Exhibit I

Sample Claim Forms

Prudential Financial

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 19101

Group Life Insurance Claim Form (Use for employee/member and dependent death claims)

How to complete and submit a Group Life Insurance Claim Form

1. **Complete Sections 1, 2, 3, 4, and 5 of the Group Contract Holder Statement portion of the Group Life Insurance Claim Form. Section 1 must be completed if the claim is for an employee/member, or for a dependent of an employee. Please be sure to complete the "Relationship to Employee" block.**
   For Dependent Term Life coverage on children, the employee is always the beneficiary. For Dependent Term Life coverage on spouses, the employee is usually the beneficiary, except for certain Group Universal Life and Group Variable Universal Life coverage, in which the employee may be able to specify other beneficiaries.

2. **Detach the Beneficiary Statement* and give a copy to each beneficiary. Ask each beneficiary to complete it and return it to you.**
   If there are multiple beneficiaries, each beneficiary should complete this form. It is only necessary for you to submit one Group Contract Holder Statement, regardless of the number of Beneficiary Statements completed. If you have difficulty obtaining forms from all beneficiaries, please submit the information you have.

   *If the beneficiary is an estate, a minor, or not competent to handle financial affairs, the Beneficiary Statement should be completed by the appropriate legal representative (executor, administrator, or guardian). If no legal representative has been or will be court-appointed, this section should be completed by the person who assumed responsibility for the estate or beneficiary.

3. **Return both the Group Contract Holder Statement and the Beneficiary Statement(s) with the required documents noted below to:**
   The Prudential Insurance Company of America
   Group Life Claim Division
   P.O. Box 8517
   Philadelphia, PA 19101

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

Documents to submit to Prudential

Submit the Group Contract Holder Statement, Beneficiary Statement(s), and the following attachments:

1. A certified copy of the death certificate.
2. A copy of the employee's enrollment card, if available.
3. Any beneficiary changes, if applicable.
4. The certificate of insurance, if available.
5. Legal documentation of the beneficiary for the following situations:

   If the beneficiary is
   (a) an estate, minor, or not competent to handle financial affairs: attach a certified copy of the court order appointing the legal representative.
   (b) a trust: include a letter verifying that the trust is still in effect. If the trust is a testamentary, attach a certified copy of the will and a certified copy of the testamentary.
   (c) no longer living: include a copy of the death certificate.
6. If the insurance was assigned, attach a copy of the assignment and all related papers. If it is a collateral assignment, attach the assignee's statement of indebtedness.
7. If an accidental death claim is being filed, attach supporting information, such as a police report or newspaper clippings.
8. If a Business Travel Accident (BTA) claim is being filed, attach information requested in (7) together with documentation further substantiating the loss, such as a trip itinerary, travel tickets, etc.

Prudential Financial

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 19101

Group Life Insurance Claim Form (Use for employee/member and dependent death claims)

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

1 Deceased's Information

First Name | MI | Last Name

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

Gender: ☐ Male ☐ Female

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

State of Residence

Did employee have accidental death coverage? ☐ 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 death, 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 Financial

Deceased'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 Term Life		$		
☐ Optional Term Life				
☐ Dependent Term Life				
☐ Dependent Optional Term Life				
☐ Group Universal Life				
☐ Group Variable Universal Life				
☐ Dependent Group Universal Life				
☐ Dependent Group Variable Universal Life				
☐ Accidental Death				
☐ Group Universal Accidental Death				
☐ Dependent Accidental Death				
☐ Optional Accidental Death				
☐ Dependent Optional Accidental Death				
☐ Dependent Group Universal Accidental Death				
☐ Business Travel Accidental Death				
☐ Dependent Business Travel Accidental Death				

Salary Amount on Last Day Worked

$ ____ per ☐ Hour ☐ Week ☐ Month ☐ Year

Was insurance ever assigned? ☐ Yes ☐ No

If yes, please attach a copy of assignment and all related papers. For collateral assignment, please attach assignee's statement of indebtedness.

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)

Was insurance in force on date of death? ☐ Yes ☐ No

If no, provide date (MM DD YYYY):

Insurance Terminated

Conversion Privilege Offered (if available)

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 accidental death.

Prudential Financial

Deceased's Social Security Number

5 Payment Information

Mail payment to: ☐ Employer at address listed on page 2 ☐ Beneficiary(ies) at address(es) listed below ☐ Other (please specify in cover letter)

Please provide the following information about the beneficiary(ies). If the claim is for a dependent child, list the employee as beneficiary.

Name of Beneficiary

Date of Birth (MM DD YYYY)

Social Security Number

Relationship to Deceased

Telephone Number

Residence: Street

Apt.

City

State

ZIP Code

Name of Beneficiary

Date of Birth (MM DD YYYY)

Social Security Number

Relationship to Deceased

Telephone Number

Residence: Street

Apt.

City

State

ZIP Code

Name of Beneficiary

Date of Birth (MM DD YYYY)

Social Security Number

Relationship to Deceased

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 Financial

Deceased's Social Security Number

5 Payment Information Continued

Mail payment to: ☐ Employer at address listed on page 2 ☐ Beneficiary(ies) at address(es) listed below ☐ Other (please specify in cover letter)

Please provide the following information about the beneficiary(ies). If the claim is for a dependent child, list the employee as beneficiary.

Name of Beneficiary

Date of Birth (MM DD YYYY)

Social Security Number

Relationship to Deceased

Telephone Number

Residence: Street

Apt.

City

State

ZIP Code

Name of Beneficiary

Date of Birth (MM DD YYYY)

Social Security Number

Relationship to Deceased

Telephone Number

Residence: Street

Apt.

City

State

ZIP Code

Name of Beneficiary

Date of Birth (MM DD YYYY)

Social Security Number

Relationship to Deceased

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 Financial

Beneficiary Statement

Each beneficiary should complete Sections 1, 2, and 3. If accidental death or Business Travel Accident benefits are being claimed, Section 4 should also be completed. Return the form to the deceased's Employer/Plan Administrator.

1 Deceased's Information

First Name | MI | Last Name

Social Security Number

2 Beneficiary's Information

First Name | MI | Last Name

Street | Suite

City | State | ZIP Code

Telephone Number | Date of Birth (MM DD YYYY)

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 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 Financial

Deceased's Social Security Number

Beneficiary Statement

If filing for an accidental death claim, please complete Section 4 below.

4 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 19101. 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.

Prudential Financial

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 19101

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 a statement of claim for payment of a loss or benefit commits a fraudulent insurance act, 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.

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 prison.

NEW JERSEY RESIDENTS— Any person who includes any false or misleading information on an application for an insurance policy 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 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 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 materially false information or conceals, for the purpose of misleading, information concerning any fact thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Prudential Financial is a service mark of The Prudential Insurance Company of America, 751 Broad Street, Newark, NJ 07102, USA and its affiliates.

Prudential Financial

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 19101

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 ☐ Union ☐ Part Time
☐ Salary ☐ Non-union ☐ 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

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				
☐ Dependant 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 Financial

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 Financial

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 19101. 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.

Prudential Financial

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 — Dr.

Telephone Number

Date Treated (MM DD YYYY)

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

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)

Prudential Financial

Claimant's Social Security Number

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)

Prudential Financial

Claimant's Social Security Number

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 a statement of claim for payment of a loss or benefit commits a fraudulent insurance act, 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.

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 prison.

NEW JERSEY RESIDENTS— Any person who includes any false or misleading information on an application for an insurance policy 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 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 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 materially false information or conceals, for the purpose of misleading, information concerning any fact thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Instructions to File a Claim for Disability Benefits

1. Complete all Sections of the Employee Statement.
2. Read the Tax Notice and complete it for voluntary Federal Income Tax withholding from disability benefit payments.
3. Ask your Doctor to complete an Attending Physician's Statement.
4. Submit these completed forms according to the directions you received from your Benefits Office.
5. If the Prudential Insurance Company of America ("Prudential") provides you with both short term and long term disability benefits, the claim for long term disability benefits will be considered as having been filed when the eligibility requirements for that coverage have been met. If you are unclear about whether or not Prudential provides you with both types of disability benefits, please consult your employer.

The Prudential Insurance Company of America
Disability Management Services
PO Box 13480, Philadelphia, PA 19101
Voice: 1-800-842-1718
Facsimile: 1-877-889-4885

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 a statement of claim for payment of a loss or benefit commits a fraudulent insurance act, 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.

For your protection, certain state laws require the following to appear on this form:

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.

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 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 subjects such person to criminal and civil penalties.

Prudential Financial

Group Disability Insurance Employee Statement

1 Employer Information

Employer Name

Control Number

Location / Division

Branch Number

2 Employee Information

First Name

MI

Social Security Number

Last Name

Suffix

Mailing Address - Line 1

Mailing Address - Line 2

Birth date (MM/DD/Year)

City

State

Zip Code

Gender

○ Male

○ Female

Marital Status

○ Unmarried

○ Married

○ Divorced

○ Widowed

Primary Phone Number

Work Phone Number

Email Address

Date Last Worked (MM/DD/Year)

Date First Absent

Date First Treated for this Condition

Date Expected to Return to Work

Spouses Date of Birth

Is Spouse Employed? ○ Yes ○ No

EDUCATION: Highest Grade Completed:

Number of Children Under 18:

Age of Youngest Child:

3 Job Information

Occupation

What Job Category best describes your required job duties? (Please check appropriate box)

○ Sedentary	○ Light	○ Medium	○ Heavy	○ Very Heavy	○ Other
Negligible Weight Mostly Sitting	Up to 10 lbs. frequently Up to 20 lbs. occasionally and / or Frequent Walk/Stand and / or Constant Push/Pull	10 to 25 lbs. freq. Up to 50 lbs. occ.	25 to 50 lbs. freq. 50 to 100 lbs. occ.	More than 50 lbs. freq. 100 lbs. occasionally	(Please describe below)

4 Primary Care Physician

Physician Name

Primary Phone Number

Street Address

Fax Number

City

State

Zip Code

For Internal Use Only

Claim Number

* 1 0 1 B 0 1

The Prudential Insurance Company of America
Disability Management Services
PO Box 13480, Philadelphia, PA 19101
Tel: 1-800-842-1718 Fax: 1-877-889-4885

Prudential Financial

Group Disability Insurance
Employee Statement

Employee Last Name

Social Security Number

5 Medical Information

All Other Physicians You Have Consulted for this Condition

Physician Name	Specialty	Phone Number

What medical condition is preventing you from working?

How does this condition interfere with your ability to perform your job?

Have you been hospitalized for this condition? ○ Yes ○ No ○ In-Patient ○ Out-Patient

If hospitalized, give dates: From: / / To: / /

If you are pregnant: Estimated Delivery Date / / Actual Delivery Date / /

Name of Your Health Insurance Company

Telephone Number

6 Other Income & Workers' Comp. Information

What other income are you entitled to receive as a result of your disability? (Examples: Social Security Disability or Retirement Benefits, Workers' Compensation, State Disability, Pension Disability or Retirement, No-Fault Auto Insurance, Salary Continuance, Group Life or Disability Plan, Health or Welfare Plan, Individual Disability Benefits.) Please send copies of any letters or notices approving or denying benefits.

Source	Applied For Yes	Applied For No	Amount	Frequency	Date Benefit Begins	Date Benefit Ends
Salary Continuance	○	○				
State Disability Benefits	○	○				
Workers' Compensation	○	○				
Other:	○	○				
Other:	○	○				

Is this condition work related? ○ Yes ○ No If Yes, do you intend to file a Workers' Compensation claim? ○ Yes ○ No

7 Fraud Notice

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. This includes Employer and Attending Physician portions of the claim form. (Please see state specific fraud warnings attached.)

X _____ Employee Signature

Date Signed / /

Prudential Financial

Group Disability Insurance Authorization

1 Claimant Information

Social Security Number

Employee Phone Number

First Name

MI

Last Name

Suffix

Email Address

Employer Name

Control Number

2 Authorization to Release Information

Authorization for Release of Information to Prudential Insurance Company
This Authorization is intended to comply with the HIPAA Privacy Rule

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 to me or on my behalf ("My Providers") to disclose my entire medical record and any other health information concerning me 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.

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 have made to restrict my protected health information do not apply to this authorization and I instruct My Providers to release and disclose my 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 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 : PO Box 13480, Philadelphia, PA 19101. 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 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.

*Limits, if any: _____

X _____
Claimant Signature

/ /
Date Signed

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.

For Internal Use Only

Claim Number

* 1 0 5 B 0 1 *

The Prudential Insurance Company of America
Disability Management Services
PO Box 13480, Philadelphia, PA 19101
Tel: 1-800-842-1718 Fax: 1-877-889-4885

Prudential Financial

Group Disability Insurance Employee Tax Notice

1 Employee Information

Social Security Number ___ - __ - ____

Employee Phone Number ___ - ___ - ____

First Name

MI

Last Name

Suffix

Email Address

Employer Name

Control Number

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.

2 Federal and State Withholding

Benefits provided under your Group Disability Income Plan may be subject to federal, state and local taxation. Contact your employee benefits representative or disability plan trustee for details on your rights and obligations under the various tax codes.

If you wish to have Federal Income Tax (FIT) withheld from any payments you may receive, indicate the amount to be withheld ($20 weekly minimum for STD/$88 monthly minumum for LTD) below and sign the authorization. Withholding requests may also be submitted on IRS Form W-4S. Withholding requests must be stated in whole dollar amounts. FIT will not be withheld if the disability benefit is not axable.

I request voluntary Federal Income Tax withholding from each payment, as authorized under section 3402(c) of the Internal Revenue Code, in the amount(s) of:

For STD ____ .00 weekly ($20.00 minimum)

For LTD ____ .00 monthly ($88.00 minimum)

3 Employee Signature

X _____ Employee Signature

__ / __ / ____ Date Signed

For Internal Use Only

Claim Number

106B01

The Prudential Insurance Company of America
Disability Management Services
PO Box 13480, Philadelphia, PA 19101
Tel: 1-800-842-1718 Fax: 1-877-889-4885

Prudential Financial

Group Disability Insurance
Attending Physician's Statement

The Employee is responsible for the completion of this form without expense to Prudential Financial.

1 Employee Information

Employer/Association Name

Control Number

Employee First Name

MI

Social Security Number

Employee Last Name

Suffix

Employee Address - Line 1

Birth date (MM/DD/Year)

Employee Address - Line 2

Gender

○ Male ○ Female

City

State

Zip Code

Occupation

I hereby authorize release of information requested on this form by the below named physician for the purpose of claim processing.

X _____ Employee Signature

Date Signed

2 To Be Completed By Attending Physician

Clinical Diagnosis

ICD-9 Code

Pregnancy EDC

Primary:

Secondary:

Secondary:

Relevant test procedures performed (Please provide results)

Surgical procedure(s) performed (Please be specific):

Date of Procedure:

Current Medications:

For Internal Use Only

Claim Number

* 1 0 3 B 0 1 *

The Prudential Insurance Company of America
Disability Management Services
PO Box 13480, Philadelphia, PA 19101
Tel: 1-800-842-1718 Fax: 1-877-889-4885

Prudential Financial

Group Disability Insurance
Attending Physician's Statement

Employee Last Name

Social Security Number - -

2

Attending Physician Information (Cont'd)

Was Claimant hospital confined? ○ Yes ○ No

If Yes, please provide name and address of hospital:

If hospitalized, give dates:
From: / /
To: / /

Other Treating Physicians or Consultants

Physician Name	Specialty	Phone Number

Do you feel the claimant is competent to endorse checks and direct the use of proceeds? ○ Yes ○ No

Nature of Medical Impairment / Limitation (Please specify nature of corresponding loss of function)

Date when significant loss of function occurred: / /

Are there Corresponding Medical Restrictions (i.e., What activities should the claimant not perform because of a significant risk to self or others?)

Prognosis for Return to Function / Return to Work:

Return to Work Plan (Please describe):

Target Date / /

Prudential Financial

Group Disability Insurance
Attending Physician's Statement

Employee Last Name

Social Security Number

2 Attending Physician Information (Cont'd)

Describe Medical Obstacles to Return to Work:

Are there any Non-Medical Factors which have a significant impact on Functional Abilities (i.e., interpersonal, financial, amily)?

Work related illness or injury? ○ Yes ○ No

Was Condition caused by a MVA? ○ Yes ○ No

If MVA, in what state did it occur?

First Visit / /

Last Visit / /

Frequency of Visits:

What Job Category best describes the claimant's functional abilities? (Please check appropriate box)

○ Sedentary	○ Light	○ Medium	○ Heavy	○ Very Heavy	○ Other
Negligible Weight Mostly Sitting	Up to 10 lbs. frequently Up to 20 lbs. occasionally and / or Frequent Walk/Stand and / or Constant Push/Pull	10 to 25 lbs. freq. Up to 50 lbs. occ.	25 to 50 lbs. freq. 50 to 100 lbs. occ.	More than 50 lbs. freq. 100 lbs. occasionally	(Please describe below)

3 Physician Information

Physician Name

Primary Phone Number

Office Address

Fax Number

City

State

Zip Code

Specialty

4 Fraud Notice

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

X

Physician Signature

Date Completed

Prudential Financial

Group Disability Insurance Employer Statement

1 Employer Information

Employer Name

Control Number

Employer Phone Number

Branch Number

Email Address

2 Employee Information

First Name

MI

Social Security Number

Last Name

Suffix

Address

City

State

Zip Code

Coverage in force when absence began (check all that apply): ○ STD ○ LTD

Employee Phone Number

Gender ○ Male ○ Female

STD Coverage Selected ○ Core ○ Optional _____

LTD Coverage Selected ○ Core ○ Optional _____

Date employee became a covered individual for the applicable Coverages:

STD: / /

LTD: / /

Date Hired (MM/DD/Year) / /

Coverage Termination Date / /

Date Last Worked / /

Date First Absent / /

Date Work Was Resumed / /

Normal Earnings Prior To This Absence (exclude bonus, overtime, etc.)

$, .

Frequency of Normal Earnings

○ Hourly ○ Monthly

○ Weekly ○ Annually

○ Bi-Weekly ○ Other _____

Last Date Employer Paid Any Compensation / /

Work Hours

Is the employee's work week Monday thru Friday? ○ Yes ○ No

Number of hours worked per normal work week:

If not Mon thru Fri, Check Days Worked

☐ Varies ☐ Wednesday ☐ Saturday

☐ Monday ☐ Thursday ☐ Sunday

☐ Tuesday ☐ Friday

Employment Status

○ Salary

○ Hourly

○ Other _____

Does employee contribute toward the STD Premium? ○ Yes ○ No

If Yes: ○ Pre Tax ○ Post Tax

If Post Tax:

_____ % paid by employer

_____ % paid by employee

Does employee contribute toward the LTD Premium? ○ Yes ○ No

If Yes: ○ Pre Tax ○ Post Tax

If Post Tax:

_____ % paid by employer

_____ % paid by employee

For Internal Use Only

Claim Number

* 1 0 2 B 0 1 *

The Prudential Insurance Company of America
Disability Management Services
PO Box 13480, Philadelphia, PA 19101
Tel: 1-800-842-1718 Fax: 1-877-889-4885

Prudential Financial

Group Disability Insurance
Employer Statement

Employee Last Name

Social Security Number ___ - __ - ____

2 Employee Information (Continued)

Is employee covered under a Prudential Group Life Insurance Policy? ○ Yes ○ No

If Yes, what is the Face Amount? $, , .00

3 Other Income, Deductions & Workers' Comp. Information

Please indicate any applicable deductions, such as Local Tax, State Income Tax, Medical, Dental, Life, 401K, that should be withheld from the employee's benefits, if approved. Please also indicate if the employee is receiving, or is eligible to receive, benefits from any other sources because of this absence, such as Salary Continuance, Workers' Compensation, Social Security Disability or Retirement Benefits, Statutory Benefits, No Fault Auto Insurance, Retirement or Pension Plan. Please send copies of any letters or notices approving or denying benefits.

Source	Applied For Yes	Applied For No	Amount	Frequency	Date Benefit Begins	Date Benefit Ends
Salary Continuance						
State Disability Benefits	☐	☐				
Workers' Compensation	☐	☐				
Other:	☐	☐				
Other:	☐	☐				

Has the employee indicated that the absence is work related? ○ Yes ○ No

Has a Workers' Compensation claim been filed? ○ Yes ○ No

4 Job Information

Occupation

DOT Job Code:

What Job Category best describes the employee's essential job duties? (Please check appropriate box)

○ Sedentary	○ Light	○ Medium	○ Heavy	○ Very Heavy	○ Other
Negligible Weight Mostly Sitting	Up to 10 lbs. frequently Up to 20 lbs. occasionally and / or Frequent Walk/Stand and / or Constant Push/Pull	10 to 25 lbs. freq. Up to 50 lbs. occ.	25 to 50 lbs. freq. 50 to 100 lbs. occ.	More than 50 lbs. freq. 100 lbs. occasionally	(Please describe below)

As the employer, would you be able to accommodate modified duty to facilitate early return to work? ○ Yes ○ No

If Yes, please explain (reduced hours, job modification, etc):

5 Fraud Notice

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. This includes the Employee and Attending Physician portions of the claim form.

X

Employer Signature

Date Signed

Prudential Financial

Group Disability Insurance
Electronic Funds Transfer Authorization

1 Enrollment

To enroll in Prudential's Electronic Funds Transfer (EFT) payment service, please provide the following information. If you elect to have Prudential deposit the funds in your savings account, you must first check with your bank to obtain the correct bank transit routing number and account number for electronic deposit. Please note that a deposit slip does not contain acceptable banking information. If you have any questions, please call us toll free at (800) 842-1718.

2 Claimant Information

Employer Name

Claimant First Name

Last Name

Social Security Number - -

Primary Phone Number - -

3 Banking Information

Bank Name

Branch Telephone Number - -

Type of Account (Select One)

○ Savings ○ Checking

Bank Transit Routing Number

(Nine digit bank transit routing)

Bank Account Number

(Bank Account Number)

4 Payment Plan Agreement

I authorize the Prudential Insurance Company of America to make electronic fund deposits of my disability benefit payment to my account. I understand that any deposit made to an inactive account will be returned to Prudential and reissued as a manual check. In addition, if any overpayment of such disability benefits is credited to my account in error, I authorize Prudential to withdraw any payments necessary in order to assure the accuracy of my claim payments.

I can cancel this authorization at any time by giving Prudential written notice. Any notice hereunder will not be deemed effective until Prudential has received my written notice.

Account Owner Name

Street Address

City

State

Zip Code -

X

Account Owner Signature

/ /

Date Signed

For Internal Use Only

Claim Number

* 1 1 3 B 0

The Prudential Insurance Company of America
Disability Management Services
PO Box 13480, Philadelphia, PA 19101
Tel: 1-800-842-1718 Fax: 1-877-889-4885

Prudential Financial

Group Disability Insurance
Electronic Funds Transfer Authorization

Instructions Only: It is not necessary to return this page with your EFT Authorization.

5

Instructions for completing Section 3, "Banking Information"

This will help you identify the necessary bank information to initiate electronic withdrawals. The nine-digit ransit
routing number is how we recognize the bank you do business with.

Record all banking information on page 1 of the form in Section 3, "Banking Information".
Please call your bank to confirm that the information you are supplying is correct.

Customer's Name
Street Address
City, State, ZIP

Check No. 1246

PAY TO THE ORDER OF _____ $ _____

_____ Dollars

Bank Name
Street Address
City, State, ZIP

A272078048A 006666D66666C 1246

This is the bank transit routing umber.

It is always 9 digits and appears between the : ymbols.

Record this number in the boxes provided in Section 3, "nine-digit bank transit routing number."

This is your bank account number. It varies in number of digits and may include dashes or spaces.

The < symbol indicates the end of the account number.

Record the account number in the boxes provided in section 3, "Bank Account Number" and include any dashes and spaces that are within the account number.

If there are any digits to the right of the < symbol (which do not represent the check sequence number), record them in the boxes provided

This is the check sequence number. It may be on either end of your check. Please do not include this on the authorization form.

Prudential Financial

LONG TERM CARE INSURANCE CLAIM FORM - GROUP
THIS SIDE MUST BE COMPLETED BY THE INSURED OR THE INSURED'S REPRESENTATIVE.

THE PRUDENTIAL INSURANCE COMPANY OF AMERICA
LONG TERM CARE CUSTOMER SERVICE CENTER
P. O. 8526, PHILADELPHIA, PA 19101
PHONE: 1-800-732-0416

A. INSURED INFORMATION: PLEASE PRINT USING BLUE OR BLACK INK.

CERTIFICATE #: _____ CONTROL #: _____ SOCIAL SECURITY #:: _____ - ____ - _____

First Name: _____ M.I: ____ Last Name: _____

Address (No P.O. Boxes Please): _____ Apt. #: _____

City: _____ State: _____ ZIP Code: _____ Date of Birth: _____

Phone (Day): _____ - _____ - _____ Phone (Other): _____ - _____ - _____ Sex: ☐ Male ☐ Female

OTHER COVERAGE: Please indicate any other source of insurance coverage: ☐ Worker's Compensation
☐ No Fault Automobile Insurance ☐ Liability Insurance ☐ Group Health Insurance ☐ Medi-Gap insurance
☐ Group Long Term Care Insurance ☐ Health Maintenance Organization (HMO) coverage ☐ Medicare ☐ Medicaid
For any other insurance checked, please give requested information:

INSURANCE CO: _____ EFFECTIVE DATE _____ POLICY #: _____

INSURANCE CO: _____ EFFECTIVE DATE _____ POLICY #: _____

ALL CLAIM SUBMISSIONS: A Plan of Care is required with the claim. We will contact you when an updated plan of care is required. Attach the bills for the services rendered by any eligible providers of care.

This claim is for: ☐ Adult Day Care ☐ Assisted Living ☐ Bed Reservation ☐ Home Health ☐ Hospice
☐ Informal Care ☐ Lifestyle Changes ☐ Nursing Home ☐ Private Care Management

- Respite Care Benefit: Were services provided to relieve an informal caregiver? ☐ Yes ☐ No
  If yes, indicate dates of informal care: From: _____ To: _____

  Informal Caregiver: _____ Relationship to Insured: _____

- Informal Care Benefit: ($ amount claimed: _____) Dates Claimed: From: _____ To: _____

- Cash Benefit Rider: You will need to complete this form at the end of each month for which you are claiming benefits under this rider. Indicate the dates for which you are claiming benefits due to a chronic illness or disability.
  From: _____ To: _____

B. INSURED'S SIGNATURE:

ATTESTATION: The information provided above is accurate and correct to the best of my knowledge and belief, and I have read the fraud warnings on the reverse side of this form.
Insured's Signature: _____ Date: _____

ASSIGNMENT OF BENEFITS:
I hereby direct that my benefits be paid to _____ (Name of Provider). This assignment of benefits will be ongoing unless I send The Prudential written notice indicating otherwise.

Insured's Signature: _____ Date: _____

SIDE 1 – INSURED INFORMATION

Prudential Financial

GROUP Long Term Care Insurance Claim Form - to be completed by the Provider for the Initial Claim Only

PROVIDER INFORMATION:
PLEASE PRINT USING BLUE OR BLACK INK.

NAME: _____ SSN or TIN: _____

PROFESSIONAL DESIGNATION: _____ LICENSE/CERT. NUMBER: _____
Street Address:
(No P. O. Boxes Please): _____

City: _____ State: _____ ZIP Code: _____ - _____

Phone 1: _____ - _____ - _____ Phone 2 : _____ - _____ - _____ FAX: _____ - _____ - _____

YOU MUST ATTACH A COPY OF THE BILL FOR ALL LONG TERM CARE SERVICES PROVIDED TO THE CLAIMANT. THIS BILLING MUST INCLUDE THE NAME OF THE PERSON WHO RECEIVED THE SERVICE, EACH DATE SERVICE IS PROVIDED, TYPE OF SERVICE PROVIDED, AND THE CHARGE FOR THAT SERVICE.

PROVIDER'S SIGNATURE:
The information provided above is accurate and correct to the best of my knowledge and belief. The fees noted are the actual fees I have charged and intend to accept for the services provided. The claimant's plan of care is attached.

Provider's Signature: X Date: _

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 of information when filing a statement of claim for payment of a loss or benefit commits a fraudulent insurance act, 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.

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.

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 violation.

Pennsylvania 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 subjects such person to criminal and civil penalties.

SIDE 2 – PROVIDER INFORMATION