Group Insurance

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

Group Life Claim for Total Disability Benefits—Attending Physician's Statement

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

1 To Be Completed By Employee

Employer's Name

Control Number

First Name

MI

Last Name

Social Security Number

Date of Birth (MM DD YYYY)

Gender

☐ Male ☐ Female

Street

Suite

City

State

ZIP Code

Occupation

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

Employee Signature X ______________________

Date (MM DD YYYY)

2 To Be Completed By Attending Physician

Physician's Instructions – Please respond within 10 days. A delay in returning a completed Attending Physician's Statement could result in your patient's being ineligible for receiving Group Life Insurance benefits. If you have any questions on the completion of this form please call Prudential toll free at 800-524-0542.

Clinical Diagnosis

ICD Diagnosis

Pregnancy EDC (MM DD YYYY)

Primary

Secondary

Pregnancy Actual Delivery Date (MM DD YYYY)

Secondary

Please provide results/objective findings (i.e., all current diagnostic test results).

Date of Procedure (MM DD YYYY)

Subjective Symptoms (Please be specific).

Surgical Procedure(s) Performed (Please be specific).

Current Medications

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Employee's Social Security Number

2 Attending Physician Information (cont'd)

Was Claimant hospital confined? ☐ Yes ☐ No

If yes, please provide name and address of hospital

If hospitalized, give dates:

From (MM DD YYYY)

To (MM DD YYYY)

Other Treating Physicians or Consultants

Name of Attending Physician (Please print).

First Name

Last Name

Specialty

Telephone Number

First Name

Last Name

Specialty

Telephone Number

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

3 Prudential Capacity Questionnaire

Date of onset of condition: From (MM DD YYYY)

1. In your medical opinion please indicate the extent to which the patient's ability to perform the following activities in an 8 hour work day is limited by his or her condition. (Circle or check the number of hours.)

The patient has the work capacity to:

Sit for: 0 1 2 3 4 5 6 7 8 hours at a time

Stand for: 0 1 2 3 4 5 6 7 8 hours at a time

Walk for: 0 1 2 3 4 5 6 7 8 hours at a time

Drive for: 0 1 2 3 4 5 6 7 8 hours at a time

Does the patient have capacity in terms of:

% of time	Never 0%	Occasionally 1-33%	Frequently 34-66%	Constantly 67-100%
Climbing Stairs	☐	☐	☐	☐
Climbing Ladders	☐	☐	☐	☐
Balancing/Heights	☐	☐	☐	☐
Stooping	☐	☐	☐	☐
Kneeling/Crawling	☐	☐	☐	☐
Reaching desk level	☐	☐	☐	☐
Reaching overhead	☐	☐	☐	☐
Right Handling/ Fingering	☐	☐	☐	☐
Left Handling/ Fingering	☐	☐	☐	☐
Lifting/Carrying up to 10 pounds	☐	☐	☐	☐
Lifting/Carrying up to 20 pounds	☐	☐	☐	☐
Lifting/Carrying up to 50 pounds	☐	☐	☐	☐

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Employee's Social Security Number

3 Prudential Capacity Questionnaire (continued)

2. Indicate the patients capacity for repetitive use of hands and feet.

Right Hand ☐ Left Hand ☐ Right Foot ☐ Left Foot ☐

Please indicate—which is the dominant hand? Right ☐ Left ☐

Vision

3. If patient's vision is impaired please describe the extent of the impairment.

Date of most recent vision test (MM DD YYYY)

Best Visual Acuity

	Right		Left
Corrected		/	
Non-Corrected		/	

Cardiac as per New York Heart Association (NYHA) Functional Capacity Classification

4. If disability is due to heart condition please complete:
Class 1 (No Limitation) ☐ Class 2 (Slight Limitation) ☐ Class 3 (Marked Limitation) ☐ Class 4 (Complete Limitation) ☐

What is current ejection fraction? %

Psychiatric

5. If psychiatric condition applies, to what degree is the patient able to perform the duties of any occupation:
Class 1 (No Limitation) ☐ Class 2 (Slight Limitation) ☐ Class 3 (Marked Limitation) ☐ Class 4 (Complete Limitation) ☐

What is the baseline GAF score? What is the current GAF score?

Please specify your **treatment plan** for restoring work readiness. If restoration of work readiness is not anticipated please indicate the **clinical evidence for loss of function** in your response(s) below.

6. In your clinical opinion, has the patient reached maximum medical improvement?
Yes ☐ No ☐

7. Are there any other restrictions/limitations not listed above that are medically necessary?

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3 Prudential Capacity Questionnaire (continued)

8. Nature of Medical Impairment/Limitation (Please specify nature of corresponding loss of function).

Date when significant loss of function occurred: (MM DD YYYY)

Target Date (MM DD YYYY)

Date Patient can return to work in any occupation.

4 Physician Information

First Name

MI

Last Name

Primary Telephone Number

Fax Number

Office Address

Suite

City

State

ZIP Code

Specialty

5 Fraud Notice

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 Signature X

Date (MM DD YYYY)

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