
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.

**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**

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

California Residents Notice - Section 1879.2 of the California Statutes regarding Insurance Fraud requires us to inform you of the following law: "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."

Colorado Residents Notice - Section 10-1 -1 27(7)(a) of the Colorado Statutes regarding Insurance Fraud requires us to inform you of the following law: "It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regards to a settlement of award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies."

Delaware Residents Notice - Section 11.913(b) of the Delaware Statutes regarding Insurance Fraud requires us to inform you of the following law: "Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony."

Florida Residents Notice - Section 81 7.234(1) b) of the Florida Statutes regarding "False and Fraudulent Insurance Claims" requires us to inform you of the following law: "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."

Idaho Residents Notice - Section 41 -1 331 of the Idaho Statutes regarding Insurance Fraud requires us to inform you of the following law: "Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement containing any false, incomplete, or misleading information is guilty of a felony."

Indiana Residents Notice - Section 27-2-16-3 of the Indiana Statutes regarding Insurance Fraud requires us to inform you of the following law: "Any person who knowingly, and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony."

New York Residents Notice - Section 28:4-403(d) of the New York Statute regarding Insurance Fraud requires us to inform you of the following law: "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."

Oklahoma Residents Notice - Section 36 3613.1 of the Oklahoma Statute regarding Insurance Fraud requires us to inform you of the following law: "WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony."

Pennsylvania Residents Notice - Section 18 Pa. C.S. 411 7(k)(l) of the Pennsylvania Statute regarding Insurance Fraud requires us to inform you of the following law: "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."

1 Employer Information

Employer Name

Address

City State Zip Code

Employer Phone Number

Email Address

Control Number

Branch Number

2 Employee Information

First Name MI **Social Security Number**

Last Name Suffix

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



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 Disability Management Services
 PO Box 13480, Philadelphia, PA 19101
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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

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

5 Instructions for completing Section 3, "Banking Information"

This will help you identify the necessary bank information to initiate electronic withdrawals. The nine-digit 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. 1245
PAY TO THE ORDER OF _____	<div style="border: 1px solid black; width: 100px; height: 30px; margin: 0 auto; display: flex; align-items: center; justify-content: center;"> \$ </div>
_____ Dollars	
Bank Name Street Address City, State, ZIP	
⑆ 272078048 ⑆ 005555 ⑆ 55555 ⑆ 1245	

↑ This is the bank transit routing number. It is always 9 digits and appears between the ⑆ symbols. 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.