Prudential

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

Tel: 800-524-0542 Fax: 888-227-6764

Group Claim Form for Survivor Benefits

(Use for employee/member survivor benefit 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

State of Residence

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

Deceased's Social Security Number

4 Insurance Coverages

Group Coverage

- [ ] Basic Term Life
- [ ] Optional Term Life

Control Number

Amount $.

Effective Date of Coverage (MM DD YYYY)

Branch

Salary Amount on Last Day Worked $.

per

- [ ] Hour
- [ ] Week
- [ ] Month
- [ ] Year

Amount of Monthly Earnings $.

Amount of Monthly Benefit Payable

to Spouse $.

to Children $.

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)

Qualified Family Members

Relationship	Name	Date of Birth (MM DD YYYY)	Date Reported for Coverage (MM DD YYYY)
Spouse			
Child			
Child			
Child			
Child			
Child			

Deceased's Social Security Number

4 Insurance Coverages (cont'd)

Group Policyholder

Please print or type name

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 warnings included as part of this form. I certify that the above statements are true.

X

Signature of Policyholder's Representative

Date (MM DD YYYY)

Survivor Statement

To be completed by surviving spouse or children. Please complete all three sections if applicable.

Deceased's Social Security Number

5

Part I—To be completed by insured's surviving spouse. *(Attach your birth certificate.)*

First Name MI Last Name

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

Your mailing address

Street Apt.

City State ZIP Code

Your home address *(if different from mailing address above)*

Street Apt.

City State ZIP Code

Was the marriage in effect at the time the insured died? ☐ Yes ☐ No

Part II—Children—To be completed by insured's spouse, if living, otherwise by insured's child or the person responsible for child's affairs.

If Part I has not been completed, please state reason. *(If deceased, furnish death certificate.)*

Were any of the insured's natural children legally adopted by another party prior to the insured's death? ☐ Yes ☐ No

If "Yes," list names of children: Social Security Number

For each dependent child eligible for survivor benefits, complete the following: *(Birth certificate should be attached.)*

Name Date of Birth (MM DD YYYY) ☐ Married ☐ Single Was the child wholly dependent upon insured at death? ☐ Yes ☐ No

If full-time student, name of school Present Home Address

Name Date of Birth (MM DD YYYY) ☐ Married ☐ Single Was the child wholly dependent upon insured at death? ☐ Yes ☐ No

If full-time student, name of school

Name Date of Birth (MM DD YYYY) ☐ Married ☐ Single Was the child wholly dependent upon insured at death? ☐ Yes ☐ No

If full-time student, name of school

Deceased's Social Security Number

Part III—Survivor—To be completed by survivor recipient other than qualified family member. *(Attach your birth certificate.)*

First Name | MI | Last Name

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

If the insured's spouse is deceased and any of the above are not of legal age, has or will a guardian be appointed? ☐ Yes ☐ No

If "Yes," please furnish a copy of the court order appointing a guardian of the estate of the minor children and the address to which any benefit checks should be sent.

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.

X______________________________ Date (MM DD YYYY)

Claimant Signature

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.

Please keep a copy of this form for your records.

Group Life coverage is issued by The Prudential Insurance Company of America, a Prudential Financial company, 751 Broad Street, Newark, NJ 07102.

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