



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
Tel: 800-524-0542 Fax: 888-227-6764

Accelerated Benefit Option Claim Form

(Use for employee/member and dependent claims.)

How to complete and submit an Accelerated Benefit Option Claim Form:

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 10) 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 5) 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.

To Be Completed by Employee

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 over time.

By electing this option, the total amount of employee or dependents 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 and any required contribution for that insurance will be reduced accordingly. Also, any amount that could otherwise have been converted to an individual contract will be reduced by the amount paid under this option.

Acknowledgement: I have read the disclosure information above.

X
Employee's Signature

Date (MM DD YYYY)
[] [] [] [] [] [] [] []

X
Beneficiary's Signature (Required only if irrevocable.)

Date (MM DD YYYY)
[] [] [] [] [] [] [] []





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
Tel: 800-524-0542 Fax: 888-227-6764

Accelerated Benefit Option Claim Form

(Use for employee/member and dependent claims.)

Employee Statement - Pages 2-4 To Be Completed By Employee Please complete in full.

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

Home Address field

Mailing Address (if different) field

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

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

Dependent Name, Social Security Number, Date of Birth (MM DD YYYY) fields

List physicians consulted because of this disability

Physician Name, Period Treated (From MM DD YYYY, To MM DD YYYY) fields

Physician Address field

Physician Name, Social Security Number, Date of Birth (MM DD YYYY) fields

Physician Address field

List any hospital confinements for this disability

Hospital Name, Period Confined (From MM DD YYYY, To MM DD YYYY) fields

Hospital Name, Period Confined (From MM DD YYYY, To MM DD YYYY) fields

Hospital Name, Period Confined (From MM DD YYYY, To MM DD YYYY) fields





Grid for Social Security Number

Accelerated Benefit Option Claim Form

(Use for employee/member and dependent claims.)

To Be Completed by Employee

Employee Statement (continued)

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

Empty box for other Prudential policies

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 For cases sitused in Connecticut and Vermont: Distribution will be lump sum payment only.

LUMP SUM

TWENTY-FOUR MONTHLY INSTALLMENTS

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

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.

I have read and understand the terms and requirements of the fraud warnings included as part of this form.

X

Employee's Signature

Date (MM DD YYYY)

Grid for Date

Telephone Number

Grid for Telephone Number





Grid for 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:

Form for Name of Insured: First Name, MI, Last Name

Form for 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:

Form for Name of Deceased or Patient: 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.

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.

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.

Form for Date (MM DD YYYY)

X _____ Signature of Insured/Patient or Personal Representative

Form for Description of Personal Representative's Authority or Relationship to Patient

Description of Personal Representative's Authority or Relationship to Patient





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
Tel: 800-524-0542 Fax: 888-227-6764

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 To Be Completed By Employer

Form section 1: Claimant's Information. Includes fields for First Name, MI, Last Name, Social Security Number, Date of Birth, Date of Disability, Gender, Relationship to Employee, AKA: First Name, Last Name.

2 Employee/Member Information

Form section 2: Employee/Member Information. Includes fields for First Name, MI, Last Name, Social Security Number, Date of Birth, Date of Employment, Hourly/Salary, Union/Non-union, Part Time/Full Time, Date Last Worked, Occupation, Where Employed, Reason for disability, Street Address, City, State, ZIP Code.

3 Employer/Association Information

Form section 3: Employer/Association Information. Includes fields for Employer's Name, Street, Suite, City, State, ZIP Code, Telephone Number.





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

To Be Completed by Physician

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

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, ICD Diagnosis, Present Condition

Objective Findings/include any results of current x-rays, E.K.G., or any other special test. Does the patient have the mental capacity to handle his/her financial affairs? Yes No

If no, briefly explain:

List any hospital confinements for this disability. Name of hospital, Period Confined (From (MM DD YYYY) To (MM DD YYYY))





Grid for Social Security Number

To Be Completed by Physician

To qualify for this benefit, your patient must have a life expectancy of twenty-four (24) 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.

Large text box for physician explanation

Stage of Cancer (if applicable) Metastasis? Yes No If yes, where? Hospice? Yes No

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.

I have read and understand the terms and requirements of the fraud warnings.

Name of Attending Physician (Please print.)

Text box for physician name

Degree/Specialty

Text box for degree/specialty

Telephone Number

Grid for telephone number

Physician's Address

Text box for physician address

Fax Number

Grid for fax number

X

Signature

Date (MM DD YYYY)

Grid for date





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
Tel: 800-524-0542 Fax: 888-227-6764

For residents of all states and jurisdictions except Alabama, Arizona, Arkansas, California, the District of Columbia, Florida, Kentucky, Louisiana, Maine, Maryland, New Hampshire, New Jersey, New York, North Carolina, Pennsylvania, Puerto Rico, Rhode Island, 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.

ALABAMA RESIDENTS — Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

ARIZONA RESIDENTS — For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

ARKANSAS, DISTRICT OF COLUMBIA, LOUISIANA and RHODE ISLAND RESIDENTS — Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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.

KENTUCKY RESIDENTS — Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

MAINE and 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.

MARYLAND RESIDENTS — Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NEW HAMPSHIRE RESIDENTS — Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

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.

NORTH CAROLINA RESIDENTS — Any person who, with the intent to injure, defraud, or deceive an insurer or insurance claimant, knowing that the statement contains false information concerning a fact or matter material to the claim may be guilty of a class H felony.





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
Tel: 800-524-0542 Fax: 888-227-6764**

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.

PUERTO RICO RESIDENTS — Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars (\$5,000) and not more than ten thousand dollars (\$10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances [be] present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

VERMONT RESIDENTS — Any person who, with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

VIRGINIA RESIDENTS — Any person who, with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

© 2017 Prudential Financial, Inc. and its related entities.

Prudential, the Prudential logo, and the Rock symbol are service marks of Prudential Financial, Inc. and its related entities, registered in many jurisdictions worldwide.

