How to Complete and Submit a Claim Form

1. If you are submitting a claim for an accident that you have not yet reported to us, please complete this claim form. Once we receive a completed claim form for an accident, we consider the accident to have been reported to us.

2. The entire claim form should be provided to the attending physician for review and completion of the Attending Physician Statement.

3. If you are submitting a claim for an accident that you have already reported to us (you have already submitted a completed claim form to us), an additional claim form is not required. Include the claim number assigned to the accident at the top of all documentation that you are submitting to us in support of a claim that has previously been reported. Fax or mail any additional documentation related to a claim to the address/fax number located in the top right corner of this form.

4. Any time you are submitting a claim to us, please provide us with supporting documents from the attending physician related to the injuries and services received for which a claim is being made. The supporting documents must include: 1) the diagnosis; 2) the specific procedure or treatment received; and 3) the date of service.

5. If you were treated at an emergency room, attach a copy of the discharge papers from the hospital.

6. If you were admitted to a hospital and if your coverage includes benefits for hospitalization, attach documentation (such as admission and discharge summary) from the hospital showing the number of days hospitalized.

7. Once all documents are completed, submit claim form (pages 1-9) and supporting documentation to Prudential at the address listed in above right corner.
Accident Insurance Claim Form
Accident Insurance—Claimant’s Statement
If someone other than the claimant has completed this form or part of this form, please give full name and relationship to claimant, if any, and attach Power of Attorney (POA) if applicable.

1 Insured/Claimant Information

Insured First Name ____________________________ Insured Last Name ____________________________

Social Security Number ____________________________ Date of Birth (mm dd yyyy) ____________

Email Address __________________________________ Telephone Number ____________________________

Address __________________________________________ Suite ____________________________

City ____________________________ State ____________________________ ZIP Code ____________________________

Employer/Association __________________________________ Control Number ____________________________

☐ Please check if the insured is the claimant; if not, please complete claimant information.

Claimant First Name ____________________________ Claimant Last Name ____________________________

Social Security Number ____________________________ Date of Birth (mm dd yyyy) ____________

Relationship to Insured ____________________________

2 Accident Details

Listed benefits
Please select the injury (ies) you sustained as a result of the accident you reported and that you are claiming on this form.

☐ Broken Tooth ☐ Paralysis ☐ Loss of Sight ☐ Lacerations
☐ Herniated/Ruptured Disc ☐ Hernia ☐ Tear ☐ Dislocation
☐ Concussion ☐ Coma ☐ Dismemberment ☐ Loss of Speech
☐ Loss of Life ☐ Loss of Hearing ☐ Burn ☐ Fractures
☐ Eye Injury

Please provide a complete description of your accident. If the accident required a police report to be filed, attach a copy of the police or accident report. If you were injured in an on-job or occupational injury, attach a copy of the first report of injury filed with your employer.

Date of Accident (mm dd yyyy) ____________________________ Location of the Accident – City, State ____________________________

Describe where and how the accident happened.

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
2 Accident Details (Continued)

Was the insured/claimant admitted to the hospital as a result of the accident?
- [ ] Yes (attach documentation (such as admission and discharge summary) from the hospital showing the number of days hospitalized)
- [ ] No

Was the insured/claimant the driver in a motor vehicle accident?
- [ ] Yes (Attach the police report.)
- [ ] No

Was the insured/claimant involved in any other type of accident that required a police report?
- [ ] Yes (Attach the police report.)
- [ ] No

Was the insured at work when the injury occurred?
- [ ] Yes (Attach a copy of report of the injury filed with your employer.)
- [ ] No

Please give names, addresses, and telephone numbers of all doctors and hospitals who have treated you for accidental injury. (Please include dates.)

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Additional Benefits Claims

Please note that sufficient proof of benefit must be provided to Prudential in order to accurately process your payment. Please also note the availability of additional covered benefits depends upon your employer contract.

- For Transportation Benefit, please provide copies of receipts for travel or provide mileage here if traveled by personal car.
- For Lodging Benefit, please attach copies of receipts for lodging.
- For Wellness Benefit, please provide proof that a health screening test was performed while claimant was not confined in a hospital.

Declaration/Release

I authorize The Prudential Insurance Company of America (Prudential) or its reinsurers to acquire from and authorize any hospital, physician, medical practitioner, clinic, medically related facility, insurance company, the Medical Information Bureau, Inc. (MIB), or consumer reporting agency to release to Prudential any information regarding me or my past or present health for the purpose of evaluating my claim for insurance benefits. I also authorize Prudential or its reinsurers to disclose all such information to any doctor, the Medical Information Bureau, Inc., or any other insurance company in order to evaluate a claim.

This authorization shall remain valid for a period of two (2) years from the date noted below. A photocopy of this authorization will be as valid as the original. A copy of the authorization is available to you or your representative upon request to Prudential.

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 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.

Tax Information:

You should consult with your tax advisor regarding the possible tax implications of the receipt of benefits under Prudential’s Accident Insurance, including the potential impact on certain other coverage or benefits that you might have or that you might obtain. Benefit payments under this coverage may be considered taxable income to the extent you pay premiums on a pre-tax basis or your employer pays premiums without including them in your income. Prudential reports taxable income to you and the IRS as required on Form 1099-MISC. Every tax situation is unique.
5 Authorization for Release of Information to The Prudential Insurance Company of America

This Authorization is intended to comply with the HIPAA Privacy Rule.

<table>
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<th>Name of Insured:</th>
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<tr>
<td>First Name</td>
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<td>Print Name of Deceased or Claimant</td>
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<tr>
<td>Date of Birth (mm dd yyyy)</td>
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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:

- 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:
- 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.

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 83408 Lincoln, NE 68501-3408. 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.

**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.
To Be Completed by the Attending Physician

Are you the claimant’s usual primary physician?  Yes ☐  No ☐

Physician Information

First Name  Last Name
Address  Suite
City  State  ZIP Code
Telephone Number

Please provide the following documentation.

1. Please provide the details that apply to your patient’s claim. (Complete all that apply):

<table>
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<tr>
<th>Date of Service (mm dd yyyy)</th>
<th>Diagnosis Description</th>
<th>CPT- Procedure Code</th>
<th>Procedure Description</th>
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2. Has the patient ever had the same or similar condition or injury?  Yes ☐  No ☐ (If yes, state when and describe.)

3. Describe any other disease or infirmity affecting the patient’s present condition and injury(ies):

__________________________________________________________________________

4. Give dates of treatment and nature or treatment other than surgical.

__________________________________________________________________________

Listed benefits

What type of injury(ies) did your patient sustain as result of the accident reported in this claim form?
(Please provide details on the page noted next to the injury, otherwise the details can be provided on the bottom of this page. If additional space is needed, attach a separate sheet.)

- Broken Tooth (Page 7)
- Hernia (Page 8)
- Burns (Page 7)
- Herniated/Ruptured Disc (Page 8)
- Coma (Page 7)
- Lacerations (Page 8)
- Concussion (Page 7)
- Loss of Hearing (Page 8)
- Dislocation (Page 7)
- Loss of Life (Page 8)
- Dismemberment (Page 7)
- Loss of Speech (Page 8)
- Eye Injury (Page 7)
- Fractures (Page 8)
- Paralysis (Page 9)
- Tear (Page 9)

Please attach supporting medical documentation for each injury claimed.
Broken Tooth (form to be completed/certified by a dentist)
1. Please identify tooth/teeth: #_______________________________
2. Was dentine exposed? ☐ Yes ☐ No Which tooth/teeth was dentine exposed? _______________________________

Burns (2nd or 3rd Degree)
1. Please identify the location of burn(s) and degree in square centimeters _______________________________
2. Total surface area of burn(s)  2nd _______________________________  3rd _______________________________

Coma (persistent vegetative state)
1. Date of onset _______________________________
2. Date patient last observed as comatose _______________________________
3. What is the injury/diagnoses? _______________________________

Concussion
1. Date of onset _______________________________
2. Date of symptoms _______________________________
3. Did the patient sustain a loss of consciousness? _______________________________ Duration?___________________________

Dislocation
1. Location of dislocation (specify joint)? _______________________________ Partial or Total? _______________________________
2. New or recurrent? _______________________________
3. If recurrent, date of original dislocation _______________________________

Dismemberment
1. Was the amputation a direct result of an accidental injury and no other cause? ☐ Yes ☐ No
2. Location of amputation? _______________________________ Right or Left? _______________________________
3. Date of amputation? _______________________________

Eye Injury
1. Did the patient sustain corneal or sclera abrasion or laceration? ☐ Yes ☐ No
If yes, please identify the eye _______________________________ Right _______________________________ Left
2. Did the patient sustain any damage to any internal eye structures or optic nerve?
If yes, please identify the eye _______________________________ Right _______________________________ Left
### Fractures
1. Location of fracture(s)? _______________________________ Right or Left? _______________________________

### Hernia
1. Location of hernia _______________________________
2. Was the hernia the direct result of an accidental injury and no other cause?  
   - Yes  
   - No
3. If no, please specify any other contributing condition _______________________________________________________________

### Herniated/Ruptured Disc
1. Please identify specific disc _______________________________ Herniated ______________ Ruptured ________________
2. Date of herniation/rupture? _______________________________

### Lacerations
1. Location of laceration? _______________________________
2. Length (in centimeters) of laceration? _______________________________

### Loss of Hearing
1. Was loss of hearing due to the accident and no other cause?  
   - Yes  
   - No
2. Did the patient sustain a total and permanent loss of hearing?  
   - Yes  
   - No
3. Please specify which ear _______________________________ Right _______________________________ Left
4. Please attach a copy of the most recent audiogram.

### Loss of Life
1. Date of Death _______________________________
2. Did the death result directly from the accidental injury and no other cause?  
   - Yes  
   - No
3. Please specify the other contributing condition(s) _____________________________________________________________
4. Please attach a copy of the death certificate if available.

### Loss of Speech
1. Was loss of speech due to an accident and no other cause?  
   - Yes  
   - No
2. Did the patient sustain a total and permanent loss of speech?  
   - Yes  
   - No
3. How many consecutive months has the loss of speech continued? _______________________________
4. Date of first observation of loss of speech _______________________________
5. Date of most recent observation of loss of speech _______________________________
**To Be Completed by the Attending Physician (Continued)**

### Loss of Sight

1. Was loss of sight due to an accident and no other cause?  
   - Yes  
   - No
2. Did the patient sustain a total and permanent loss of sight?  
   - Yes  
   - No  
   Which eye(s)? _________________
3. Visual Acuity
   - Date of first observation _______________________________  
     - Right Corrected ________  
     - Left Corrected ________
   - Date of last observation _______________________________  
     - Right Corrected ________  
     - Left Corrected ________
4. Please attach records from ophthalmologist.

### Paralysis

1. Did the patient sustain a total and permanent loss of movement in one or more limbs?  
   - Yes  
   - No
2. Please identify the specific limb(s) _______________________________  
   - _________ Right  
   - _________ Left
3. Date of paralysis _______________________________

### Tear

1. Did the patient sustain a completely torn cartilage, ligament, tendon, or rotator cuff?  
   - Yes  
   - No
2. Please specify the tear  
   - _________ Cartilage  
   - _________ Ligament  
   - _________ Tendon  
   - _________ Rotator Cuff
3. Please specify the location  
   - _______________________________  
   - Right  
   - _________ Left
4. Date of the tear _______________________________

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**Physician Verification**

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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 warning and I certify the above statements are true.

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<th>Physician Signature</th>
<th>Date (mm dd yyyy)</th>
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For residents of all states except Alabama, Arizona, Arkansas, California, the District of Columbia, Florida, Kentucky, Louisiana, Maine, Maryland, New Hampshire, New Jersey, New York, 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 subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

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.

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 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, with the intent to defraud or knowing that he 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.

IMPORTANT INFORMATION

LOUISIANA RESIDENTS — The Louisiana Department of Insurance is located at 1702 N. 3rd Street, Baton Rouge, LA 70802 and can be reached by calling 800-259-5300. Written inquiries can be sent to the Louisiana Department of Insurance, Post Office Box 94214, Baton Rouge, LA 70804.

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