

**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



# Claim for Total Disability Benefits-Claimant Statement



## 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).
- |  |  |  |  |  |
|--|--|--|--|--|
| <input type="checkbox"/> <b>Sedentary</b><br>Negligible Weight<br>Mostly Sitting | <input type="checkbox"/> <b>Light</b><br>Up to 10 lbs. frequently<br>Up to 20 lbs. occasionally<br>and/or<br>Frequent Walk/Stand<br>and/or<br>Constant Push/Pull | <input type="checkbox"/> <b>Medium</b><br>Up to 25 lbs.<br>frequently<br>Up to 50 lbs.<br>occasionally | <input type="checkbox"/> <b>Heavy</b><br>25 to 50 lbs.<br>frequently<br>50 to 100 lbs.<br>occasionally | <input type="checkbox"/> <b>Very Heavy</b><br>More than 50 lbs.<br>frequently<br>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? <input type="checkbox"/> Yes <input type="checkbox"/> No | c. Travel? <input type="checkbox"/> Yes <input type="checkbox"/> No               |
| b. Technical knowledge or special skills? <input type="checkbox"/> Yes <input type="checkbox"/> No    | d. Managing/supervising? <input type="checkbox"/> Yes <input type="checkbox"/> No |
13. If you were not employed, were you:  Retired  Homemaker  Student  Other





# Claim for Total Disability Benefits-Claimant Statement



## 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: \_\_\_\_\_





# Claim for Total Disability Benefits-Claimant Statement

## 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)
	/ /	/ /
	/ /	/ /
	/ /	/ /



# Claim for Total Disability Benefits-Claimant Statement



## 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.



## Attending Physician Statement

### A) Claimant Information

First name \_\_\_\_\_

Last Name \_\_\_\_\_

/ /

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

Social Security Number \_\_\_\_\_

**Gender**
 Male

 Female

 Please check if your life insurance policy is sponsored through your employer, and provide the information below:

Employer's Name \_\_\_\_\_

Location/Division \_\_\_\_\_

Control Number(s):

Branch Code(s):

### B) Condition History/Prognosis

 1. Clinical Diagnosis      **ICD Code is Required**      Date when significant loss of function occurred (mm/dd/yyyy)

Primary

\_\_\_\_\_

\_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Secondary

\_\_\_\_\_

Secondary

\_\_\_\_\_

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

3. Return-to-work/recovery expected target date (mm/dd/yyyy)      \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

4. Please describe any medical obstacles preventing return-to-work/recovery

 5. Has the patient reached maximum medical improvement?    Yes    No

6.      \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_      \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_      \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

What was the date of the patient's first office visit? (mm/dd/yyyy)

Most recent visit (mm/dd/yyyy)

Next scheduled visit (mm/dd/yyyy)

Return this page with the completed form.



## Attending Physician Statement

### C) Clinical Workup

1. Provide clinical observations which, in your professional opinion, qualify partial or total disability. If chronic or a prior condition, please explain what has changed.

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2. Dominant hand  Left  Right Height \_\_\_\_\_ Weight \_\_\_\_\_

3. Please provide information regarding pertinent tests, therapies, procedures and surgeries:

Test/Therapies	Date	Results at Onset of Disability	Date	Current Results

Procedures/Surgeries	Date	Type of Procedure/Surgery	Outcome/Complication

Please attach any related diagnostic information to support the claim.

4. List current medications including their dose and frequency.

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### D) Other Treating Physicians/Hospitalization

First Name	Last Name	Speciality	Phone Number

Hospital Name	Date of Admission	Date of Release	Phone Number

Return this page with the completed form.



## Attending Physician Statement

### E) Physical Capacity

1. Based on a normal day, what is the patient's capacity in terms of:

	0%	1-33%	34-66%	67-100%
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing Stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing Ladders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Balancing /Heights	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stooping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kneeling /Crawling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching Desk Level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching Overhead	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Right Handling /Fingering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Left Handling /Fingering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting/Carrying (up to 10 pounds)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting/Carrying (up to 20 pounds)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting/Carrying (up to 50 pounds)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. Are there any other restrictions/limitations that are medically necessary?  Yes  No

If yes, please explain

3. Visual impairment (if applicable)

Date	Test	OD%	OS%
	Visual Field Percentage		
	Visual Acuity - Corrected		
	Visual Acuity - Not Corrected		

Return this page with the completed form.

## Attending Physician Statement

### F) Behavioral Health

(Please complete this section if the disabling condition is due to a behavioral health disorder)

1. When was the patient first diagnosed with the behavioral health disorder? \_\_\_\_\_

2. Do you provide medications management?  Yes  No

**If Yes, indicate if the patient adheres to treatment recommendations and provide the treatment response**

3. Do you provide counseling/therapy?  Yes  No

**If Yes, indicate if the patient adheres to treatment recommendations and provide the treatment response**

4. Has formal psychological testing been completed?  Yes  No **If Yes, please provide the following:**

\_\_\_\_\_ / /  
Type of testing

\_\_\_\_\_ / /  
Date (mm/dd/yyyy)

\_\_\_\_\_ / /  
Name of testing provider (Provide a copy of report, if available)

5. Is there a history of alcohol or substance abuse? **If Yes, the patient (please check one):**

is actively using  has been in remission for \_\_\_\_\_ months \_\_\_\_\_ years

### G) Physician Information/Fraud Notice

\_\_\_\_\_  
Physician's First Name

\_\_\_\_\_  
Physician's Last Name

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
Apt/Suite (optional)

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
ZIP Code

\_\_\_\_\_  
Specialty

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
Fax Number

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 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 warning as I certify the above statements are true.**

X

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_ / /  
Date (mm/dd/yyyy)

Return this page with the completed form.



## Authorization to Release Information

### The Authorization is intended to comply with the HIPAA Privacy Rule

For the purposes of evaluation of a claim for insurance benefits, I authorize all physicians, hospitals, clinics, medical providers, health plans, other health care providers, laboratories, insurance companies, pharmacies, pharmacy benefit managers, employers, investigative consumer reporting agencies and other agencies, including governmental organizations and the Social Security Administration, to provide to Prudential the Claimant's entire medical record (excluding psychotherapy notes), employment record, pharmacy record, insurance claim record, and insurance policy information. Upon the presentation of the original or photocopy of this signed authorization, I request the Social Security Administration to release to Prudential any and all information regarding earnings and any other information that may determine eligibility for benefits under the Social Security Act.

I authorize the entities listed above to permit Prudential or its authorized representative to obtain a copy of the entire medical record, including but not limited to, treatment for communicable diseases such as the human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS), drug and alcohol use and all other information relative to the physical health, mental health, dental care, or employment pertaining to Claimant.

For the purpose of processing and payment of claims in an efficient and prompt manner, I authorize Prudential to consolidate and disclose completed claim forms and documents to appropriate associates for each and every one of Prudential Financial, Inc.'s affiliates or business units for which a claim for payment or distribution is made.

First Name	Last Name
Claim number (if available)	Social Security number (last 4 digits)
Employee phone number	Date of birth (mm/dd/yyyy)
Control number	or Policy Number

This authorization will remain valid while the claim is pending, but not for more than two years except to the extent that state law provides a shorter duration. This authorization can be revoked by giving written notice to Prudential. Prudential may be unable to complete the claim process and may deny benefits if this form is unsigned or revoked. Prudential will not release this information to any other entity other than its reinsurers or service providers without written authorization, unless required or allowed by law or ordered by a court of law. A copy of this authorization form will be provided to you upon request. A photocopy 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 70183, Philadelphia PA 19176. I understand that a revocation is not effective to the extent that any of my medical providers have 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 disclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

Once disclosed to Prudential, this information will no longer be protected by the Health Insurance Portability and Accountability Act, but will be protected by other applicable federal and state laws relating to the protection of personal information. For purposes of this authorization, I hereby revoke any prior restriction on disclosure of medical records provided to any medical provider and authorize the release of the Claimant's entire medical record to Prudential, excluding psychotherapy notes.

X Signature	/ / Date (mm/dd/yyyy)
X Witness	X Relationship