



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

Group Claim Form for Survivor Benefits (Use for employee/member survivor benefit claims)

Group Insurance Contract Holder Statement To be completed by Employer/Plan Administrator. Please complete all five sections.

1 Deceased's Information

Form for Deceased's Information including fields for First Name, MI, Last Name, Social Security Number, Date of Birth, Date of Death, Gender, and State of Residence.

2 Employee/Member Information

Form for Employee/Member Information including fields for First Name, MI, Last Name, Social Security Number, Date of Birth, Date of Employment, Occupation, Where Employed, and reasons for not being actively at work.

3 Employer/Association Information

Form for Employer/Association Information including fields for Employer's Name, Street, City, State, ZIP Code, Telephone Number, and Suite.



Deceased's Social Security Number

SSN input boxes

4 Insurance Coverages

Group Coverage

Basic Term Life

Optional Term Life

Control Number

Control Number input boxes

Amount

Amount input boxes with dollar sign

Effective Date of Coverage (MM DD YYYY)

Effective Date of Coverage input boxes

Branch

Branch input boxes

Salary Amount on Last Day Worked

Salary Amount input boxes with dollar sign

per

Hour Week Month Year

Amount of Monthly Earnings

Amount of Monthly Earnings input boxes with dollar sign

Amount of Monthly Benefit Payable

to Spouse

to Spouse input boxes with dollar sign

to Children

to Children input boxes with dollar sign

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

Conversion Privilege Offered (if available)

Qualified Family Members

Relationship Name

Relationship Name input boxes

Date of Birth (MM DD YYYY)

Date of Birth input boxes

Date Reported for Coverage (MM DD YYYY)

Date Reported for Coverage input boxes

Group Policyholder

Please print or type name

Date (MM DD YYYY)

Date input boxes

X

Signature of Policyholder's Representative



Deceased's Social Security Number

SSN input boxes

5 Survivor Statement

Part I—to be completed by insured's surviving spouse (Attach your birth certificate.)

First Name, MI, Last Name input boxes

Social Security Number, Date of Birth (MM DD YYYY), Date of Marriage (MM DD YYYY) input boxes

Your mailing address: Street, Apt., City, State, ZIP Code input boxes

Your home address (if different from mailing address above): Street, Apt., City, State, ZIP Code input boxes

Was the marriage in effect at the time the insured died? Yes No

Part II—Children—to be completed by insured's spouse, if living, otherwise by insured's child or the person responsible for child's affairs

If Part I has not been completed, please state reason. (If deceased, furnish death certificate)

Reason for incomplete Part I input box

Were any of the insured's natural children legally adopted by another party prior to the insured's death? Yes No

If "Yes," list names of children:

Table with columns for child names and Social Security Number

For each dependent child eligible for survivor benefits, complete the following: (Birth certificate should be attached.)

Child 1: Name, Date of Birth, Married/Single, Was the child wholly dependent upon insured at death?

Child 1: If full-time student, name of school; Present Home Address

Child 2: Name, Date of Birth, Married/Single, Was the child wholly dependent upon insured at death?

Child 2: If full-time student, name of school; Present Home Address

Child 3: Name, Date of Birth, Married/Single, Was the child wholly dependent upon insured at death?

Child 3: If full-time student, name of school; Present Home Address





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**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.

**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.

**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.

**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.

