Prudential

Group Insurance

Please send the completed form and all attachments to:

The Prudential Insurance Company of America
Beneficiary Services
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
   Beneficiary Services
   P.O. Box 70182
   Philadelphia, PA 19176

   If you have any questions, please call our Beneficiary Services at 800-524-0542 and a customer service representative will assist you.

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Accelerated Benefit Option Claim Form

(Use for employee/member and dependent claims.)

To be Completed by Employee

Disclosure Statement This accelerated life benefit does not and is not intended to qualify as long-term care insurance under Washington state law. Washington state law prevents this accelerated life benefit from being marketed or sold as long-term care insurance or as providing long-term care benefits.

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, Medicare, Social Security, Supplemental Security Income (SSI), 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.

Acknowledgement: I have read the disclosure information above.

X _____ Date (MM DD YYYY) ☐☐ ☐☐ ☐☐☐☐

Employee's Signature

X _____ Date (MM DD YYYY) ☐☐ ☐☐ ☐☐☐☐

Beneficiary's Signature (Required only if irrevocable.)

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Accelerated Benefit Option Claim Form

(Use for employee/member and dependent claims.)

Employee Statement – Pages 2-4 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 | From (MM DD YYYY) | To (MM DD YYYY)

Dr.

Address

Name | From (MM DD YYYY) | To (MM DD YYYY)

Dr.

Address

List any hospital confinements for this disability

Period Confined

Name of hospital | From (MM DD YYYY) | To (MM DD YYYY)

Prudential

Claimant's Social Security number

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 sitused in Connecticut and Vermont: 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 has 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

Prudential

Group Insurance

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Beneficiary Services
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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)

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 ☐ Salary ☐ Union ☐ Non–union ☐ Part-Time ☐ 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 copy 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

Signature X

Date (MM DD YYYY)

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)

Prudential

Claimant's Social Security number

To Be Completed by Physician

To qualify for this benefit, your patient must have a life expectancy of twenty-four (24) 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).**

Date (MM DD YYYY)

X

Signature

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For residents of all states and jurisdictions except Alabama, Alaska, Arizona, Arkansas, California, Colorado, Delaware, the District of Columbia, Florida, Idaho, Indiana, Kentucky, Louisiana, Maine, Maryland, Minnesota, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Puerto Rico, Rhode Island, Tennessee, Texas, Utah, Vermont, Virginia, Washington and West Virginia; WARNING: Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person, or knowing that he or she 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.

ALASKA RESIDENTS - A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

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.

ARKANSAS, DISTRICT OF COLUMBIA, LOUISIANA, MASSACHUSETTS, RHODE ISLAND and WEST VIRGINIA 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.

CALIFORNIA and TEXAS RESIDENTS – For your protection, California and Texas law requires the following to appear on this form. Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

COLORADO RESIDENTS – It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

DELAWARE RESIDENTS – Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

IDAHO RESIDENTS – Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement containing any false, incomplete, or misleading information is guilty of a felony.

INDIANA RESIDENTS – A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

KENTUCKY RESIDENTS – Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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, TENNESSEE, VIRGINIA, and WASHINGTON RESIDENTS - It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

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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.

MINNESOTA RESIDENTS – A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

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 includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NEW MEXICO 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 CIVIL FINES AND CRIMINAL 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.

OHIO RESIDENTS – Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

OKLAHOMA RESIDENTS – WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete, or misleading information is guilty of a felony.

OREGON RESIDENTS – Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurance company, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

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 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.