Prudential

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

CLAIMANT STATEMENT/ATTENDING PHYSICIAN STATEMENT

Employer/Association _____ **Control Number** | | | | | | |

Your Name (Please print) _____ Claim Number | | | | | | | | |

Your Home Address _____
No. Street City St./Prov. ZIP/Pac

Your Mailing Address _____
(If different from home) No. Street City St./Prov. ZIP/Pac

1 To Be Completed By Claimant

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

1. Describe your illness or injury: _____

_____

2. Describe any changes in your condition and/or living situation since you stopped working: _____

_____

3. What symptoms/limitations interfere with you performing work? _____

_____

4. What are your plans for returning to work? _____

Are you currently working or have you attempted to return to work? ☐ Yes ☐ No

If yes, please provide employer's name and dates: _____

Are you attempting to obtain support/resources to help you find work for wages/volunteer work? _____

Please explain: _____

5. What are your daily activities, and how do you spend your time? _____

_____

6. Are you receiving disability or retirement benefits from the Social Security Administration? ☐ Yes ☐ No

For what illness? _____

7. Are you receiving Workers' Compensation benefits? ☐ Yes ☐ No

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 and I certify the above statements are true.

Claimant's Signature _____ Date _____

2 **To Be Completed By Physician**

Attending Physician's Statement

Patient's Name_____ Date of Birth_____

1. Diagnosis?

What symptoms does the patient have? _____

ICD Diagnosis:	**DSM Diagnosis:**
	Axis I Clinical
	Axis II Developmental & Personality
	Axis III Physical Conditions
	Axis IV Psychosocial Stressors
Pregnancy EDC	

Objective Findings (Clinical, X-ray, EKG, Lab, Tests) _____

2. Treatment

a. First Visit_____ Last Visit_____ Frequency_____

b. What type of treatment is the patient receiving?_____

c. What recent changes have occurred in patient's condition? _____

d. Has patient been hospital confined? ☐ Yes ☐ No Confined from _____ to _____

e. Names of other treating physicians/consultants

f. Name _____ Specialty_____

Address _____ Phone Number_____

g. What recent changes have occurred in patient's condition? _____

h. What improvement do you expect? _____When? _____

3. 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 Occupation _____

_____

4. 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_____

2 **To Be Completed By Physician (continued)**

5. Return-to-Work Plan

What specific symptoms impact job performance at this time? _____

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 would prevent employee from working while receiving treatment? _____

Have you discussed a return-to-work plan with your patient? ☐ Yes ☐ No

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

please explain _____

Physician's Name (please type or print) _____

Board Certified/Eligible _____ # _____

Office Address _____ Phone Number _____

Degree/Specialty _____

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's Signature _____ Date Completed _____

Prudential

Claim Number

3 **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 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, and includes 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 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 (his/her) 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.

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.

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, 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.

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.