The Prudential Insurance Company of America
Waiver of Premium Unit
P.O. Box 70183, Philadelphia, PA 19176
Tel 800-524-0542 Fax 877-862-0269

Claim for Total Disability Benefits—Claimant Statement

- Complete all sections of the **Claimant Statement**. Failure to complete this form in its entirety could result in an inability to determine your eligibility for benefits.
- Submit the completed forms to:

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Waiver of Premium Unit
P.O. Box 70183, Philadelphia, PA 19176

Or fax the completed forms to: 877-862-0269

If you have any questions, please call our Customer Service line at 800-524-0542 and a customer service representative will assist you.

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1. Your Policy / Plan Information

Please check if your life insurance policy is sponsored through your employer, and provide the information below:

Employer's Name

Location/Division

Control Number(s):

Branch Code(s):

Please check if you have an Individual Life Insurance policy that was not purchased through an employer, and provide your policy number(s):

Policy Number(s)

2. Your Personal Information

First name

MI

Last name

/ /
Date of birth (mm/dd/yyyy)

– –
Social Security Number

Gender Male Female

Married Yes No

Spouse Date of Birth / /

Youngest Child Date of Birth / /

Street address

Apt/Suite (optional)

City

State

ZIP Code –

Your Mailing Address (if different from home address)

Street address

Apt/Suite (optional)

City

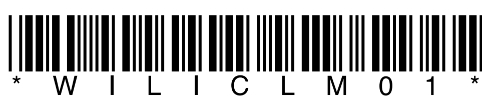
State

ZIP Code –

– –
Primary telephone number

– –
Work telephone number

Return this page with the completed form.



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3. Your Employment Information

1. What was your last date at work? / /
2. Why did you stop working? Disability Layoff Retirement Terminated Resigned/Other (describe below)

3. Name of last employer

4. Address of employer City State

ZIP Employer's Phone Number

5. Occupation Date of hire / /
6. Number of years worked for this employer Number of years worked in this occupation
7. Describe your Job Duties
8. What job category best describes your essential job duties? (Please check the appropriate box).

Sedentary	Light	Medium	Heavy	Very Heavy
Negligible Weight Mostly Sitting	Up to 10 lbs. frequently Up to 20 lbs. occasionally and/or Frequent Walk/Stand and/or Constant Push/Pull	Up to 25 lbs. frequently Up to 50 lbs. occasionally	25 to 50 lbs. frequently 50 to 100 lbs. occasionally	More than 50 lbs. frequently 100 lbs. occasionally

9. Base salary on last day worked: $. per hour per week per month per year

   Were you: Full-time Part-time Number of hours per week

10. Are you self-employed? Yes No If Yes, is business still in operation? Yes No

11. What is the name of your company? Location
    a. If the business is still operating, did you hire someone to handle your duties? Yes No
    b. If the business is no longer operating, on what date did you close or sell your business? / /
12. Did your usual job involve:
    a. The use of machines, tools, or equipment? Yes No
    b. Technical knowledge or special skills? Yes No
    c. Travel? Yes No
    d. Managing/supervising? Yes No
13. If you were not employed, were you: Retired Homemaker Student Other

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4. Your Work History and Education

Please provide information regarding your previous work history.

Employer	Occupation	Job Duties	Begin & End dates	Reason for Leaving
			/ / to / /	
			/ / to / /	
			/ / to / /	

Education

Highest grade level completed HS Diploma Yes No College completed Yes No Date

G.E.D Yes No Major Degree

Certificates, licenses or special training

5. Information Regarding your Disability

1. / / Date first treated for this condition (mm/dd/yyyy)) / / Estimated/expected to return to work (mm/dd/yyyy)
2. What medical condition is preventing you from working?
3. Check all that apply to this disability Work Related Accident/injury Sickness Motor vehicle accident
4. If Accident/injury, please describe
5. Are you currently working for another Employer? Yes No
6. If yes, please provide the occupation Date hired (mm/dd/yyyy)
7. Are you able to care for all of your activities of daily living (grooming, dressing, bathing, etc.)? Yes No
   If No, what activities do you require assistance? Please explain
8. What other activities do you perform, including hobbies and interests if not previously mentioned?

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6. Treatment Provider for Your Current Disability

1. Please provide information on the Treatment Provider for your current disability.

Physician's First Name MI Last Name

Specialty Primary Telephone Number – – Fax Number – –

Office Address Apt/Suite

City State ZIP Code –

First Office Visit (mm/dd/yyyy) / / Last Office Visit (mm/dd/yyyy) / /

7. Additional Treating Providers

Physician's First Name Last Name

Specialty Primary Telephone Number – – Fax Number – –

Office Address Apt/Suite

City State ZIP Code –

First Office Visit (mm/dd/yyyy) / / Last Office Visit (mm/dd/yyyy) / /

Diagnosis/Symptoms:

Treatment Plan:

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7. Additional Treating Providers (continued)

Physician's First Name
Last Name

Specialty
Primary Telephone Number – –
Fax Number – –

Office Address
Apt/Suite

City
State
ZIP Code –

First Office Visit (mm/dd/yyyy) / /
Last Office Visit (mm/dd/yyyy) / /

Diagnosis/Symptoms:

Treatment Plan:

List any Hospital/Facility confinement(s) for this disability.

Name of Hospital/Facility and Address	Period Confined From	Period Confined To

Return this page with the completed form.
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8. Income Information

1. Are you currently receiving vocational assistance or retraining for another occupation? Yes No
2. Have you applied for Social Security Disability Benefits? Yes No
   If yes, what is the status of your application?
   Approval date / /
3. Do you have Group Long Term Disability coverage with Prudential? Yes No

List sources of income for support (e.g., Disability income benefits, Social Security Disability, Retirement, Pension, Workman's Compensation).

Please Note: Eligibility for Social Security Disability or other disability plans does not automatically qualify you under the Prudential policy's disability benefit provision. Eligibility will be assessed based on the information submitted from your attending physician(s).

9. Signature

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. I certify that the above statements are true.

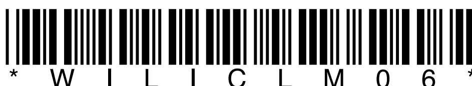
X
Claimant's signature — / / month / day / year

Or if the Claimant is unable to sign, the signature and address of the Claimant's legal representative.

X
Claimant's representative signature — Relationship — / / month / day / year

Representative's address

For Claimant's Legal Representative only. If the claimant is unable to sign this form, the claimant's legal representative may sign. Only those representatives who are court-appointed guardians or have a power of attorney specific to this type of claim may sign. Supporting documentation of the appointment must be submitted to Prudential with this form.



Prudential

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Claim Fraud Warnings

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.

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.

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