

Exhibit I

Sample Claim Forms

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.



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 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 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



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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
<input type="checkbox"/> Basic Term Life		\$		
<input type="checkbox"/> Optional Term Life				
<input type="checkbox"/> Dependent Term Life				
<input type="checkbox"/> Dependent Optional Term Life				
<input type="checkbox"/> Group Universal Life				
<input type="checkbox"/> Group Variable Universal Life				
<input type="checkbox"/> Dependent Group Universal Life				
<input type="checkbox"/> Dependent Group Variable Universal Life				
<input type="checkbox"/> Accidental Death				
<input type="checkbox"/> Group Universal Accidental Death				
<input type="checkbox"/> Dependent Accidental Death				
<input type="checkbox"/> Optional Accidental Death				
<input type="checkbox"/> Dependent Optional Accidental Death				
<input type="checkbox"/> Dependent Group Universal Accidental Death				
<input type="checkbox"/> Business Travel Accidental Death				
<input type="checkbox"/> 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 Yes No

Conversion Privilege Offered (if available) Yes No

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.



Deceased's Social Security Number

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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)	
<input type="text"/>		<input type="text"/>	
Social Security Number	Relationship to Deceased	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"/>	

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

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

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

Please print or type name

Signature X

Date (MM DD YYYY)



Deceased's Social Security Number

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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)	
<input type="text"/>		<input type="text"/>	
Social Security Number	Relationship to Deceased	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"/>	

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

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

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

Please print or type name

Date (MM DD YYYY)

Signature X



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-BBEN, 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 _____ Date (MM DD YYYY)
 Signature



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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

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MI

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Last Name

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Date of Birth (MM DD YYYY)

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I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided treatment, payment or services pertaining to:

First Name

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MI

--	--

Last Name

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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:

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Date (MM DD YYYY)

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X

Signature of Insured/Patient or Personal Representative

Description of Personal Representative's Authority or Relationship to Patient

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



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.



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 Date Last Worked (MM DD YYYY)
 Salary Non-union Full Time

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

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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
<input type="checkbox"/> Basic AD&D		\$		
<input type="checkbox"/> Group Universal AD&D				
<input type="checkbox"/> Dependent AD&D				
<input type="checkbox"/> Optional AD&D				
<input type="checkbox"/> Dependent Optional AD&D				
<input type="checkbox"/> Dependent Group Universal AD&D				
<input type="checkbox"/> Business Travel AD&D				
<input type="checkbox"/> Dependent Business Travel AD&D				

Salary Amount on Last Day Worked

\$

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 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)

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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)

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Social Security Number

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 Relationship to Employee

Telephone Number

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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)

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Signature



□ □ □ □ □ □ □ □ □ □ □ □

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-BBEN, 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.

Date (MM DD YYYY)

□ □ □ □ □ □ □ □ □ □ □ □

X

Signature



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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)
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1. Describe the accident causing the injury/impairment

2. Was there any disease or 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)
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Address

Name of Physician Dr:	Telephone Number 	Date Treated (MM DD YYYY)
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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 Wrist—Date of Amputation (MM DD YYYY) Below

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

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

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

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

1. Vision acuity	a. Date of first observation (MM DD YYYY) 	Uncorrected		Corrected	
	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?	3. If totally blind, give date when this occurred:
Right Eye (MM DD YYYY) Left Eye (MM DD YYYY)	Right Eye (MM DD YYYY) Left Eye (MM DD YYYY)



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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.

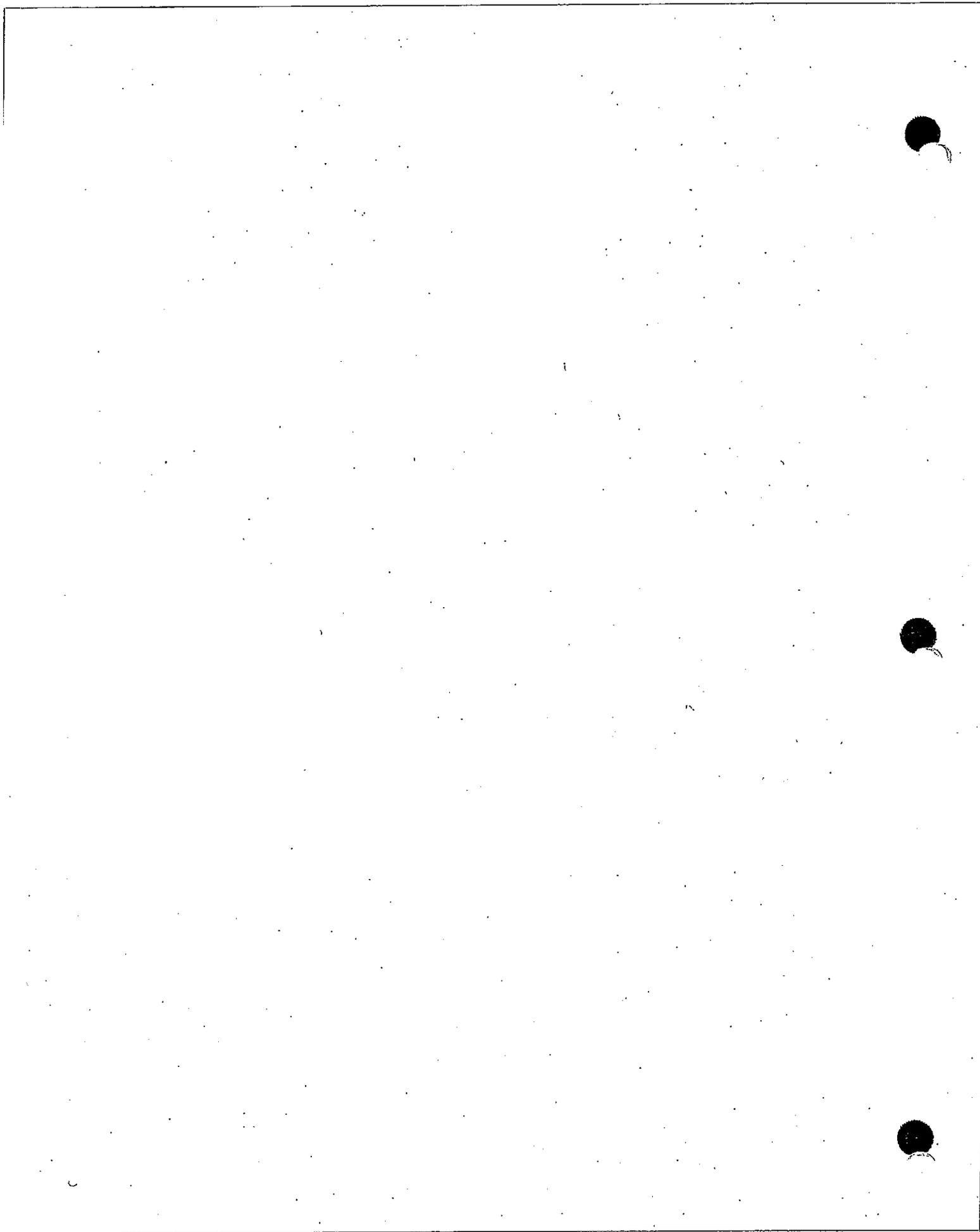
CALIFORNIA RESIDENTS— For your protection, California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in prison.

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.





Group Disability Insurance
Claim Instructions

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.

Do Not Return This Page - Keep for Your Records

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

Employee Last Name Social Security Number - -

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 - -

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 No	Amount	Frequency	Date Benefit Begins	Date Benefit Ends
Salary Continuance	<input type="radio"/> Yes <input type="radio"/> No				
State Disability Benefits	<input type="radio"/> Yes <input type="radio"/> No				
Workers' Compensation	<input type="radio"/> Yes <input type="radio"/> No				
Other:	<input type="radio"/> Yes <input type="radio"/> No				
Other:	<input type="radio"/> Yes <input type="radio"/> No				

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

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



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



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

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

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 <input type="radio"/> Male <input type="radio"/> 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

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



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

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 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



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

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

Instructions for completing Section 3, "Banking Information"

This will help you identify the necessary bank information to initiate electronic withdrawals. The nine-digit transit 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 number.

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

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

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

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.

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

