



# Group Insurance

Please send the completed form and all attachments to:

**The Prudential Insurance Company of America  
Group Life Claim Division  
P.O. Box 8517  
Philadelphia, PA 19176**

## 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 Acknowledgement. They should then read the Important Tax Information and Tax Certification (page 8) and complete, sign, and date the Tax Certification.

#### 2. Accelerated Benefit Option Claim Form

Employees should complete the "Employee Statement" (pages 2, 3 and 5).

#### 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 completed Employee Statement.

#### 4. Mail the completed forms to:

The Prudential Insurance Company of America  
Group Life Claim Division  
P.O. Box 8517  
Philadelphia, PA 19176

If you have any questions, please call our Group Life Claim Division at 800-524-0542 and a customer service representative will assist you.

### Disclosure Statement

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 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.

**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.

Acknowledgement: I have read the disclosure information above.

  X    
Employee's Signature

Date (MM DD YYYY)  

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  X    
Beneficiary's Signature (Required only if irrevocable)

Date (MM DD YYYY)  

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### Employee Statement Please complete in full.

Name			Social Security Number			Date of Birth (MM DD YYYY)		
<input type="text"/>			<input type="text"/>			<input type="text"/>		
Home/Mailing Address								
<input type="text"/>								
Employer Name								
<input type="text"/>								
Last day worked prior to current disability (MM DD YYYY)			Date first treated by physician (MM DD YYYY)			Amount being claimed		
<input type="text"/>			<input type="text"/>			\$ <input type="text"/>		

\*If claim is for a dependent, please provide the following information:

Name			Social Security Number			Date of Birth (MM DD YYYY)		
<input type="text"/>			<input type="text"/>			<input type="text"/>		
List physicians consulted because of this disability			Period Treated					
Name			From (MM DD YYYY)			To (MM DD YYYY)		
<input type="text"/>			<input type="text"/>			<input type="text"/>		
Address								
<input type="text"/>								
Dr. <input type="text"/>			<input type="text"/>			<input type="text"/>		
Address								
<input type="text"/>								

List any hospital confinements for this disability			Period Confined					
Name of hospital			From (MM DD YYYY)			To (MM DD YYYY)		
<input type="text"/>			<input type="text"/>			<input type="text"/>		
<input type="text"/>			<input type="text"/>			<input type="text"/>		
<input type="text"/>			<input type="text"/>			<input type="text"/>		

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 situated in Connecticut: Distribution will be lump sum payment only.  **LUMP SUM**  **SIX MONTHLY INSTALLMENTS**

I hereby certify that these statements are true:

X  
Employee's Signature

Date (MM DD YYYY)



### 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)

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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.

Unless limits\* are shown below, this form pertains to all of the records listed above.

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 8517, 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.

\*Limits, if any:

Date (MM DD YYYY)

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**X**  
 \_\_\_\_\_  
 Signature of Insured/Patient or Personal Representative

Description of Personal Representative's Authority or Relationship to Patient

**NOTICE TO MONTANA RESIDENTS:** You or your authorized representative are entitled to receive a copy of this Authorization, and upon request, a record of any subsequent disclosures of personal or privileged information.



**Accelerated Benefit Option Claim Form Attending Physician's Certification** (Please print)

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 \_\_\_\_\_ CD-9 CM Disease Code \_\_\_\_\_ Present Condition \_\_\_\_\_

Objective Findings/include any results of current x-rays, E.K.G., or any other special test \_\_\_\_\_

Is the patient capable of handling his/her own affairs?  Yes  No

List any hospital confinements for this disability \_\_\_\_\_

Name of hospital \_\_\_\_\_ Period Confined From (MM DD YYYY) [ ][ ][ ][ ] To (MM DD YYYY) [ ][ ][ ][ ]

**To qualify for this benefit, your patient must have a life expectancy of twelve (12) 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

Name of Attending Physician (Please print) \_\_\_\_\_ Degree/Specialty \_\_\_\_\_ Telephone Number [ ][ ][ ][ ] [ ][ ][ ][ ][ ] [ ][ ][ ][ ][ ]

Physician's Address \_\_\_\_\_

**X**  
Signature

Date (MM DD YYYY) [ ][ ][ ][ ] [ ][ ][ ][ ][ ]



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**IMPORTANT TAX INFORMATION**


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This information will help you complete the Tax Certification section below, which is required by the Internal Revenue Service. Please read it carefully. Prudential and its representatives cannot give legal or tax advice. You may wish to consult your tax or legal advisor for more information.

**Citizenship.** You must indicate if you are not a U.S. citizen or resident alien. In that case, you must state the country of which you are a citizen and submit a completed IRS Form W-8BEN.

**Backup withholding.** You must tell us if the IRS has notified you that you are subject to backup withholding because you did not 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 recently told you that you are no longer subject to a backup withholding order, or (c) you are exempt from such withholding.**

**Taxpayer Identification Number and date of birth.** You must include your Taxpayer Identification Number (TIN) and date of birth. The TIN for the certificate is:

- Your Social Security Number if you are an individual or the owner of a sole proprietorship.
- The Employer Identification Number (EIN) if you represent a trust, estate, corporation, partnership, or tax-exempt organization.
- The TIN of the grantor/trustee or that of the actual owner of a trust-like entity not recognized as a legal or valid trust under state law.

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**Tax Certification** (See Important Tax Information above for additional information on this section)

**If this section is not completed, we may be required to withhold federal and state income tax.**

**Complete section (a) or (b) below:**

**(a) Under penalties of perjury, I certify that my correct Taxpayer Identification Number is:**

**Claimant/Assignee's Social Security Number or Employer Identification Number**      **Claimant's Date of Birth**

<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>
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**Complete the following, if applicable.**

**I am not subject to backup withholding for the reasons stated under "Backup Withholding" in the Important Tax Information section.** (Check the box only if you are subject to backup withholding)

**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 not a U.S. person (including resident alien). I am a citizen of**   
*(Attach completed IRS Form W-8BEN, if applicable)*

**The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.**

X \_\_\_\_\_  
 Claimant's Signature

Date (MM DD YYYY)

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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**For residents of all states except California, District of Columbia, Florida, New Jersey, New York, Pennsylvania, 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.

**CALIFORNIA RESIDENTS** — For your protection, California 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.

**DISTRICT OF COLUMBIA 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.

**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.

**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.

**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 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 a statement of claim for payment of a loss or benefit may have violated state law, is 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.

**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.

