Prudential

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

Group Accidental Injury Claim Form (Use for employee/member and dependent injury claims)

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

1 Claimant's Information

First Name | MI | Last Name

Social Security Number | Date of Birth (MM DD YYYY) | Date of Loss (MM DD YYYY)

Gender: ☐ Male ☐ Female

Relationship to Employee: ☐ Employee ☐ Spouse ☐ Child ☐ Other

State of Residence

Did accident occur at work? ☐ Yes ☐ No

Date of Accident (MM DD YYYY) | State of Accident

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 ☐ Salary ☐ Union ☐ Non–union ☐ Part Time ☐ Full Time

Date Last Worked (MM DD YYYY)

Occupation | Where Employed

If not actively at work immediately prior to accident, what was the reason?

☐ Disability ☐ Leave of Absence ☐ Vacation ☐ Discharge
☐ Resigned ☐ Retired ☐ Temporary Layoff ☐ Other

Street Address (where employed) | Apt.

City | State | ZIP Code

3 Employer/ Association Information

Employer's Name

Street | Suite

City | State | ZIP Code

Telephone Number

Prudential

Claimant's Social Security 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 AD&D		$		
☐ Group Universal AD&D		$		
☐ Dependent AD&D		$		
☐ Optional AD&D		$		
☐ Dependent Optional AD&D		$		
☐ Dependent Group Universal AD&D		$		
☐ Business Travel AD&D		$		
☐ Dependent Business Travel AD&D		$		

Salary Amount on Last Day Worked

$ ____.____ per ☐ Hour ☐ Week ☐ Month ☐ Year

Please enter the amount being claimed under each applicable coverage.

Group Coverage	Amount to be Distributed
	$
	$
	$

Is there contributory insurance? ☐ Yes ☐ No

Date Last Premium Paid (MM DD YYYY)

Did the employee and/or the covered dependent suffer a loss as defined by the BTA contract? ☐ Yes ☐ No

If yes, an officer of the company must provide a written statement validating the circumstances of the accident.

5 Payment Information

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

Please provide the following information:

Name of Claimant

Date of Birth (MM DD YYYY)

Social Security Number

Relationship to Employee

Telephone Number

Residence: Street

Apt.

City

State

ZIP Code

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

Please print or type name

Date (MM DD YYYY)

Signature X

Prudential

Claimant's Social Security Number

6 **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 W9 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.

Social Security Number or Taxpayer Identification Number of beneficiary

Check here 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
Signature

Date (MM DD YYYY)

Prudential

Claimant's Social Security Number

7

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)

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)

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.

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Claimant's Social Security Number

Attending Physician's Statement (Please print)

Please complete top section and other portion(s) of form that apply to loss incurred.

Name of Patient

Date of First Treatment for Present Injury (MM DD YYYY)

Date of Accident Causing Present Injury (MM DD YYYY)

1. Describe the accident causing the injury/impairment

2. Was there any disease of condition prior to the date of the accident that might have served as contributing cause? If so, please describe. Please provide any test results and office notes from before and after the accident.

Were there contributing diseases/medical conditions preceding this accident? ☐ Yes ☐ No

If "Yes," please state diagnosis and attach relevant clinical records.

3. If physicians other than yourself treated the insured for this contributory condition, please give the following:

Name of Physician — Telephone Number — Date Treated (MM DD YYYY)

Dr.

Address

Dr.

Address

4. If treated at a hospital, give name of institution with dates of admission and discharge.

Name of hospital — Date Admitted (MM DD YYYY) — Date Discharged (MM DD YYYY)

If claim is for loss of limb, please indicate whether the loss is above the wrist or ankle:

Right Hand: ☐ Above ☐ Below — Wrist—Date of Amputation (MM DD YYYY)

Right Foot: ☐ Above ☐ Below — Ankle—Date of Amputation (MM DD YYYY)

Left Hand: ☐ Above ☐ Below — Wrist—Date of Amputation (MM DD YYYY)

Left Foot: ☐ Above ☐ Below — Ankle—Date of Amputation (MM DD YYYY)

If claim is for loss of vision, please complete the following:

1. Vision acuity

	Uncorrected		Corrected	
a. Date of first observation (MM DD YYYY)	Right Eye	Left Eye	Right Eye	Left Eye
b. Date of last observation (MM DD YYYY)	Right Eye	Left Eye	Right Eye	Left Eye

2. From what date has vision recorded in question 1b existed?

Right Eye (MM DD YYYY) — Left Eye (MM DD YYYY)

3. If totally blind, give date when this occurred:

Right Eye (MM DD YYYY) — Left Eye (MM DD YYYY)

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4. If eye has been enucleated, give date

Right Eye (MM DD YYYY)

Left Eye (MM DD YYYY)

5a. In your opinion, can vision be improved by treatment, surgery, or corrective lenses? ☐ Yes ☐ No

b. What are your recommendations for treatment?

If claim is for loss of speech, please complete the following:

1. Record of speech

a. Date of first observation (MM DD YYYY)

b. Date of last observation (MM DD YYYY)

2. What is the injury/diagnosis causing loss of vocalization?

If claim is for loss of hearing, please complete the following:

1. Hearing Acuity

a. Date of first observation (MM DD YYYY) Right Ear Left Ear

b. Date of last observation (MM DD YYYY) Right Ear Left Ear

2. Please provide the speech reception threshold:

a. With amplification device Right Ear db Left Ear db

b. Without amplification device Right Ear db Left Ear db

3. Please provide the speech discrimination score:

a. With amplification device Right Ear % Left Ear %

b. Without amplification device Right Ear % Left Ear %

4. What is the injury/diagnosis causing hearing loss?

If claim is for paralysis or "loss of use," please complete the following:

1. Record of paralysis

a. Describe the injury/diagnosis causing paralysis:

b. Describe the loss of function:

If claim is for coma, please complete the following:

1. Record of coma

a. Date of onset (MM DD YYYY)

b. Date patient last observed as comatose (MM DD YYYY)

2. What is the injury/diagnosis?

Name of Attending Physician (Please print)

Degree/Specialty

Telephone Number

Physician's Address

X

Signature

Date (MM DD YYYY)

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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.

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 JERSEY RESIDENTS — Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

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.

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.