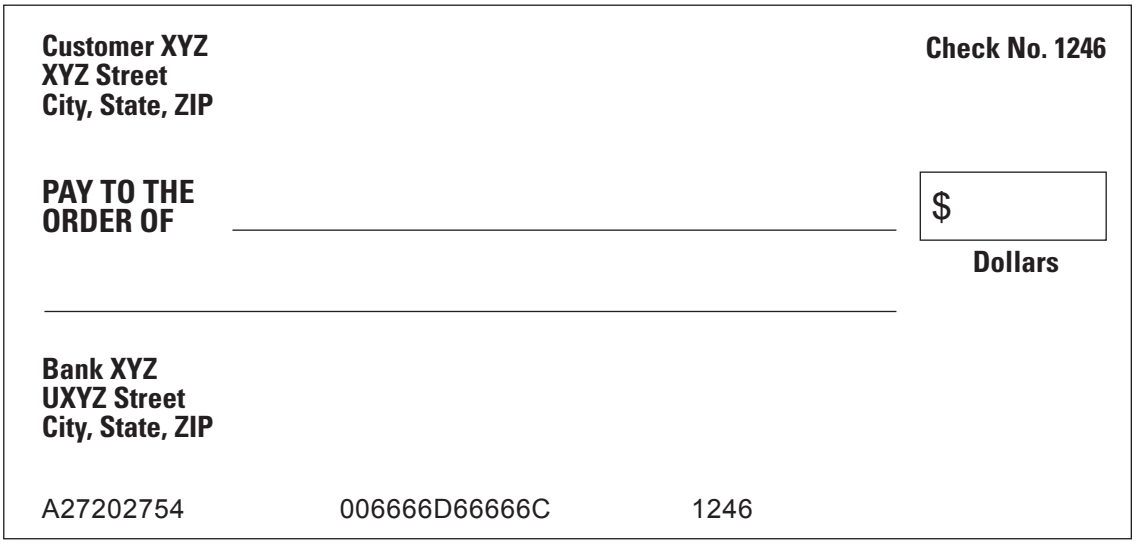
Prudential

Claimant's Social Security Number

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 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.*

Prudential

Group Disability Insurance

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/mybenefits

Group Disability Insurance Authorization

1 Claimant's Information

First Name | MI | Last Name

Social Security Number | Employee Phone Number | Control Number

2 Authorization for Release of Information to Prudential Insurance Company

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

I authorize and instruct any health plan, physician, health care professional, medical professional, hospital, clinic, laboratory, pharmacy, clearinghouse, data warehouse, or other organization that aggregates and maintains pharmacy data, MIB, Inc. (formerly known as the Medical Information Bureau), medical facility, or other health care provider or insurance company or producer that has provided treatment, payment, or services to me or on my behalf ("My Providers") to disclose my entire medical record and any other information concerning me or my mental or physical health to the Prudential Insurance Company of America (Prudential) and its agents, employees, and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

I authorize any insurance company, employer, the Social Security Administration, or other person or institutions to provide any information, data, or records relating to my Social Security, Workers' Compensation, credit, financial, earnings, activities, or employment history to Prudential.

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

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

This information is to be disclosed under this Authorization so that Prudential may: 1) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 2) obtain reinsurance; 3) administer coverage; and 4) conduct other legally permissible activities that relate to any coverage or benefits I have or have applied for with Prudential.

This Authorization shall remain in force for 24 months following the date of my signature below, while the coverage is in force, except to the extent that state law imposes a shorter duration. A copy of this Authorization is as valid as the original. I understand that I have the right to revoke this Authorization in writing, at any time, by sending a written request for revocation to Prudential at: P.O. Box 13480, Philadelphia, PA 19176. I understand that a revocation is not effective to the extent that any of My Providers or Prudential has relied on this Authorization or to the extent that Prudential has a legal right to contest a claim under any insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and will no longer be protected by the HIPAA Privacy Rule governing privacy and confidentiality of health information.

I understand that if I refuse to sign this Authorization to release the entire medical record, Prudential may not be able to process my claim for benefits and may not be able to make any benefit payments. I understand that I have the right to receive a copy of this Authorization.

Authorization for Release of Information to Prudential Insurance Company

*Limits, if any:

Date (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.