The Prudential Insurance Company of America
Prudential Claims
Tel: 800-524-0542 Fax: 877-862-0269

Claim for Total Disability Benefits-Claimant Statement

A) Your Policy / Plan Information

Employer's Name

Location/Division

Group Control Number(s):

Branch Code(s):

Claim Number(s):

B) Your Personal Information

First name

Last name

Location/Division

Date of Birth (mm/dd/yyyy)

Social Security Number

Gender ○ Male ○ Female

Married ☐ Yes ☐ No

Spouse Date of Birth (mm/dd/yyyy)

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

Street Address

Apt/Suite (optional)

City

State

ZIP Code

Your Mailing Address (if different from home address)

Street Address

Apt/Suite (optional)

City

State

ZIP Code

Primary telephone number

Work telephone number

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C) Your Employment Information

1. What was your last date at work? (mm/dd/yyyy) ____/____/____

2. Why did you stop working? ☐ Disability ☐ Layoff ☐ Retirement ☐ Terminated ☐ Resigned/Other (describe below)

3. Name of last employer _____

4. Address of employer _____

City _____ State _____ ZIP Code _____ Employer's Phone Number _____

5. Occupation _____ Date of hire (mm/dd/yyyy) ____/____/____

6. Number of years worked for this employer _____ Number of years worked in this occupation _____

7. Describe your Job Duties _____

8. What job category best describes your 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

9. Base salary on last day worked: $ _____ ☐ per hour ☐ per week ☐ per month ☐ per year

Were you: ☐ Full-time ☐ Part-time Number of hours per week : _____

10. Are you self-employed? ☐ Yes ☐ No If Yes, is business still in operation? ☐ Yes ☐ No

11. What is the name of your company? _____

Location _____

a. If the business is still operating, did you hire someone to handle your duties? ☐ Yes ☐ No

b. If the business is no longer operating, on what date did you close or sell your business? ____/____/____ (mm/dd/yyyy)

12. Did your usual job involve:

a. The use of machines, tools, or equipment? ☐ Yes ☐ No

b. Technical knowledge or special skills? ☐ Yes ☐ No

c. Travel? ☐ Yes ☐ No

d. Managing/supervising? ☐ Yes ☐ No

13. If you were not employed, were you: ☐ Retired ☐ Homemaker ☐ Student ☐ Other

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D) Your Work History and Education

Please provide information regarding your previous work history.

Employer	Occupation	Job Duties	Begin & End dates (mm/dd/yyyy)	Reason for Leaving
			/ / to / /	
			/ / to / /	
			/ / to / /	

Education

Highest grade level completed

HS Diploma ☐ Yes ☐ No College completed ☐ Yes ☐ No Date (mm/dd/yyyy) / /

G.E.D ☐ Yes ☐ No Major _____ Degree _____

Certificates, licenses or special training _____

E) Information Regarding your Disability

/ / 1. Date first treated for this condition (mm/dd/yyyy)

/ / Estimated/expected to return to work (mm/dd/yyyy)

2. What medical condition is preventing you from working? _____

3. Check all that apply to this disability ☐ Work Related ☐ Accident/injury ☐ Sickness ☐ Motor vehicle accident

4. If Accident/injury, please describe _____

5. Are you currently working for another Employer? ☐ Yes ☐ No

6. If yes, please provide the occupation _____ Date hired (mm/dd/yyyy) / /

7. Are you able to care for all of your activities of daily living (grooming, dressing, bathing, etc.)? ☐ Yes ☐ No

If No, what activities do you require assistance? Please explain

_____

_____

8. What other activities do you perform, including hobbies and interests if not previously mentioned?

_____

_____

F) Treatment Provider for Your Current Disability

1. Please provide information on the Treatment Provider for your current disability

Physician's First Name _____ Last Name _____

Specialty _____ Primary telephone number _____ Fax Number _____

Office Address _____ Apt/Suite (optional) _____

City _____ State _____ ZIP Code _____

First Office Visit (mm/dd/yyyy) / / _____ Last Office Visit (mm/dd/yyyy) / / _____

G) Additional Treating Providers

Physician's First Name _____ Last Name _____

Specialty _____ Primary telephone number _____ Fax Number _____

Office Address _____ Apt/Suite (optional) _____

City _____ State _____ ZIP Code _____

First Office Visit (mm/dd/yyyy) / / _____ Last Office Visit (mm/dd/yyyy) / / _____

Diagnosis/Symptoms: _____

Treatment Plan: _____

G) Additional Treating Providers (continued)

Physician's First Name _____ Last Name _____

Specialty _____ Primary telephone number _____ Fax Number _____

Office Address _____ Apt/Suite (optional) _____

City _____ State _____ ZIP Code _____

First Office Visit (mm/dd/yyyy) / / Last Office Visit (mm/dd/yyyy) / /

Diagnosis/Symptoms: _____

Treatment Plan: _____

List any Hospital/Facility confinement(s) for this disability.

Name of Hospital/Facility and Address	**Period Confined From** (mm/dd/yyyy)	**Period Confined To** (mm/dd/yyyy)
	/ /	/ /
	/ /	/ /
	/ /	/ /

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H) Income Information

1. Are you currently receiving vocational assistance or retraining for another occupation? ☐ Yes ☐ No

2. Have you applied for Social Security Disability Benefits? ☐ Yes ☐ No

If yes, what is the status of your application? _____

Approval date (mm/dd/yyyy) ____/____/____

3. Do you have Group Long Term Disability coverage with Prudential? ☐ Yes ☐ No

List sources of income for support (e.g., Disability income benefits, Social Security Disability, Retirement, Pension, Workman's Compensation).

Please Note: Eligibility for Social Security Disability or other disability plans does not automatically qualify you under the Prudential policy's disability benefit provision. Eligibility will be assessed based on the information submitted from your attending physician(s).

I) Claimant Certification / Fraud Warning

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. I certify that the above statements are true.

_____ ____/____/____

Claimant's Signature mm/dd/yyyy

Or if the Claimant is unable to sign, the signature and address of the Claimant's legal representative.

_____ ____/____/____

Claimant's representative Signature Relationship mm/dd/yyyy

_____

Representative's address

For Claimant's Legal Representative only. If the claimant is unable to sign this form, the claimant's legal representative may sign. Only those representatives who are court-appointed guardians or have a power of attorney specific to this type of claim may sign. Supporting documentation of the appointment must be submitted to Prudential with this form.

Claim Fraud Warnings

For residents of all states except Alabama, Alaska, Arizona, Arkansas, California, Colorado, Delaware, the District of Columbia, Florida, Idaho, Indiana, Kentucky, Louisiana, Maine, Maryland, Massachusetts, 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.**

Claim Fraud Warnings

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.