Prudential

Prudential Claims
The Prudential Insurance Company of America
Tel: 844-455-1002
www.prudential.com/mybenefits

Claim Form Instruction Sheet

How to Complete a Claim Form

- Please complete all sections and sign the claim form.
  - On your behalf, Prudential will request the required documentation from any physicians and hospitals to complete the review of your claim. Physicians and hospitals have varying response times, and we have found that the average turnaround time for these requests is between 9 and 15 business days.
  - If you already have any documentation from the healthcare provider(s) related to this claim, we would ask you to submit it with this claim.
- If submitting a claim for an additional covered benefit, sufficient proof of benefit must be provided for the claim to be reviewed.
- Please complete the Electronic Funds Transfer (EFT) authorization portion of the claim form to receive approved payment(s) by Direct Deposit. If not completed, you will receive approved payment(s) by check.
- **Please note:** a benefit payment under any of Prudential's Voluntary Supplemental Heath Coverages may have a potential impact on other coverages or benefits that you might have or that you might obtain.
- You may wish to consult with your **tax advisor** to understand your specific situation. Some examples include:
  - Benefit payments under this coverage may be considered taxable income to the extent you pay premiums on a pre-tax basis or your employer pays premiums without including them in your income.
  - Benefits payments may have potential impacts on an individual's Health Savings Account (HSA).
  - Prudential reports taxable income to you and the IRS as required on Form 1099. Every tax situation is unique.

How to Submit a Claim Form

- Please submit your completed claim form and supporting documentation

Online at:
www.prudential.com/mybenefits

Fax to:
844-929-9780

Mail to:
The Prudential Insurance Company of America
c/o Accenture Insurance Services
as Third-Party Administrator
P.O. Box 71330, Philadelphia, PA 19176-1330

Accident Insurance Claim
Claimant's Statement

A) Member/Claimant Information

Member First Name

Member Last Name

/ /
Date of Birth (mm/dd/yyyy)

Email Address

Preferred Contact Number

Social Security Number

Street Address

Apt/Suite (optional)

City

State

ZIP Code

Employer Name/Association

If claimant is different from the member, provide claimant information.

Claimant First Name

Claimant Last Name

/ /
Date of Birth (mm/dd/yyyy)

Relationship to Member: ☐ Spouse/Domestic Partner ☐ Dependent

B) Accident Details

/ /
Date of Accident (mm/dd/yyyy)

Describe where and how the accident happened. Include any follow-up dates of treatment and any therapy treatment related to the accident. If the accident required a police report to be filed, attach a copy of the police or accident report. If you were injured in an on-job or occupational injury, attach a copy of the first report of injury filed with your employer.

Was the claimant at work when the injury occurred? ☐ Yes ☐ No

Was the claimant hospitalized as the result of injury? ☐ Yes ☐ No

C) Accident Covered Benefits

Some benefits may not be available in your Accident plan. **Please refer to your Certificate of Coverage for covered benefits**. Please select the benefit(s) you are claiming:

- ☐ Advanced Diagnostic Test
- ☐ Ambulance
- ☐ Blood/Plasma/Platelets
- ☐ Broken Tooth
- ☐ Burns/Skin Grafts
- ☐ Coma
- ☐ Concussion
- ☐ Dismemberment
- ☐ Emergency Room/Physician Office/Urgent Care
- ☐ Eye Injury
- ☐ Fracture
- ☐ General/Epidural Anesthesia
- ☐ Hospital/Intensive Care Unit Admission
- ☐ Hospital/Intensive Care Unit Confinement
- ☐ Inpatient/Outpatient Surgery
- ☐ Inpatient Rehabilitation
- ☐ Laceration
- ☐ Loss of Hearing/Sight/Speech
- ☐ Loss of Life
- ☐ Paralysis
- ☐ Physician Follow-Up Visit
- ☐ Prosthetic Device/Joint Replacement
- ☐ Puncture Wound
- ☐ X-Ray
- ☐ Therapy Services _____
  (Please indicate the type of therapy: Cognitive behavioral, Occupational, Physical, Respiratory, Speech, or Vocational)
- ☐ Other Benefit _____
  (Please indicate any additional benefits claimed)

Please note the availability of additional covered benefits depends upon your Certificate of Coverage and requires a claim on one of the above covered conditions.

- ☐ Child Care
- ☐ Child Organized Sport
- ☐ Home/Vehicle Modification
- ☐ Lodging/Transportation
- ☐ Prescription Drugs

D) Physician Contact Information

Please give names, addresses, and telephone numbers of all physicians who have treated you for the accidental injury

First Name/Last Name

Address

City | State | ZIP Code

Telephone Number | Date Treated (mm/dd/yyyy) / /

If physician named above is not your primary care physician, provide primary care physician information.

First Name/Last Name

Address

City | State | ZIP Code

Telephone Number | Date Treated (mm/dd/yyyy) / /

E) Hospital/Facility Contact Information

If the claimant was hospitalized as the result of this injury, please complete this section with names, addresses, and telephone numbers of all hospitals/facilities that provided treatment for your accidental injury.

Hospital/Facility Name

Address

City | State | ZIP Code

Telephone Number | Admission Date (mm/dd/yyyy) | Discharge Date (mm/dd/yyyy)

F) Electronic Funds Transfer (EFT) Authorization

Bank Name

Branch Telephone

Type of Account: ☐ Checking ☐ Savings

Bank Transit Routing Number (9 digits)

Bank Account Number

I authorize The Prudential Insurance Company of America (Prudential) to make electronic funds deposits of my Accident, Critical Illness, and/or Hospital Indemnity Insurance benefit payments (claim payments) into the above 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 Accident, Critical Illness, and/or Hospital Indemnity Insurance benefits 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 my Accident, Critical Illness, and/or Hospital Indemnity Insurance coverage and nothing in this authorization shall be deemed to be an approval of any such benefits.

X _____ / /

Signature of the Member | Date Signed (mm/dd/yyyy)

G) Tax Certification

Please complete any applicable portions of **(b)**. See Definitions below for more information.

(a) Under penalties of perjury, I certify that:

- I am a U.S. Person (including resident alien);
- The Social Security/Tax ID number provided in Part A above is my correct SSN/TIN;
- I am not subject to backup withholding due to failure to report interest or dividend income; and
- I am not subject to FATCA reporting.

(b) Check the boxes below, if applicable:

☐ I am not a U.S. person (including resident alien). I am a citizen of _____.
Attach the applicable IRS Form W-8 (BEN, BEN-E, ECI, EXP, IMY).

☐ I am subject to backup withholding due to the failure to report interest or dividend income (see "Backup Withholding" in the tax certification Information section).

☐ I am subject to FATCA reporting.

Definitions

BACKUP WITHHOLDING

You must tell us if the IRS has notified you that you are subject to backup withholding because you didn't report all your taxable interest and dividends on your tax return. You are not subject to backup withholding if either (a) you did not receive such a notice from the IRS, (b) the IRS told you that you are no longer subject to a backup withholding order, or (c) you are exempt from such withholding. If you have been notified that you are subject to backup withholding, please check the box as indicated.

FOREIGN ACCOUNT TAX COMPLIANCE ACT (FATCA)

Any entity making a payment of U.S. source income must consider whether it is subject to FATCA. A payor must collect documentation about the payee's status or withhold at 30%. Nontaxable payments, such as income tax-free death benefits from nonqualified life insurance contracts, are not subject to FATCA.

CITIZENSHIP

You must indicate if you are not a U.S. Person (including resident alien). In that case, you must state the country in which you are a citizen and submit the applicable IRS Form W-8 (BEN, BEN-E, ECI, EXP, IMY). In most situations, the IRS Form W-8BEN will be the appropriate IRS Form W-8.

H) Claimant Certification/Fraud Warning

I hereby certify that the answers I have provided to the foregoing questions are both complete and true to the best of my knowledge and belief.

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

NEW 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.

Signature of Claimant _____

Name _____ Date (mm/dd/yyyy) ___/___/_____

I signed this form on behalf of the claimant as _____ (indicate relationship and attach copy of Power of Attorney, guardianship, conservatorship, etc. if applicable)

Authorization to Release/Obtain Information

The Authorization is intended to comply with the HIPAA Privacy Rule

Name of the Claimant:

First Name _____ Last Name _____

/ /

Date of Birth (mm/dd/yyyy)

I authorize The Prudential Insurance Company of America (Prudential) or its reinsurers to acquire from and authorize any hospital, physician, medical practitioner, clinic, medically related facility, insurance company, the Medical Information Bureau, Inc. (MIB), or consumer reporting agency to release to Prudential any information regarding me or my past or present health for the purpose of evaluating my claim for insurance benefits. I also authorize Prudential or its reinsurers to disclose all such information to any doctor, the Medical Information Bureau, Inc., or any other insurance company in order to evaluate a claim.

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 the claimant 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 71330, Philadelphia PA 19176-1330**. 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.

/ / X _____ _____

Date (mm/dd/yyyy) Signature of Claimant or Personal Representative Description of Personal Representative's Authority or Relationship to Claimant

Claim Fraud Warnings

For residents of all states and jurisdictions except Alabama, Arizona, Arkansas, California, the District of Columbia, Florida, Kentucky, Louisiana, Maine, 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.

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.

CALIFORNIA AND TEXAS RESIDENTS—For your protection, California and Texas 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.

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.

Claim Fraud Warnings

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.

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.

IMPORTANT INFORMATION

LOUISIANA RESIDENTS—The Louisiana Department of Insurance is located at 1702 N. 3rd Street, Baton Rouge, LA 70802 and can be reached by calling 800-259-5300. Written inquiries can be sent to the Louisiana Department of Insurance, Post Office Box 94214, Baton Rouge, LA 70804.