Prudential Financial

Group Insurance

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 Life Insurance Claim Form (Use for employee/member and dependent death claims)

How to complete and submit a Group Life Insurance Claim Form

1. **Complete Sections 1, 2, 3, 4, and 5 of the Group Contract Holder Statement portion of the Group Life Insurance Claim Form. Section 1 must be completed if the claim is for an employee/member, or for a dependent of an employee. Please be sure to complete the "Relationship to Employee" block.**
   For Dependent Term Life coverage on children, the employee is always the beneficiary. For Dependent Term Life coverage on spouses, the employee is usually the beneficiary, except for certain Group Universal Life and Group Variable Universal Life coverage, in which the employee may be able to specify other beneficiaries.

2. **Detach the Beneficiary Statement* and give a copy to each beneficiary. Ask each beneficiary to complete it and return it to you.**
   If there are multiple beneficiaries, each beneficiary should complete this form. It is only necessary for you to submit one Group Contract Holder Statement, regardless of the number of Beneficiary Statements completed. If you have difficulty obtaining forms from all beneficiaries, please submit the information you have.

   *If the beneficiary is an estate, a minor, or not competent to handle financial affairs, the Beneficiary Statement should be completed by the appropriate legal representative (executor, administrator, or guardian). If no legal representative has been or will be court-appointed, this section should be completed by the person who assumed responsibility for the estate or beneficiary.

3. **Return both the Group Contract Holder Statement and the Beneficiary Statement(s) with the required documents noted below to:**
   The Prudential Insurance Company of America
   Group Life Claim Division
   P.O. Box 8517
   Philadelphia, PA 19176

   If you have any questions, please call our Group Life Claim Division at 800-524-0542 and a customer service representative will assist you.

Documents to submit to Prudential

Submit the Group Contract Holder Statement, Beneficiary Statement(s), and the following attachments:

1. A certified copy of the death certificate.

2. A copy of the employee's enrollment card, if available.

3. Any beneficiary changes, if applicable.

4. The certificate of insurance, if available.

5. Legal documentation of the beneficiary for the following situations:

   If the beneficiary is
   (a) an estate, minor, or not competent to handle financial affairs: attach a certified copy of the court order appointing the legal representative.
   (b) a trust: include a letter verifying that the trust is still in effect. If the trust is a testamentary, attach a certified copy of the will and a certified copy of the testamentary.
   (c) no longer living: include a copy of the death certificate.

6. If the insurance was assigned, attach a copy of the assignment and all related papers. If it is a collateral assignment, attach the assignee's statement of indebtedness.

7. If an accidental death claim is being filed, attach supporting information, such as a police report or newspaper clippings.

8. If a Business Travel Accident (BTA) claim is being filed, attach information requested in (7) together with documentation further substantiating the loss, such as a trip itinerary, travel tickets, etc.

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Group Life Insurance Claim Form (Use for employee/member and dependent death claims)

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

1 Deceased's Information

First Name | MI | Last Name

Social Security Number | Date of Birth (MM DD YYYY) | Date of Death (MM DD YYYY)

Gender: ☐ Male ☐ Female

Relationship to Employee: ☐ Employee ☐ Spouse ☐ Child ☐ Other

State of Residence

Did employee have accidental death coverage? ☐ Yes ☐ No

Date of Accident (MM DD YYYY) | State of Accident

AKA: First Name | Last Name

2 Employee/ Member Information

First Name | MI | Last Name

Social Security Number | Date of Birth (MM DD YYYY)

Date of Employment (MM DD YYYY)

☐ Hourly ☐ Salary ☐ Union ☐ Non–union ☐ Part Time ☐ Full Time

Date Last Worked (MM DD YYYY)

Occupation | Where Employed

If not actively at work immediately prior to death, what was the reason?

☐ Disability ☐ Leave of Absence ☐ Vacation ☐ Discharge
☐ Resigned ☐ Retired ☐ Temporary Layoff ☐ Other

Street Address (where employed) | Apt.

City | State | ZIP Code

3 Employer/ Association Information

Employer's Name

Street | Suite

City | State | ZIP Code

Telephone Number

Prudential Financial

Deceased's Social Security Number

4 Insurance Coverages

Complete only the coverage(s) that apply to this claim.

Group Coverage	Control Number	Amount	Effective Date of Coverage (MM DD YYYY)	Branch
☐ Basic Term Life		$.		
☐ Optional Term Life		.		
☐ Dependent Term Life		.		
☐ Dependent Optional Term Life		.		
☐ Group Universal Life		.		
☐ Group Variable Universal Life		.		
☐ Dependent Group Universal Life		.		
☐ Dependent Group Variable Universal Life		.		
☐ Accidental Death		.		
☐ Group Universal Accidental Death		.		
☐ Dependent Accidental Death		.		
☐ Optional Accidental Death		.		
☐ Dependent Optional Accidental Death		.		
☐ Dependent Group Universal Accidental Death		.		
☐ Business Travel Accidental Death		.		
☐ Dependent Business Travel Accidental Death		.		

Salary Amount on Last Day Worked

$. per

☐ Hour ☐ Week ☐ Month ☐ Year

Was insurance ever assigned? ☐ Yes ☐ No

If yes, please attach a copy of assignment and all related papers. For collateral assignment, please attach assignee's statement of indebtedness.

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)

Did the employee and/or the covered dependent suffer a loss as defined by the BTA contract? ☐ Yes ☐ No

If yes, an officer of the company must provide a written statement validating the circumstances of the accidental death.

Prudential Financial

Deceased's Social Security Number

5 Payment Information

Mail payment to: ☐ Employer at address listed on page 2 ☐ Beneficiary(ies) at address(es) listed below ☐ Other (please specify in cover letter)

Please provide the following information about the beneficiary(ies). If the claim is for a dependent child, list the employee as beneficiary.

Name of Beneficiary

Date of Birth (MM DD YYYY)

Social Security Number

Relationship to Deceased

Telephone Number

Residence: Street

Apt.

City

State

ZIP Code

Name of Beneficiary

Date of Birth (MM DD YYYY)

Social Security Number

Relationship to Deceased

Telephone Number

Residence: Street

Apt.

City

State

ZIP Code

Name of Beneficiary

Date of Birth (MM DD YYYY)

Social Security Number

Relationship to Deceased

Telephone Number

Residence: Street

Apt.

City

State

ZIP Code

Completed by (name of representative of the employer or benefit administrator)

Please print or type name

Signature X

Date (MM DD YYYY)

Prudential Financial

Deceased's Social Security Number

5 Payment Information Continued

Mail payment to: ☐ Employer at address listed on page 2 ☐ Beneficiary(ies) at address(es) listed below ☐ Other (please specify in cover letter)

Please provide the following information about the beneficiary(ies). If the claim is for a dependent child, list the employee as beneficiary.

Name of Beneficiary

Date of Birth (MM DD YYYY)

Social Security Number

Relationship to Deceased

Telephone Number

Residence: Street

Apt.

City

State

ZIP Code

Name of Beneficiary

Date of Birth (MM DD YYYY)

Social Security Number

Relationship to Deceased

Telephone Number

Residence: Street

Apt.

City

State

ZIP Code

Name of Beneficiary

Date of Birth (MM DD YYYY)

Social Security Number

Relationship to Deceased

Telephone Number

Residence: Street

Apt.

City

State

ZIP Code

Completed by (name of representative of the employer or benefit administrator)

Please print or type name

Date (MM DD YYYY)

Signature X

Prudential Financial

Beneficiary Statement

Each beneficiary should complete Sections 1, 2, and 3. If accidental death or Business Travel Accident benefits are being claimed, Section 4 should also be completed. Return the form to the deceased's Employer/Plan Administrator.

1 Deceased's Information

First Name | MI | Last Name

Social Security Number

2 Beneficiary's Information

First Name | MI | Last Name

Street | Suite

City | State | ZIP Code

Telephone Number | Date of Birth (MM DD YYYY)

3 Taxpayer Identification Number and Certification

Prudential requires your Taxpayer Identification Number. The Taxpayer Identification Number is either the Social Security Number or the Employer Identification Number. If you:

- are an individual, your Taxpayer Identification Number is the Social Security Number.
- represent a trust or estate, the Taxpayer Identification Number is its Employer Identification Number.
- represent a minor, please provide the minor's Social Security Number.
- are applying for a Taxpayer Identification Number, please write "applied for" in the space provided.

TAXPAYER IDENTIFICATION NUMBER/FORM W9 CERTIFICATION:
Under penalties of perjury, I certify that the number shown on this form is my correct Taxpayer Identification Number (Social Security Number). I further certify that the citizen/residency status I have listed on this form is my correct citizen/residency status. I am not subject to backup withholding because (a) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding, (b) the IRS has told me that I am no longer subject to a backup withholding order, or (c) I am exempt from backup withholding.

Social Security Number or Taxpayer Identification Number of beneficiary

Check here only if you are subject to backup withholding:

☐ **I have been notified by the Internal Revenue Service that I am subject to backup withholding due to underreporting of interest or dividends.**

☐ **I am not a U.S. person (including resident alien). I am a citizen of**
(Attach completed IRS Form W-8BEN, if applicable)

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

Date (MM DD YYYY)

X
Signature

Prudential Financial

Deceased's Social Security Number

Beneficiary Statement If filing for an accidental death claim, please complete Section 4 below.

4

Authorization for Release of Information to Prudential Insurance Company

This Authorization is intended to comply with the HIPAA Privacy Rule

Name of Insured:

First Name | MI | Last Name

Date of Birth (MM DD YYYY)

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:

First Name | MI | Last Name

Print Name of Deceased or Patient

or on my (his/her) behalf ("My Providers") to disclose my (his/her) entire medical record for me or my dependents 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.

Unless limits* are shown below, this form pertains to all of the records listed above.

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: P.O. Box 8517, Philadelphia, PA 19176. 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.

*Limits, if any:

Date (MM DD YYYY)

X

Signature of Insured/Patient or Personal Representative

Description of Personal Representative's Authority or Relationship to Patient

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.

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For residents of all states except CA, FL, NJ, NY, PA, UT, VT, VA and WA; 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.

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.

VERMONT and WASHINGTON 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.