Prudential

Group Insurance
Statement of Dependent Eligibility

Mail the completed form to:
The Prudential Insurance Company of America
ATTN: Medical Underwriting
80 Livingston Avenue, Roseland, NJ 07068
Or fax completed form to: 1-877-605-6680

PART 1 – TO BE COMPLETED BY THE EMPLOYEE OR PARTICIPANT

Please complete Section I and then complete Section II, III, or IV, whichever is applicable to the dependent named in Section 1. The Physician's Statement on page 2 of this form should be submitted only if you have completed Section III. It is necessary to submit a Physician's Statement for a disabled dependent only once each year unless otherwise requested. The completed form should be returned to your employer/administrator for completion of Part III.

SECTION I – GENERAL INFORMATION (PLEASE PRINT)

1. Employee or Participant's Name _____ Social Security No. _____
2. Present Address: No. _____ Street _____ City _____ State _____ ZIP _____
3. Dependent's Information: (do not use nicknames or initials)
   (a) Full First Name _____ Last Name _____ Relationship _____
   (b) Date of Birth _____ Gender: ☐ Male ☐ Female
   Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced If married, give date of marriage _____
4. Dependent is: (NOTE: More than one of the following may be checked.)
   (a) ☐ A full-time student — age 25 and over (Complete Section II below.)
   (b) ☐ A disabled child — age 25 and over (Complete Section III below.)
   (c) ☐ A child living in the employee's household who requires special certification to qualify as a dependent (Complete section IV below.)
5. Is dependent covered under any other employer plan of health benefits, group health insurance, or prepayment health benefits? ☐ Yes ☐ No

SECTION II – FULL-TIME STUDENT (TO BE COMPLETED ONLY IF YOU CHECKED 4(A) IN SECTION I)

1. Name and address of school _____
2. Course of study or training _____
3. Current school term from _____ 20 _____ to _____ 20 _____
4. Prior school term from _____ 20 _____ to _____ 20 _____
5. Expected date of course completion or graduation _____
6. Dependent:
   (a) Was eligible for coverage under the Group Benefit Plan as a dependent prior to attainment of age 25. ☐ Yes ☐ No
   (b) Is employed on a full-time basis. ☐ Yes ☐ No
   If yes, is such employment only during a regularly scheduled school vacation? ☐ Yes ☐ No
   (c) Is principally supported by me.* ☐ Yes ☐ No
   (d) Is receiving an estimated total income of $ _____ per month from all sources other than me. ☐ Yes ☐ No
7. Remarks _____

SECTION III – DISABLED CHILD (TO BE COMPLETED ONLY IF YOU CHECKED 4(B) IN SECTION I)

1. The Physician's Statement on page 2 of this form must be completed by the dependent's physician.

2. Dependent:
   (a) Was eligible for coverage under the Group Benefit Plan as a dependent on the day preceding the child's 25th birthday. ☐ Yes ☐ No
   (b) Has been continuously incapable of self-support because of a disabling sickness or injury since the day prior to attainment of age 25. ☐ Yes ☐ No
   (c) Is principally supported by me.* ☐ Yes ☐ No
   (d) Is receiving an estimated total income of $ _____ per month from all sources other than me.
3. Remarks _____

SECTION IV – CHILD LIVING IN THE EMPLOYEE'S OR PARTICIPANT'S HOUSEHOLD (TO BE COMPLETED ONLY IF YOU CHECKED 4(C) IN SECTION I)

1. This dependent permanently resides in my household. ☐ Yes ☐ No
2. Dependent is solely supported by me. ☐ Yes ☐ No
3. I am the legal guardian of the dependent. ☐ Yes ☐ No
4. Remarks _____

*The term "principally supported by me" as used above means a child who is dependent upon you for more than one-half of the dependent child's support as defined by the Internal Revenue Code of the United States.

PART II – TO BE COMPLETED BY THE DEPENDENT'S PHYSICIAN

Please complete this statement in reference to the dependent named in Part I of this form. It is necessary for the employee or participant, who is responsible for any fee for the completion of this statement, to submit only one such statement each year unless otherwise requested.

1. Patient's name _____ **Date of birth** _____

2. History

(a) When did present illness begin or injury occur? Date _____

(b) Was the patient incapable of self-support because of this disabling illness or injury on the day preceding the dependent child's 25th birthday? ☐ Yes ☐ No If yes, has the patient been continuously so disabled to the present time? ☐ Yes ☐ No

3. Present condition

(a) Subjective symptoms _____

(b) Objective findings (Please give date and report of surgery, X-rays, electrocardiograms, or other special tests.)

_____

_____

_____

(c) Is the patient (check one) ☐ Ambulatory ☐ Bed confined ☐ House confined ☐ Hospital confined

4. Diagnosis, description of the condition or medical history causing disability (give as much information as possible)

_____

_____

_____

_____

_____

_____

5. Treatment Give dates of first and last visits and frequency of visits

First visit _____

Last visit _____

Frequency _____

6. Progress (check one) ☐ Recovered ☐ Improved ☐ Unimproved ☐ Retrogressed

7. Prognosis (estimate in months and years) _____

8. Degree of disability

(a) Has this patient been able to do full- or part-time work of any kind? ☐ Yes ☐ No If yes, from what date? _____

(b) If not, when do you think the patient will be able to do some work of any kind? _____

(c) Is the patient capable of self-support? ☐ Yes ☐ No If yes, indicate date patient became capable of self-support. _____

Remarks _____

_____

_____

_____

_____

Name of physician (print) _____ Phone (_____)_____

Address: No. _____ Street _____ City _____ State _____ ZIP _____

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.

Physician Signature _____

Degree _____ Social Security No. _____ Date _____

Authorization for Release of Information to The Prudential Insurance Company of America
This authorization is intended to comply with the HIPAA Privacy Rule

Name of proposed insured/patient (please print) Date of Birth

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, medical facility, or other health care provider that has provided payment, treatment, or services to me or on my behalf within the past five years ("My Providers") to disclose the entire medical record and any other health information concerning me and/or any dependent proposed for coverage in the application to The Prudential Insurance Company of America ("Prudential") and through it, to its reinsurers, authorized agents, and the Medical Information Bureau, Inc. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection (In Vermont, this information is excluded.) and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol and/or drugs, but excludes psychotherapy notes. I also authorize the Medical Information Bureau, Inc. to release any data it may have about me and/or any dependent proposed for coverage to Prudential.

By my signature below, I acknowledge that any agreements I or my dependents have made to restrict my health information do not apply to this Authorization and I instruct My Providers to release and disclose the entire medical record for me and/or my dependent without restriction.

This health information is to be disclosed under this Authorization so that Prudential may: 1) underwrite an application for coverage and make risk determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with Prudential.

This Authorization shall remain in force for 24 months following the date of my signature below, and 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 signed request for revocation to The Prudential Insurance Company of America, Group Medical Underwriting, P. O. Box 8796, Philadelphia, PA 19176, Attention: Senior Medical Underwriting Consultant. I understand that a revocation is not effective to the extent that Prudential has relied on this Authorization or to the extent that Prudential has a legal right to contest a claim under insurance coverage or to contest the coverage 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. (In Montana only: I may request a record of any subsequent disclosures of protected health information.)

I understand that if I refuse to sign this Authorization to release the entire medical record for me and/or my dependent, Prudential may not be able to process an application for coverage, or if coverage has been issued, 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.

Signature of Employee or Participant Date

Employee/Participant Social Security Number

I authorize the release of my entire medical record in accordance with the above.

Signature of Spouse (if applying for coverage) Date

PART III – TO BE COMPLETED BY THE EMPLOYER/ADMINISTRATOR

Employee or Participant's name _____ Social Security No. _____

Control No. _____ Branch _____

Employer/Administrator _____ Signed _____

Date _____ Title _____

For residents of all states except Alabama, Arkansas, the District of Columbia, Florida, Kentucky, Louisiana, Maine, Maryland, 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.

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.

KENTUCKY RESIDENTS—Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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 JERSEY RESIDENTS—Any person who includes any false or misleading information on an application for an insurance policy 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 or misleading information concerning a fact or matter material to the claim may be guilty of a Class H felony.

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/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.

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. **This notice ONLY applies to accident and disability income coverage.**

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

Date_____ **20**_____ **Signed (Employee or Participant)** _____

Dependent signature (if not a minor) _____

Medical Information Notice

When we evaluate your request for insurance, the state of health of the person(s) for whom insurance is requested is, of course, extremely important to us. Consequently, we need to ask you questions about the health and medical history of each person. In addition, you are also requested to authorize any physician or hospital to provide us with reports, if necessary, about the health of each person. In some instances, we may require a physical examination.

Information regarding your insurability will be treated as confidential. We may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life, disability, or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file. We may reveal this information as necessary, to a doctor, if we find a serious health problem that you do not know about. We may also reveal this information to persons conducting mortality or morbidity studies. We will, if you ask, give you a description of other circumstances when we disclose information about you without your prior authorization.

You have the right to see any of the information we collect about you and to make corrections if necessary. If you ask, we will furnish you with instruction on how to exercise this right. In addition, upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901. If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Mass. 02184-8734. Information for consumers about MIB may be obtained on its website at **www.mib.com**.

It is required that you be given this notice.
Please read it carefully and keep it for your records.