Prudential

Living Benefit Option Claim Form

Group Insurance
The Prudential Insurance Company of America

HOW TO PRESENT A CLAIM

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 below and Tax Certification section on page 2 and complete, sign and date the Tax Certification.

2. Living Benefit Option Claim Form
Both the "Employee's Statement" (page 2) and the "Group Policyholder's Statement" (page 3) attached to these instructions must be completed. The employee's section of the form should be completed first and returned to the benefits administrator (Group Policyholder).

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 illness. It should be mailed to Prudential with the Living Benefit Claim Form.

"Notice to all parties completing this form: It is fraudulent to fill out this form with information you know to be false or to omit important facts. Criminal and/or civil penalties can result from such acts."

Virginia 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.

Disclosure Statement
The money received from the Living 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 Living Benefit Option payment, or a portion thereof, may be considered taxable income. Prudential recommends that assistance be sought from a personal tax adviser and/or an attorney regarding how the election of this option may affect your personal situation. Prudential offers this option based on our interpretation of current law, which may change in the future.

By electing this option, the total amount of employee term life insurance otherwise payable at death, including any amount under an extended death benefit, will be reduced by the amount paid under the Living Benefit Option. Also, any amount that could otherwise have been converted to an individual insurance contract will be reduced by the amount paid under this option.

Acknowledgement: I have read the disclosure information above.

_____ _____
Employee's Signature Date

_____ _____
Beneficiary's Signature (Required only if irrevocable) Date

IMPORTANT TAX INFORMATION

This information will help you complete the Tax Certification section on page 2, which is required by the Internal Revenue Service. Please read it carefully. Prudential and its representatives cannot give tax or legal advice. You may wish to consult your tax or legal adviser 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.

TAX CERTIFICATION (see Important Tax Information on page 1 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- Claimant/Assignee's Employer Identification number Claimant's date of birth

|__|__|__| - |__|__| - |__|__|__|__| |__|__| - |__|__|__|__|__|__|__| |__|__| |__|__| |__|__|__|__|

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 above.
(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.**

(b) ☐ **I am not a U.S. citizen or 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 _____ X _____
Claimant's signature Date Assignee's signature (if applicable) Date

Employee's Statement/Please complete in full Your full name	Your date of birth Mo. Day Yr.	Social Sec./Ins. No.
Your home address		Amount being claimed $
Your mailing address (if different from home address)	Last day worked prior to current disability Mo. Day Yr.	Date first treated by physician Mo. Day Yr.

List physicians consulted because of this disability

Name	Address	Period treated
Dr. _____	_____	From_____To_____
Dr. _____	_____	From_____To_____

List any hospital confinements for this disability

Name of hospital	Address	Period continued
_____	_____	From_____To_____
_____	_____	From_____To_____

If you have any other Prudential policies, please show policy number(s):

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: ☐ LUMP SUM ☐ SIX MONTHLY INSTALLMENTS

I hereby certify that these statements are complete and true:

Employee's signature_____ Date_____
Mo. Day Year

Important: The following authorization must also be completed by the employee. When completed by the employee, this form should be returned to the Group Policyholder together with an Attending Physician's Certification Form completed by the doctor currently treating the employee.

To all physicians, hospitals, medical service providers, druggists, employers, other insurance companies, and all other agencies and organizations. You are authorized to permit The Prudential Insurance Company of America, or its representatives, to obtain or view a copy of all your records pertaining to the examination, treatment, history, prescriptions, and employment of

_____
Print Name

A photostatic copy of this authorization shall be considered as effective and valid as the original.

Date:_____ 20_____ Witness_____ Signature_____

Prudential

Living Benefit Option Claim Form

Group Insurance
The Prudential Insurance Company of America
For Prudential Use Only
Date Reported
Claim Number
Return to

Group Policyholder's Statement

Employee Soc. Sec. No.	Control number	Name of employee First M.I. Last

Date of birth Mo. Day Yr.	Date employed Mo. Day Yr.	Date last worked Mo. Day Yr.	Did employee cease work solely because of disability (if "No" attach explanation) ☐ Yes ☐ No	State of residence	Sex ☐ M ☐ F

Total Amount of Insurance	Branch code(s)	Effective date of coverage Mo. Day Yr. / Insurance in force? If "No" attach explanation ☐ Yes ☐ No	Date to which premium been paid Mo. Day Yr.	Location Name and Address where Employed
Basic: $				
Supp: $		Amount of base salary or wage ☐ Weekly ☐ Monthly ☐ Annually $ Amount	Was insurance assigned? ☐ Yes ☐ No	

Total $	Is this contributory insurance? ☐ Yes ☐ No If "Yes" date claimant paid contribution to: Mo. Day Yr.	Occupation prior to disability

Amount of insurance claimed under this benefit $	Maximum Amount Available $	Has any other claim been submitted for this employee under the Group Life Insurance Policy (i.e.) Extension of Death Benefit? ☐ Yes ☐ No

Group Policyholder Name | Address | Telephone No.

Mail payment to:	Completed by (Please type or print)
☐ Policyholder at address shown ☐ Claimant at address shown ☐ Other (please specify in cover letter)	Signature of Policyholder's Representative

Space below for Prudential use only

☐ Lump Sum ☐ Six installments of $_____
Due on the_____ of each month, beginning _____
Final Installation Due: _____

Check payable for:

	Field Code	Debit		Credit	Payment Instructions:
Living Benefit Option	G2				
		Amount of check			
	Totals				

Examined	Date	Examined	Date	Approved	Date

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Living Benefit Option Claim Form
Attending Physician's Certification

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The patient is responsible for the completion of this form without expense to Prudential. You may mail this form directly to:

Please print
Name of patient _____ Date of birth ____/____/____ Social Security No.: _____-_____-_____

Patient's address _____
No. Street City St./Prov. Zip/Pac

_____
Employer's name Control number

_____
Signed (Patient) Date

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 Mo. Day Yr. | Date of last visit Mo. Day Yr. | Date total disability began Mo. Day Yr.

_____
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

_____
If hospitalized
Name of Hospital | Address | Dates confined

_____
To qualify for this benefit, the patient must have a life expectancy of six (6) months or less.
Does your patient meet this requirement? ☐ Yes ☐ No

Remarks:
_____
_____
_____
_____
_____

_____
Name (attending physician) Please print | Degree/Specialty | Telephone No.

_____
No. Street City St./Prov. Zip/Pac

_____
Signature Date