Prudential Financial

Group Life Insurance Claim For Total Disability Benefits

(Waiver of Life Insurance Premuium Application)

Instructions to file a Claim for Group Life Insurance Coverage for Total Disability

1. Complete all sections of the **Employee Statement (Form GL.2003.015)**.
2. Ask your doctor to complete the **Attending Physician's Statement (Form GL.2002.119)**.
3. Your Employer will complete the sections of the **Employer Statement (Form GL.2003.015)**.
4. Submit these completed forms according to the directions you received from your Benefits Office.

New Mexico Public Schools Ins. Auth.
410 Old Taos Highway
Santa Fe, NM 87501

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 a statement of claim for payment of a loss or benefit commits a fraudulent insurance act, 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.

For your protection, certain State Laws require the following to appear on this form:

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.

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 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 materially false information or conceals for the purpose of misleading, information concerning any fact thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties

Group Policyholder's Statement/Please complete in full. Please have employee complete Employee's Statement on reverse.

Group Policy Number	Claim branch code	Name of employee	Is employee ☐ Bargaining ☐ Non Bargaining ☐ Hourly ☐ Salaried	Occupation prior to disability
97332				

Social Security Number	Date of birth Mo./Day/Yr.	Date employed Mo./Day/Yr.	Date last worked Mo./Day/Yr.	Did employee cease work solely because of disability? ☐ Yes ☐ No If "No," attach explanation.

Effective date of coverage Mo./Day/Yr.	Insurance inforce? If "No," attach explanation. ☐ Yes ☐ No	Date to which premium has been paid Mo./Day/Yr.	Was insurance ever assigned? ☐ Yes ☐ No	If "Yes," attach copy of assignment and all related papers. For collateral assignment, attach assignee's statement of indebtedness.

Amount of insurance $	Amount of base salary or wage ☐ Weekly ☐ Monthly ☐ Annually	Amount $	Date to which salary or wage paid Mo./Day/Yr.

If employee has Optional Coverage, attach a copy of proof of enrollment.

Is this employee covered under an LTD plan administered by Prudential: ☐ Yes ☐ No

Control Number 97332

Job Description (Include amount of weight lifted or carried and percentage of day spent sitting, walking, and standing. If available, please attach a copy of the Job Description.)

Group Policyholder Name	Address	Telephone Number
Completed by (Please type or print)	Signature of Policyholder's Representative	Date

Note: Complete section below only if employee has Survivor Benefits Life Insurance coverage under this policy.

Survivor Benefits Life Insurance
Marital Status:
☐ Single
☐ Divorced
☐ Widowed
☐ Married

If married, date of marriage Mo./Day/Yr.

Amount of monthly benefits payable

Spouse	Children	Total
$	$	$

Family members (show information for each). If none, indicate "None."

Relationship	Name	Date of birth Mo./Day/Yr.	Date reported for coverage Mo./Day/Yr.
Spouse			
Child			
Child			
Child			

Completed by (Please type or print)

Signature of Policyholder's Representative

Employee's Statement/Please complete in full

Your full name	Your date of birth Mo./Day/Yr.	Social Security/Canadian Ins. No.
Your home address	Telephone Number	Employer's address
Your mailing address (if different from home address)	Last day worked prior to current disability Mo./Day/Yr.	Date first treated by physician Mo./Day/Yr.
What event caused you to stop working?		

List physicians you consulted because of this disability

Name	Address	Telephone Number	Period treated	
Dr.			From	To
Dr.			From	To

List any hospital confinements for this disability

Name of hospital	Address	Period confined	
		From	To
		From	To

Have you been approved for Social Security Disability Benefits or Canada/Quebec Pension Benefits because of disability? ☐ Yes ☐ No

How many times have you applied?

If you have any other Prudential policies (group or individual), please list policy number(s):

Have you converted your group coverage to an individual policy? ☐ Yes ☐ No

Indicate if you have insurance with another company (accident, sickness, disability, life)

Name of company	Address

Grade completed: ☐ Elementary ☐ High School ☐ College ☐ Graduate School Degree ______

Trade Schools attended or special training received?

List your previous occupations

Job Title	Employer Name and Address	Dates employed	
		From	To
		From	To
		From	To

What are your hobbies and/or other special interests?

I hereby certify that these statements are complete and true:

Employee's signature ______________________ Date: ______________

Important: The following authorization must also be completed by the employee. When completed by the employee, this form should be returned to the Group Policyholder together with an Attending Physician's Statement of Disability (Form INST-A003275) completed by the doctor currently treating the employee. Medical proof must be submitted covering the period from date last worked to present.

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

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 to me or on my behalf ("My Providers") to disclose my entire medical record and any other health information concerning me 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 any insurance company, employer, the Social Security Administration, or other person or institutions to provide any information, data, or records relating to my Social Security, workers' compensation, credit, financial, earnings, 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 have made to restrict my protected health information do not apply to this authorization and I instruct My Providers to release and disclose my 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 have or have 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 482, Livingston, NJ 07039. 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 the entire 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 receive a copy of this authorization.

*Limits, if any:

____

____

____

Signature of Insured/Patient or Personal Representative | Date

____

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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Prudential Financial

ATTENDING PHYSICIAN'S STATEMENT

Employer/Association ______________________ **Control Number** 97332

Notice to all parties completing this form: It is fraudulent to fill out this form with information you know to be false or to omit important facts. Criminal and/or civil penalties can result from such acts.
Virginia Residents: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

The employee is responsible for the completion of this form without expense to Prudential.

You may mail form directly to: ______________________

To Be Completed By Employee (Please print.):

Employee's Name ______________________ Date of Birth (MM/DD/YYYY) __________

Employee's Address ______________________
No. Street City St./Prov. Zip/Pac

Occupation ______________________

I hereby authorize release of information requested on this form by the below named physician for the purpose of claim processing.

Employee's Signature ______________ Date __________ Social Security Number ____-____-____

To Be Completed By Attending Physician:

1. Patient History

What illness or symptoms caused the patient to stop working? ______________________

When? __________ Why then? ______________________

What is the usual duration of this condition? ______________________

Has employee ever had same or similar condition? When? ______________________

Describe course and outcome of previous condition ______________________

Did the sickness or injury occur on the job? ☐ Yes ☐ No If Yes and Workers' Compensation Benefits are not payable, please explain ______________________

If condition due to automobile accident, indicate state in which it occurred ______________________

2. Past Medical History

Other medical history (dates and treatment) ______________________

3. Current Medical History

Physical or Mental Signs/Symptoms	How This Impacts Job Performance	Your Recommendation
1.		
2.		
3.		

Remarks ______________________

Did the employee have specific problems on the job? ☐ Yes ☐ No If Yes, please explain ______________________

Is there any history or signs of head injury (date, describe circumstances)? ______________________

Cardiac Capacity

American Heart Association Functional Capacity Limitation

☐ Class 1/None ☐ Class 2/Slight ☐ Class 3/Marked ☐ Class 4/Complete

Was or is the patient in a Cardiac Rehab Program? ☐ Yes ☐ No Date from __________ through __________

Blood pressure (last visit) Systolic __________ Diastolic __________

4. **ICD-9 Diagnosis:**

____
____
____
____
Pregnancy EDC ______________________

DSM Diagnosis:
Axis I Clinical ______________________
Axis II Developmental & Personality ______________________
Axis III Physical Conditions ______________________
Axis IV Psychosocial Stressors ______________________
Axis V Global Functioning ______________________

Objective Findings (Clinical, X-ray, EKG, LAB, Tests)______________________

5. **Psychosocial**
   a. Describe any significant events in the employee's past or recent history (including when)______________________
   b. What are the employee's current supports? ______________________
   c. What are the employee's current activities? ______________________
   d. Is the spouse employed? ☐ Yes ☐ No Spouse's Operation______________________
      Has the illness interfered? ☐ Yes ☐ No If Yes, please describe______________________
   e. Has the employee lost contact with friends or family? ☐ Yes ☐ No

6. **Treatment**
   First Visit__________ Last Visit__________ Frequency__________
   List all medications______________________
   Has patient been hospital confined? ☐ Yes ☐ No Confined from__________ through__________
   If Yes, give name and address of hospital______________________

7. **Prognosis**
   Has the employee made significant progress? ☐ Yes ☐ No If No, explain______________________
   What changes do you expect in the near future?______________________
   Describe Medical obstacles to return to work______________________

8. **Return to Work Plan**
   What work duties can employee perform?______________________
   What duties can employee not perform?______________________
   What changes would allow employee to work:
   Own job?______________________ When?__________
   Job Modification?______________________ When?__________
   Trial work?______________________ When?__________
   Part-time?______________________ When?__________
   Any other job? – Type of work______________________ When?__________
   What steps has the employee taken to return to work?______________________
   Could the employee work while receiving treatment? If No, why not?______________________

Names of other Treating Physicians/Consultants	Specialty	Address	Phone No.

Do you feel the patient is competent to endorse checks and direct the use of the proceeds? ☐ Yes ☐ No

Physician's Name (please type or print)______________________
Board Certified/Eligible______________________ #__________
Office Address______________________ Phone Number__________
Degree/Specialty______________________
Physician's Signature______________________ Date Completed__________

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Group Term Life Insurance Portability Option

If you have been actively employed prior to leaving your employer, and you are not retiring or disabled, you may apply for Group Term Life Insurance coverage under Prudential's portability option. This option may be available to you and your dependents (if you continue your coverage). Portable coverage terminates according to the terms of the group portability contract, however coverage will not be continued beyond age 70.

When To Apply

You must apply for the Portability Option within <u>31 days of your termination date</u>. If you apply within 31 days, there will be no lapse in your coverage.

How To Apply

1. Your employer completes Sections 2 and 3 of the Portability Election Form.
2. You need to complete Sections 1, 4, 5, 6, 7, and 8 of the Portability Election Form. Please designate a beneficiary in Section 5 since this form replaces your previous beneficiary form. You are automatically the beneficiary for any dependent coverages.
3. Return the completed portability form to this address:

The Prudential Insurance Company of America
Group Life Recordkeeping
P.O. Box 923
Horsham, PA 19044-0923

5. Requests for increases in coverage may only be made when you initially elect the portability option. Employees may increase coverage by at least $20,000, but by no more than the employee's annual earnings amount. An increase in coverage is not available for children. Decreases in coverage may be requested at any time. If you are requesting an increase, you must also complete an Evidence of Insurability form. You can get this form by contacting your employer or Prudential.

Confirmation of Coverage

After you have completed all of the above steps, Prudential will send you a billing statement within six weeks, which will confirm that your coverage is in effect. All payments must be made promptly to prevent lapse or termination of your Group Term Life Insurance coverage.

If You Have Questions

If you have questions, you may contact Prudential Group Life Recordkeeping at **800-778-3827.**

The description above is intended to be a summary of the portability provision and does not include all plan provisions, exclusions, and limitations. Details of your portability provision can be found in your certificate. If there are any discrepancies between this piece and the certificate, the certificate governs. Prudential Group Term Life Insurance is underwritten by The Prudential Insurance Company of America, 751 Broad Street, Newark, New Jersey, 07102. Prudential Financial is a service mark of The Prudential Insurance Company of America, Newark, NJ, and affiliates.

INST-A000527 Ed. 10/2001 (Discouraged)

Group Term Life Insurance Coverage Portability Election Form*

Please return this form to:
The Prudential Insurance Company of America
Group Life Recordkeeping
P.O. Box 923
Horsham, PA 19044-0923

1. Employee Data (to be completed by employee)

Last Name	First Name	MI	Sex: Male ☐ Female ☐

Street Address	Apartment #	City	State	ZIP

Date of Birth	Social Security Number	Daytime Phone Number	Home Phone Number

Email Address	Marital Status: Married ☐ Single ☐ Divorced ☐ Widower ☐

2. Group Term Life Insurance Coverage Amount(s) (to be completed by employer)

Complete all blocks. If your current Optional Term plan does not include some of the options below (e.g. Accidental Death and Dismemberment (AD&D) or Dependent Term Life), or the employee is not enrolled in the option, please indicate 'not applicable' (**NA**).

Salary and Date of Last Day Actively at Work	Group Contract Number 97332
Current Optional Term Life Coverage Amount - Employee	Current AD&D Coverage Amount - Employee
Current Dependent Term Life Coverage Amount - Spouse $	Current AD&D Coverage Amount - Spouse
Current Dependent Term Life Coverage Amount – Children $	Current AD&D Coverage Amount – Children

3. Assignment Data (to be completed by employer)

Has this insurance been assigned? Yes No **If NO, sign the certification at the bottom of this section. If YES, complete this section with assignee or trustee information and attach copy of the assignment form.**

Last Name of Assignee or Trustee	First Name	MI

Street Address	Apartment #	City	State	ZIP

Daytime Phone Number	Home Phone Number	Social Security Number or Tax Identification Number

I certify that, to the best of my knowledge and belief, the information provided in sections 2 and 3 is correct, and the employee who is named on this form is eligible for portability according to the terms specified in the Prudential group contract.

X

Signature of Employer Representative (Employer certification for portability eligibility) *Date*

4. Group Term Life Insurance Coverage Amount(s) (to be completed by employee)

Please note: If you are eligible for AD&D coverage, any amounts elected must be equal to or less than the group term life amount. All insurance amounts will be rounded down to the nearest $1,000. Coverage amounts will be reduced by any accelerated benefits paid under the Living Benefit Option.

Optional Term Life and Dependent Term Life Coverage	AD&D Coverage
Employee (Optional Term Life Insurance): Retain current face amount Elect lower amount Elect higher amount $ ___	**Employee:** Retain current face amount Elect lower amount Elect higher amount $ ___
Spouse (Dependent Term Life Insurance): Retain current face amount Elect lower amount Elect higher amount $ ___	**Spouse:** Retain current face amount Elect lower amount Elect higher amount ___
Children (Dependent Term Life Insurance): Retain current face amount Elect lower amount $ ___	**Children:** Retain current face amount Elect lower amount $ ___

*Participants are eligible if they have been actively employed prior to leaving their employer, and they are not retiring or disabled.

5. Employee Beneficiary Designations (to be completed by employee or assignee, if assigned)

A. PRIMARY BENEFICIARIES: Please designate at least one primary beneficiary. Use a separate sheet if you want to name more than two primary beneficiaries, or if the beneficiary is your estate or a trust.

Last Name	First Name	MI	Social Security Number	Date of Birth	Relationship	Percentage

B. CONTINGENT BENEFICIARIES: Death benefits will be paid to the contingent beneficiaries if the primary beneficiary(ies) is not alive. Use a separate sheet if you want to name more than five contingent beneficiaries.

Last Name	First Name	MI	Social Security Number	Date of Birth	Relationship	Percentage

6. Dependent Term Life Insurance Coverage - Spouse (to be completed by employee)

This section should only be completed if you previously had dependent coverage with Prudential for your spouse and you wish to continue this dependent coverage.

Note: You must elect portability in order for your spouse to have portable coverage. The employee is the beneficiary for Dependent Term Life Insurance.

Spouse's Last Name	First Name	MI	Social Security Number	Date of Birth

7. Dependent Term Life Insurance Coverage - Children (to be completed by employee)

This section should only be completed if you previously had dependent coverage with Prudential for your children and you wish to continue this dependent coverage.

Note: You must elect portability in order for your children to take portable coverage. The employee is the beneficiary for Dependent Term Life Insurance.

Youngest Child's Last Name	First Name	MI	Social Security Number	Date of Birth

8. Employee/Assignee Signature(s) (to be completed by employee/assignee)

I hereby request coverage under the Group Term Life Insurance Portability Plan. I understand that I will be billed on a quarterly basis and that a $3 billing fee per quarter will apply. I understand that, if I elect to convert my coverage to an individual policy, I waive my right to apply for coverage under the Portability Plan. I understand that my Group Term Life Insurance coverage will be subject to the rules of the group contract governing the Portability Plan. I also understand that I may apply for coverage under the Portability Plan subject to the following:

- This selection is made within 31 days of the date that I am no longer eligible for coverage through my former employer.
- I am subject to the age reductions outlined in the group contract.
- Group Term Life Insurance for my dependents is only available with my election of portable Group Term Life Insurance.
- Portability is not available if over age 70 at the time of election.
- Group Term Life Insurance for my dependents ends when they no longer qualify as eligible dependents.
- Group Term Life Insurance and coverage under all applicable riders will end if I fail to make any payment needed to keep my coverage in force within 31 days from the date due.

X	X
Employee's Signature *Date*	*Assignee's Signature (if applicable)* *Date*

9. For Prudential Use Only

Effective Date of Coverage: |__|__|__|__|__|__|__|__| (mm/dd/yyyy)

*Participants are eligible if they have been actively employed prior to leaving their employer, and they are not retiring or disabled.

IMPORTANT NOTICE REQUIRED BY CERTAIN STATE REGULATORS:

Arkansas 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.

Colorado Residents: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading information to a policyholder or claimant for the purpose of defrauding, or attempting to defraud, the policyholder or claimant with regards to a settlement of award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

District of Columbia Residents: WARNING – It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

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.

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 Residents: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or a denial of insurance benefits.

Maryland Residents: Any person who knowingly gives false or deceptive information when completing this application, for the purpose of defrauding the company, may be found guilty of insurance fraud.

Minnesota Residents: You may elect to continue coverage at your expense if your employment is terminated, either voluntarily or involuntarily, or if you are laid off, as long as the group policy is still in force with the employer. Coverage may be continued until you obtain coverage under another group policy or you return to work from lay-off; however, the maximum period that coverage may be continued is 18 months.

New Jersey Residents: Any person who includes any false or misleading information on an application on an insurance policy is subject to criminal and civil penalties.

New Mexico 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 civil fines and criminal 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.

Ohio Residents: Any person who, with 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 is guilty of insurance fraud.

Pennsylvania Residents: Any person who knowingly and with intent to defraud any insurance company or person files an application of 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 subjects such person to criminal and civil penalties.

Tennessee Residents: It is a crime to knowingly provide false, incomplete, or misleading information to any party to a workers' compensation transaction for the purpose of committing fraud. Penalties include imprisonment, fines, and denial of insurance benefits.

Virginia Residents: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.