

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—Employer Statement

Employee	City No. 1	MI Last Name										
Employee Information	First Name Social Security Number D	MI Last Name te of Birth (MM DD YYYY) Gender Male Female										
	Date of Employment (MM DD YYYY) Date Last	Vorked (MM DD YYYY) Home Telephone Number										
	Hourly Salary Union	Hourly Salary Union Non-Union Part-Time Full-Time Exempt Non-exem										
	Date First Absent (MM DD YYYY) Date Wor	Resumed (MM DD YYYY) Date to Which Salary or Wage Was Paid (MM DD YYYY)										
Insurance Coverages	For any optional or supplemental cover Complete only the coverage(s) that apply to this	nges, attach a copy of proof of enrollment										
up Coverage	Control Number Amount	Effective Date of Coverage (MM DD YYYY) Branch										
Basic Term Life												
Optional Term Life												
Dependent Optional Term Life												
Group Universal Life												
Group Variable Universal Life												
Optional Accidental Death												
Dependent Optional Accidental Death												
Business Travel Accidental Death												
Critical IIIness												
Dependent Critical Illness												
Accident Insurance												
Dependent Accident Insurance												
	Base Salary Amount on Last Day Worked S Hour Week Month Y	Was insurance ever assigned? If "Yes," please attach a copy of assignment and all related papers. For collateral assignment, please attach Assignee's Statement of Indebtedness.										
	per	ever assigned? all related papers. For coll. Yes No attach Assignee's Statemer										

Ed. 09/2015



Employee's Social Security Number							

Type of Compensation	n Amour	nt			Period	From (MM DD Y	YYY)		То (мм р	D YYYY)		
Overtime	\$											
	→		+	`}								=
Bonus				•						Щ		
Other												
Description												
	. , , .			lf yes, p	orovide date (MM DD YYYY)	\neg					
Has insurance percent increased in the last to		Yes	No									
Was evidence of insur	rahility required			Is there	contributory				Last Pren	nium Paid	MM DD YYYY	<u> </u>
to secure current cove	erage?	Yes	No	insuran		Ye	s No					
				If no, provi	de date: <u>In</u>	surance Term	inated (мм D	D YYYY)	Convers	sion Privile	ge Offered	(MI
Was insurance in force worked?	e on last day	Yes	No									L
Is this employee cover	red under an		N	0				7				
LTD plan administered	d by Prudential?	Yes	No	Control Nu	mber							
Survivor Benefit Life A	Annlicable?	Yes	No									
odivivoi bollolle Ello 7	тррпоавто.											
ls this employee cover	red for Total and	Permanent Disa	bility Benef	fits under this	group life ins	urance policy	? Y	es N	lo			
							?	es N	lo			
Did this employee elec	ct the payment m	nethod, if eligibl	e, prior to h	nis or her	group life ins	urance policy	·?	es N	lo			
Is this employee cover Did this employee election disability? If "Yes," pro	ect the payment movide proof of elec	nethod, if eligibl ction, lump sum,	e, prior to h or installme	nis or her ent payments.	Yes	No	·?	es N	lo			
Did this employee elec	ect the payment movide proof of elec	nethod, if eligibl ction, lump sum,	e, prior to h or installme	nis or her ent payments.	Yes		?	es N	lo			
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tial	
Street Address (where employed)	Suite
City State ZIP Cod	e
Completed by (Please print or type)	
or knowing that he is facilitating commission of a fraud, submits incomplete misleading facts or information when filing an insurance application or a state benefit commits a fraudulent insurance act, is/may be guilty of a crime, and state law. Penalties may include fines, civil damages, and criminal penalties addition, an insurer may deny insurance benefits if false information material applicant or if the applicant conceals, for the purpose of misleading, informat I have read and understand the terms and requirements of the fraud statements are true.	tement of claim for payment of a loss or may be prosecuted and punished under , including confinement in prison. In ly related to a claim was provided by the ion concerning any fact material thereto.
Signature of Policyholder's	Date (MM bb YYYY)
Representative X	
Employer Telephone Number	
Email Address	

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Employee's Social Security Number