

Group Life Claim for Total Disability Benefits—Employee Statement

Instructions to file a Claim for Group Life Insurance Coverage for Total Disability

1. Complete all sections of the **Employee Statement (Form GL.2003.015)**
2. Ask your doctor to complete the **Attending Physician's Statement GL.2002.119)**
3. Submit these completed forms according to the directions you received from your Benefits Office or mail them to:

The Prudential Insurance Company of America
Disability Management Services
Waiver of Premium Unit
P.O. Box 482
Livingston, NJ 07039-0482

Or fax the completed forms to:
973-548-7530

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

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 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 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.



Group Life Claim For Total Disability Benefits—Employee Statement

Tel 800-524-0542 Fax 973-548-7530

Group Insurance Employee's Statement To be completed by Employee. Please complete all five sections.

1 Employer/ Association Information

Employer's Name

Control Number/s

Location/Division

Branch Number/s

2 Employee Information

First Name

MI

Last Name

Social Security Number

Date of Birth (MM DD YYYY)

Gender

 Male Female

Marital Status

 Unmarried Divorced
 Married Widowed

Spouse Date of Birth (MM DD YYYY)

Youngest Child Date of Birth (MM DD YYYY)

Street

Suite

City

State

ZIP Code

Your Mailing Address (if different from home address)

Street

Suite

City

State

ZIP Code

Primary Telephone Number

Work Telephone Number

Education—Highest Level Completed

 Elementary High School College Graduate School

List trade schools attended or special training received

Date of Employment (MM DD YYYY)

Date Last Worked (MM DD YYYY)

Date First Treated for This Condition (MM DD YYYY)

Date First Absent (MM DD YYYY)

Date Work Resumed (MM DD YYYY)

Date Expected to Return to Work (MM DD YYYY)



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4 Primary Care Physician

Name of Attending Physician (Please print)

First Name	MI	Last Name

Primary Telephone Number	Fax Number

Office Address	Suite

City	State	ZIP Code

Specialty

5 Medical Information

Other Treating Physicians or Consultants

Name of Attending Physician (Please print)

First Name	Last Name

Specialty	Telephone Number

First Name	Last Name

Specialty	Telephone Number

List any hospital confinement for this disability

Name of Hospital and Address

Period Confined

From (MM DD YYYY)

To (MM DD YYYY)

Name of Hospital and Address

From (MM DD YYYY)

To (MM DD YYYY)

What medical condition is preventing you from working?

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What impairment prevents you from performing the essential functions of your occupation or any other occupation?

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If you are pregnant:	Expected Delivery Date (MM DD YYYY)	Actual Delivery Date (MM DD YYYY)



