



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

Tel: 800-524-0542 Fax: 888-227-6764

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 10) and complete, sign, and date the Tax Certification.

2. Accelerated Benefit Option Claim Form

Both the "Employee Statement" (page 2) and the "Group Contract Holder Statement" (page 5) attached to these instructions must be completed. Section 1 of the "Group Contract Holder Statement" must be completed if the claim is for an employee/member or for a dependent of an employee. The "Employee Statement" should be completed and returned to the benefits administrator (Group Contract Holder).

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 Accelerated Benefit Option Claim Form.

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.

To Be Completed by Employee

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.

Acknowledgement: I have read the disclosure information above.

X _____
Employee's Signature

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

X _____
Beneficiary's Signature (Required only if irrevocable.)

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





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To Be Completed by Employee

Employee Statement – Pages 2-4 To Be Completed By Employee Please complete in full.

Name	Social Security Number	Date of Birth (MM DD YYYY)
<input type="text"/>	<input type="text"/>	<input type="text"/>

Home Address

Mailing Address (if different)

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"/>

Address

Name	From (MM DD YYYY)	To (MM DD YYYY)
<input type="text"/>	<input type="text"/>	<input type="text"/>

Address

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"/>





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To Be Completed by Employee Employee Statement (continued)

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

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.

X

Employee's Signature

Date (MM DD YYYY)

Telephone Number





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Accelerated Benefit Option Claim Form

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Group Insurance Contract Holder Statement To be completed by Employer/Plan Administrator. Please complete all five sections.

1 Claimant's Information

To Be Completed By Employer

First Name MI Last Name

Social Security Number Date of Birth (MM DD YYYY) Date of Disability (MM DD YYYY)

Gender Male Female Relationship to Employee Employee Spouse Child Other State of Residence

AKA: First Name Last Name

2 Employee/Member Information

First Name MI Last Name

Social Security Number Date of Birth (MM DD YYYY)

Date of Employment (MM DD YYYY) Hourly Union Part Time Date Last Worked (MM DD YYYY)
 Salary Non-union Full Time

Occupation Where Employed

If not actively at work immediately prior to disability, what was the reason? (Attach explanation, if applicable.)

Disability Leave of Absence Vacation Discharge
 Resigned Retired Temporary Layoff Other

Street Address (where employed)

City State ZIP Code

3 Employer/Association Information

Employer's Name

Street Suite

City State ZIP Code

Telephone Number



4 Insurance Coverages

Complete only the coverage(s) that apply to this claim.

Group Coverage	Control Number	Amount	Effective Date of Coverage (MM DD YYYY)	Branch
Basic Term Life	<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"/> <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"/>
Optional Term Life	<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"/> <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"/>
Dependent Term Life	<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"/> <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"/>
Dependent Optional Term Life	<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"/> <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"/>
Group Universal Life	<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"/> <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"/>
Group Variable Universal Life	<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"/> <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"/>
Dependent Group Universal Life	<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"/> <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"/>
Dependent Group Variable Universal Life	<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"/> <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"/>

Employee/Member Salary Amount on Last Day Worked

 \$.
 per
 Hour Week Month Year

 Was insurance ever assigned?
 Yes No

Optional Term Life, if applicable, must be supported by proof of enrollment.

Maximum Amount Available Under the Accelerated Benefit Option

 \$.

Please enter amount being claimed under each applicable coverage.

Group Coverage	Amount to be Distributed
<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"/>	\$ <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"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/>

 Has insurance percentage increased in last two years? Yes No If yes, provide date (MM DD YYYY):

Was evidence of insurability required to secure current coverage?	Yes	No	Is there contributory insurance?	Yes	No	Date Last Premium Paid (MM DD YYYY)
						<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>





Claimant's Social Security Number

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5 Payment Information

Mail payment to: Employer at address Claimant at address Other (please specify in
 listed on previous page listed below cover letter)

Please provide the following information about the claimant.

Name of Claimant		Date of Birth (MM DD YYYY)	
<input type="text"/>		<input type="text"/>	
Social Security Number	Relationship to Employee	Telephone Number	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
Residence: Street		Apt.	
<input type="text"/>		<input type="text"/>	
City	State	ZIP Code	
<input type="text"/>	<input type="text"/>	<input type="text"/>	

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.

I have read and understand the terms and requirements of the fraud warnings.

Completed by (name of representative of the employer or benefit administrator)

Please print or type name

Date (MM DD YYYY)

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Signature X 

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

To Be Completed by Physician

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)
<input type="text"/>	<input type="text"/>	<input type="text"/>

Patient's Address
<input type="text"/>

Employer's Name	Control Number
<input type="text"/>	<input type="text"/>

	Date (MM DD YYYY)
<input type="text"/>	<input type="text"/>

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)
<input type="text"/>	<input type="text"/>	<input type="text"/>

Diagnosis	ICD Diagnosis	Present Condition
<input type="text"/>	<input type="text"/>	<input type="text"/>

Objective Findings/include any results of current x-rays, E.K.G., or any other special test	Does the patient have the mental capacity to handle his/her financial affairs?	Yes	No
<input type="text"/>		<input type="checkbox"/>	<input type="checkbox"/>

If no, briefly explain:

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"/>





To Be Completed by Physician

To qualify for this benefit, your patient must have a life expectancy of six (6) 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.

[Empty box for physician explanation]

Stage of Cancer (if applicable) Metastasis? Yes No If yes, where?

Hospice? Yes No

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.

I have read and understand the terms and requirements of the fraud warnings.

Name of Attending Physician (Please print.) Degree/Specialty Telephone Number

Physician's Address Fax Number

X Signature

Date (MM DD YYYY)



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IMPORTANT TAX INFORMATION
1 Insured/Dependent's Information

First Name	MI	Last Name
<input type="text"/>	<input type="text"/>	<input type="text"/>
Social Security Number		
<input type="text"/>	<input type="text"/>	<input type="text"/>

2 Employee's Information

First Name	MI	Last Name
<input type="text"/>	<input type="text"/>	<input type="text"/>
Street		Suite
<input type="text"/>		<input type="text"/>
City	State	ZIP Code
<input type="text"/>	<input type="text"/>	<input type="text"/>
Telephone Number	Date of Birth (MM DD YYYY)	
<input type="text"/>	<input type="text"/>	

3 Taxpayer Identification Number and Certification

Prudential requires your Taxpayer Identification Number. The Taxpayer Identification Number is either the Social Security Number or the Employer Identification Number. If you:

- Are an individual, your Taxpayer Identification Number is the Social Security Number.
- Represent a trust or estate, the Taxpayer Identification Number is its Employer Identification Number.
- Represent a minor, please provide the minor's Social Security Number.
- Are applying for a Taxpayer Identification Number, please write "applied for" in the space provided.

TAXPAYER IDENTIFICATION NUMBER/FORM W-9 CERTIFICATION:

Under penalties of perjury, I certify that the number shown on this form is my correct Taxpayer Identification Number (Social Security Number). I further certify that the citizen/residency status I have listed on this form is my correct citizen/residency status. I am not subject to backup withholding because (a) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding, (b) the IRS has told me that I am no longer subject to a backup withholding order, or (c) I am exempt from backup withholding. I am exempt from FATCA reporting.

Social Security Number or Taxpayer Identification Number of beneficiary

Check all applicable boxes.

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 subject to FATCA reporting.

If not a U.S. person (including resident alien), submit the applicable Form W-8 (BEN, BEN-E, ECI, EXP or IMY).

X _____
Signature

Date Signed (MM DD YYYY)



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For residents of all states and jurisdictions except Alabama, Arizona, Arkansas, California, the District of Columbia, Florida, Louisiana, Maine, Kentucky, Maryland, New Hampshire, New Jersey, New York, North Carolina, Pennsylvania, Puerto Rico, Rhode Island, 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.

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.

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.

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.





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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, 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.

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.

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