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

Group Accidental Injury – Attending Physician's Statement

1 To be Completed By Employee

First Name | MI | Last Name

Residence: Street | Apt.

City | State | ZIP Code

Telephone Number

Social Security Number | Date of Birth (MM DD YYYY) | Date of Loss (MM DD YYYY)

Gender: ☐ Male ☐ Female

Relationship to Employee: ☐ Employee ☐ Spouse ☐ Child ☐ Other

State of Residence

Did accident occur at work? ☐ Yes ☐ No

Date of accident (MM DD YYYY)

State where accident occurred

AKA: First Name | Last Name

2 To Be Completed by Attending Physician

Please complete top section and other portion(s) of form that apply to loss incurred.

Name of Patient

Date of First Treatment for Present Injury (MM DD YYYY)

Date of Accident Causing Present Injury (MM DD YYYY)

1. Describe the accident causing the injury/impairment.

2. Were there contributing diseases/medical conditions preceding this accident? ☐ Yes ☐ No

If "Yes," please state diagnosis and attach relevant clinical records.

3. If physicians other than yourself treated the insured for this contributory condition, please give the following:

Name of Physician | Telephone Number | Date Treated (MM DD YYYY)

Dr.

Address

Dr.

Address

Prudential

Claimant's Social Security Number

2 To Be Completed by Attending Physician (continued)

4. If treated at a hospital, give name of institution with dates of admission and discharge.

Name of hospital	Date Admitted (MM DD YYYY)	Date Discharged (MM DD YYYY)

If claim is for loss of limb, please indicate whether the loss is above the wrist or ankle:

Right Hand: ☐ Above ☐ Below Wrist—Date of Amputation (MM DD YYYY)

Right Foot ☐ Above ☐ Below Ankle—Date of Amputation (MM DD YYYY)

Left Hand: ☐ Above ☐ Below Wrist—Date of Amputation (MM DD YYYY)

Left Foot: ☐ Above ☐ Below Ankle—Date of Amputation (MM DD YYYY)

If claim is for loss of thumb and index finger of same hand, please indicate whether the loss is through or above the metacarpophalangeal joints of both thumb and index finger:

Right Hand: ☐ Yes ☐ No Extent of Severence: Date of Severence (MM DD YYYY)

Left Hand: ☐ Yes ☐ No Extent of Severence: Date of Severence (MM DD YYYY)

If claim is for loss of vision, please complete the following:

1. Vision acuity

	Uncorrected		Corrected	
a. Date of first observation (MM DD YYYY)	Right Eye	Left Eye	Right Eye	Left Eye
b. Date of last observation (MM DD YYYY)	Right Eye	Left Eye	Right Eye	Left Eye

2. From what date has vision recorded in question 1b existed?

Right Eye (MM DD YYYY) Left Eye (MM DD YYYY)

3. If totally blind, give date when this occurred:

Right Eye (MM DD YYYY) Left Eye (MM DD YYYY)

4. If eye has been enucleated, give date

Right Eye (MM DD YYYY) Left Eye (MM DD YYYY)

5a. In your opinion, can vision be improved by treatment, surgery, or corrective lenses? ☐ Yes ☐ No

b. What are your recommendations for treatment?

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2 To Be Completed by Attending Physician (continued)

If claim is for total loss of speech, please complete the following:

1. Record of speech

a. Date of first observation (MM DD YYYY)

b. Date of last observation (MM DD YYYY)

2. What is the injury/diagnosis causing loss of vocalization?

If claim is for loss of hearing, please complete the following and include available hearing test:

1. Hearing acuity

a. Date of first observation (MM DD YYYY) — Right Ear / Left Ear

b. Date of last observation (MM DD YYYY) — Right Ear / Left Ear

2. Please provide the speech reception threshold:

a. With amplification device		b. Without amplification device	
Right Ear	Left Ear	Right Ear	Left Ear
db	db	db	db

3. Please provide the speech discrimination score:

a. With amplification device		b. Without amplification device	
Right Ear	Left Ear	Right Ear	Left Ear
%	%	%	%

4. What is the injury/diagnosis causing hearing loss?

If claim is for paralysis or "loss of use," please complete the following:

1. Record of paralysis

a. Describe the injury/diagnosis causing paralysis:

b. Describe the loss of function:

If claim is for coma, please complete the following:

1. Record of coma

a. Date of onset (MM DD YYYY)

b. Date patient last observed as comatose (MM DD YYYY)

2. What is the injury/diagnosis?

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2 To Be Completed by Attending Physician (continued)

If claim is for total and permanent disability, please complete the below:

Dates the patient was absent from work because of injuries sustained in the accident?

From (MM DD YYYY) To (MM DD YYYY)

Date patient released to return to work (MM DD YYYY)

Subjective symptoms:

Objective findings (Include results of MRIs, CAT scans, x-rays, or any other diagnostic tests):

In your medical opinion, is patient **now** totally disabled? ☐ Yes ☐ No

☐ For his/her regular occupation ☐ For any occupation

If "Yes" when do you think patient will be able to resume any work?

For his/her regular occupation:

For any occupation:

If "No" when was the patient able to resume work?

For his/her regular occupation:

For any occupation:

In your medical opinion, is the patient **totally** and **permanently** disabled from performing any occupation? ☐ Yes ☐ No

Name of Attending Physician (Please print.) Degree/Specialty Telephone Number

Physician's Address

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.

X
Signature

Date (MM DD YYYY)