

The Prudential Insurance Company of America  
 Disability Management Services  
 P.O. Box 13480, Philadelphia, PA 19176  
 Tel: 800-842-1718 Fax: 877-889-4885  
[www.prudential.com/mybenefits](http://www.prudential.com/mybenefits)

**Group Disability Insurance Authorization**
**1 Claimant's Information**

First Name	MI	Last Name
<input type="text"/>	<input type="text"/>	<input type="text"/>
Claim Number	Social Security Number (Last four digits)	Employee Phone Number
<input type="text"/>	<input type="text"/>	<input type="text"/>
Date of Birth (mm yyyy)	Control Number	
<input type="text"/>	<input type="text"/>	

**2 Authorization for Release of Information to The 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.

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 health care items or services for which a healthcare provider has been paid out of pocket in full.





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Group Disability Insurance Authorization

Form fields for First Name, MI, Last Name, and Claim Number.

2 Authorization for Release of Information to The Prudential Insurance Company

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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 The Prudential Insurance Company.

X \_\_\_\_\_ Date (mm dd yyyy)
Employee Signature (indicate how related if signed by other than claimant)

