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 19176

Accelerated Benefit Option Claim Form-New York (Use for employee/member and dependent claims)

How to present a claim

1. Disclosure Statement and Tax Certification
Employees should first carefully read the Disclosure Statement below and sign and date the Acknowledgement. They should then read the Important Tax Information and Tax Certification (page 8) and complete, sign, and date the Tax Certification.

2. Accelerated Benefit Option Claim Form
Both the "Employee Statement" (page 2) and the "Group Contract Holder Statement" (page 4) attached to these instructions must be completed. Section 1 of the "Group Contract Holder Statement" must be completed if the claim is for an employee/member or for a dependent of an employee. The "Employee Statement" should be completed and returned to the benefits administrator (Group Contract Holder).

3. Attending Physician Certification
Medical evidence of terminal illness should be submitted on the Attending Physician's Certification form. This form should be completed by the physician and certify the nature of the employee's or dependent's illness. It should be mailed to Prudential with the Accelerated Benefit Option Claim Form.

4. Mail the completed forms to:
The Prudential Insurance Company of America
Group Life Claim Division
P.O. Box 8517
Philadelphia, PA 19176

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

Disclosure Statement

The money received from the Accelerated Benefit Option can be used for any purpose. If you exercise this option and accept payment, you should be aware that such payment may adversely affect your eligibility for Medicaid or other government benefits or entitlements. In addition, the Accelerated Benefit Option payment, or a portion thereof, may be considered taxable income. Prudential recommends that assistance be sought from a personal tax advisor and/or an attorney regarding how election of this option may affect your personal situation. Prudential offers this option based on our interpretation of current law, which may change in the future.

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

Receipt of accelerated death benefits may affect eligibility for public assistance programs such as medical assistance (Medicaid), Aid to Families with Dependent Children, and Supplemental Security Income. Prior to applying for accelerated death benefits, certificateholders should consult with the appropriate social services agency concerning how receipt will affect the eligibility of the recipient and/or the recipient's spouse or dependents. Receipt of accelerated death benefits may be taxable. Prior to applying for such benefits, certificateholders should seek assistance from a qualified tax advisor. No health care facility as defined in Section 20 of the Public Health law can require any person to accelerate payment of a death benefit as a condition of admission to such health care facility or for providing any care in such facility. Insurers are prohibited from paying accelerated death benefits to the certificateholders for a period of 14 days from the date on which the certificateholder is provided a numerical computation of the accelerated death benefit and an illustration of the effect of an accelerated death benefit claim on contract values.

Acknowledgement: I have read the disclosure information above.
I am applying for accelerated death benefits voluntarily and without coercion on the part of any third party.

X _____ Date (MM DD YYYY) ☐☐ ☐☐ ☐☐☐☐
Employee's Signature

X _____ Date (MM DD YYYY) ☐☐ ☐☐ ☐☐☐☐
Beneficiary's Signature (Required only if irrevocable)

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Accelerated Benefit Option Claim Form (Use for employee/member and dependent claims)

Employee Statement Please complete in full.

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

Home Address

Mailing Address (if different)

Last day worked prior to current disability (MM DD YYYY) | Date first treated by physician (MM DD YYYY) | Amount being claimed

$

*If claim is for a dependent, please provide the following information:

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

List physicians consulted because of this disability

Name | Period Treated: From (MM DD YYYY) | To (MM DD YYYY)

Dr.

Address

Dr.

Address

List any hospital confinements for this disability

Name of hospital | Period Confined: From (MM DD YYYY) | To (MM DD YYYY)

If you have any other Prudential policies, please show policy number(s) (complete as it pertains to employee or dependent):

Has this insurance been assigned? ☐ Yes ☐ No

Has any government agency required that you involuntarily exercise this option as a condition for obtaining or retaining a government benefit or entitlement? ☐ Yes ☐ No

Has any creditor required that you exercise this option? ☐ Yes ☐ No

Optional Payment Election ☐ **LUMP SUM**

I hereby certify that these statements are true:

Date (MM DD YYYY)

X

Employee's Signature

Prudential Financial

Claimant's Social Security Number

Authorization for Release of Information to Prudential Insurance Company

This Authorization is intended to comply with the HIPAA Privacy Rule

Name of Insured:

First Name | MI | Last Name

Date of Birth (MM DD YYYY)

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

First Name | MI | Last Name

Print Name of Deceased or Patient

or on my (his/her) behalf ("My Providers") to disclose my (his/her) entire medical record for me or my dependents and any other health information concerning me (him/her) to The Prudential Insurance Company of America (Prudential) and its agents, employees, and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

I authorize all non-health organizations, any insurance company, employer, or other person or institutions to provide any information, data or records relating to credit, financial, earnings, travel, activities or employment history to Prudential.

Unless limits* are shown below, this form pertains to all of the records listed above.

By my signature below, I acknowledge that any agreements I (he/she) have made to restrict my (his/her) protected health information do not apply to this authorization and I instruct My Providers to release and disclose my (his/her) entire medical record without restriction.

This information is to be disclosed under this Authorization so that Prudential may: 1) administer claims and determine or fulfill responsibility for coverage and provision of benefits, 2) obtain reinsurance; 3) administer coverage; and 4) conduct other legally permissible activities that relate to any coverage I (he/she) have (has) or have (has) applied for with Prudential.

This authorization shall remain in force for 24 months following the date of my signature below, while the coverage is in force, except to the extent that state law imposes a shorter duration. A copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to Prudential at: PO Box 8517, Philadelphia, PA 19176. I understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization or to the extent that Prudential has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that if I refuse to sign this authorization to release my complete medical record, Prudential may not be able to process my claim for benefits and may not be able to make any benefit payments. I understand that I have the right to request and receive a copy of this authorization.

*Limits, if any:

Date (MM DD YYYY)

X

Signature of Insured/Patient or Personal Representative

Description of Personal Representative's Authority or Relationship to Patient

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

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Group Insurance

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Accelerated Benefit Option Claim Form (Use for employee/member and dependent 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 Disability (MM DD YYYY)

Gender: ☐ Male ☐ Female

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

State of Residence

AKA: First Name | Last Name

2 Employee/ Member Information

First Name | MI | Last Name

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

Date of Employment (MM DD YYYY)

☐ Hourly ☐ 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 disability, what was the reason? (Attach explanation, if applicable.)

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

Street Address (where employed)

City | State | ZIP Code

3 Employer/ Association Information

Employer's Name

Street | Suite

City | State | ZIP Code

Telephone Number

Prudential Financial

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 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		.		

Employee/Member Salary Amount on Last Day Worked

$.

per

☐ Hour ☐ Week ☐ Month ☐ Year

Was insurance ever assigned?

☐ Yes ☐ No

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

Maximum Amount Available Under the Accelerated Benefit Option

$.

Please enter amount being claimed under each applicable coverage

Group Coverage	Amount to be Distributed
	$.
	$.
	$.

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)

Prudential Financial

Claimant's Social Security Number

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 about the claimant.

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

Signature X

Date (MM DD YYYY)

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

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

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

Patient's Address

Employer's Name | Control Number

X _____ Date (MM DD YYYY)

Patient's Signature

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

Date of first visit (MM DD YYYY) | Date of last visit (MM DD YYYY) | Date total disability began (MM DD YYYY)

Diagnosis | CD-9 CM Disease Code | Present Condition

Objective Findings/include any results of current x-rays, E.K.G., or any other special test

Is the patient capable of handling his/her own affairs? ☐ Yes ☐ No

List any hospital confinements for this disability

Name of hospital | Period Confined From (MM DD YYYY) | To (MM DD YYYY)

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

Does your patient meet this requirement? ☐ Yes ☐ No

If "Yes," briefly explain the basis for your opinion of the patient's life expectancy. The patient's most recent clinical records must be provided.

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

Physician's Address

X _____ Date (MM DD YYYY)

Signature

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Philadelphia, PA 19176

IMPORTANT TAX INFORMATION

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

Citizenship. You must indicate if you are not a U.S. citizen or resident alien. In that case, you must state the country of which you are a citizen and submit a completed IRS Form W-8BEN.

Backup withholding. You must tell us if the IRS has notified you that you are subject to backup withholding because you did not report all your taxable interest and dividends on your tax return. **You are not subject to backup withholding if either (a) you did not receive such a notice from the IRS, (b) the IRS recently told you that you are no longer subject to a backup withholding order, or (c) you are exempt from such withholding.**

Taxpayer Identification Number and date of birth. You must include your Taxpayer Identification Number (TIN) and date of birth. The TIN for the certificate is:

- Your Social Security Number if you are an individual or the owner of a sole proprietorship.
- The Employer Identification Number (EIN) if you represent a trust, estate, corporation, partnership, or tax-exempt organization.
- The TIN of the grantor/trustee or that of the actual owner of a trust-like entity not recognized as a legal or valid trust under state law.

Tax Certification **(See Important Tax Information above for additional information on this section)**

If this section is not completed, we may be required to withhold federal and state income tax.

Complete section (a) or (b) below:

(a) Under penalities of perjury, I certify that my correct Taxpayer Identification Number is:

Claimant/Assignee's Social Security Number or Employer Identification Number **Claimant's Date of Birth**

Complete the following, if applicable.

I am not subject to backup withholding for the reasons stated under "Backup Withholding" in the Important Tax Information section. *(Check the box only if you are subject to backup withholding)*

☐ **I have been notified by the Internal Revenue Service that I am subject to backup withholding due to underreporting of interest or dividends.**

(b) ☐ **I am not a U.S. person (inclulding 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 _____ Date (MM DD YYYY) ☐☐ ☐☐ ☐☐☐☐

Claimant's Signature

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Philadelphia, PA 19176

For residents of all states except California, Florida, New Jersey, New York, Pennsylvania, Utah, Vermont, Virginia and Washington; WARNING: Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person, or knowing that he is facilitating commission of a fraud, submits incomplete, false, fraudulent, deceptive or misleading facts or information when filing an insurance application or a statement of claim for payment of a loss or benefit commits a fraudulent insurance act, is/may be guilty of a crime and may be prosecuted and punished under state law. Penalties may include fines, civil damages and criminal penalties, including confinement in prison. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant or if the applicant conceals, for the purpose of misleading, information concerning any fact material thereto.

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

FLORIDA RESIDENTS — Any person knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing false, incomplete, or misleading information is guilty of a felony of the third degree.

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

NEW YORK RESIDENTS — Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

PENNSYLVANIA and UTAH RESIDENTS — Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any material fact thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

VIRGINIA RESIDENTS — Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person, or knowing that he is facilitating commission of a fraud, submits incomplete, false, fraudulent, deceptive or misleading facts or information when filing a statement of claim for payment of a loss or benefit may have violated state law, is guilty of a crime and may be prosecuted and punished under state law. Penalties may include fines, civil damages and criminal penalties, including confinement in prison. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant or if the applicant conceals, for the purpose of misleading, information concerning any fact material thereto.

VERMONT RESIDENTS — Any person who knowingly presents a false or fraudulent claim for payment of a loss or knowingly makes a false statement in an application for insurance may be guilty of a criminal offense under state law.

WASHINGTON RESIDENTS — Any person who knowingly provides false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company commits a crime. Penalties include imprisonment, fines, and denial of insurance benefits.