

The Prudential Insurance Company of America
Disability Management Services
P.O. Box 13480, Philadelphia, PA 19176
Tel: 800-842-1718 Fax: 877-889-4885
<http://www.prudential.com/inst/gldi>

Disability Claim Instructions

Instructions to File a Claim for Disability Benefits

1. Notify your employer of your absence, that you will be filing a claim and request they provide Prudential with their Employer's Statement
2. Complete all Sections of the Employee's Statement
3. Ask your Doctor to complete the Attending Physician's Statement
4. Have these statements submitted according to the directions you received from your Benefits Office
5. If you wish to have voluntary Federal Income Tax withholding from disability benefit payments, read and complete the Tax Notice.

In order for a claim for benefits to be considered filed, Prudential requires an employee's statement, employer's statement, and attending physician's statement to be submitted.

Your Claim Will Be Considered Filed When:

- If you have STD coverage with Prudential, your claim for STD benefits will be considered filed the later of (1) when we receive the employee's statement, the employer's statement and the attending physician's statement, and (2) the start of your STD Elimination Period.
- If you have LTD coverage with Prudential, your claim for LTD benefits will be considered filed the later of (1) when we receive the employee's statement, the employer's statement, and the attending physician's statement, and (2) the date that is 45 days before the end of your LTD Elimination Period.
- If you have both STD and LTD coverages with Prudential and you have filed a claim for STD, there is no need to re-submit the statements noted above for the LTD portion of your claim. However, your claim for LTD benefits will be considered filed in this case the later of (1) when we receive the statements indicated above; and (2) the date that is 45 days before the end of your LTD Elimination period, provided you are receiving STD benefits on that date. If you are approved for STD benefits at a later date, your LTD claim will be considered filed on the date of the STD approval.



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For residents of all states except California, Florida, New Jersey, New York, Pennsylvania, 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.

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.

FLORIDA RESIDENTS— Any person knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing false, incomplete, or misleading information is guilty of a felony of the third degree.

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.

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.

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.

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 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 a statement of claim for payment of a loss or benefit may have violated state law, is 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.

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.



1 Employer Information

Employer Name: **S t a t e o f N e w J e r s e y** Control Number: **0 0 1 4 8 0 0**

Location / Division: _____ Branch Number: _____

2 Employee Information

First Name: _____ MI: _____ Social Security Number: _____ - _____ - _____

Last Name: _____ Suffix: _____

Mailing Address - Line 1: _____

Mailing Address - Line 2: _____ Birth date (MM/DD/Year): _____ / _____ / _____

City: _____ State: _____ Zip Code: _____ - _____ Gender: Male Female Marital Status: Unmarried Married Divorced Widowed

Primary Phone Number: _____ - _____ - _____ Work Phone Number: _____ - _____ - _____

Email Address: _____

Date Last Worked (MM/DD/Year): _____ / _____ / _____ Date First Absent: _____ / _____ / _____ Date First Treated for this Condition: _____ / _____ / _____

Date Expected to Return to Work: _____ / _____ / _____ Spouses Date of Birth: _____ / _____ / _____ Is Spouse Employed? Yes No

EDUCATION: Highest Grade Completed: _____ Number of Children Under 18: _____ Age of Youngest Child: _____

3 Job Information

Occupation: _____

What Job Category best describes your required job duties? (Please check appropriate box)

Sedentary **Light** **Medium** **Heavy** **Very Heavy** **Other**

Negligible Weight Mostly Sitting | Up to 10 lbs. frequently and/or Frequent Walk/Stand and/or Constant Push/Pull | 10 to 25 lbs. freq. Up to 50 lbs. occ. | 25 to 50 lbs. freq. 50 to 100 lbs. occ. | More than 50 lbs. freq. 100 lbs. occasionally | (Please describe below)

4 Primary Care Physician

Physician Name: _____ Primary Phone Number: _____ - _____ - _____

Street Address: _____ Fax Number: _____ - _____ - _____

City: _____ State: _____ Zip Code: _____ - _____

For Internal Use Only

Claim Number: _____



Employee Last Name Social Security Number - -

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Medical Information

All Other Physicians You Have Consulted for this Condition

Physician Name	Specialty	Phone Number

What medical condition is preventing you from working? _____

How does this condition interfere with your ability to perform your job? _____

Have you been hospitalized for this condition? Yes No In-Patient Out-Patient

If hospitalized, give dates: From: / / To: / /

If you are pregnant: Estimated Delivery Date / / Actual Delivery Date / /

Name of Your Health Insurance Company Telephone Number - -

6

Other Income & Workers' Comp. Information

What other income are you entitled to receive as a result of your disability? (Examples: Social Security Disability or Retirement Benefits, Workers' Compensation, State Disability, Pension Disability or Retirement, No-Fault Auto Insurance, Salary Continuance, Group Life or Disability Plan, Health or Welfare Plan, Individual Disability Benefits.) Please send copies of any letters or notices approving or denying benefits.

Source	Applied For Yes No	Amount	Frequency	Date Benefit Begins	Date Benefit Ends
Salary Continuance	<input type="radio"/> <input type="radio"/>				
State Disability Benefits	<input type="radio"/> <input type="radio"/>				
Workers' Compensation	<input type="radio"/> <input type="radio"/>				
Other:	<input type="radio"/> <input type="radio"/>				
Other:	<input type="radio"/> <input type="radio"/>				

Is this condition work related? Yes No If Yes, do you intend to file a Workers' Compensation claim? Yes No

7

Fraud Notice

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. This includes Employer and Attending Physician portions of the claim form. (Please see state specific fraud warnings attached.)

X _____ Employee Signature / / Date Signed



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Employer Statement

1 Employer Information

Employer's Name: Control Number (required):

Street: Suite: STD Branch (required):

City: State: ZIP Code: LTD Branch (required):

Employer's Telephone Number: Extension: Email Address:

2 Employee Information

First Name: MI: Last Name:

Address 1: Social Security Number:

Address 2: Telephone Number:

City: State: Zip: Gender: Male Female

Please check the type of claim you are filing. Check all that apply:

<input type="checkbox"/> STD Core	<input type="checkbox"/> STD Supplemental _____	Employment Status	Coverage Effective Date (date the employee became covered under the policy).		
<input type="checkbox"/> LTD Core	<input type="checkbox"/> LTD Supplemental _____			<input type="checkbox"/> Salaried Employee	STD: <input type="text"/>
<input type="checkbox"/> TDB (NJ)	<input type="checkbox"/> DBL (NY) <input type="checkbox"/> VDI (CA)			<input type="checkbox"/> Hourly Employee	LTD: <input type="text"/>
		<input type="checkbox"/> Other _____			

Date Hired (MM DD YYYY): Coverage Termination Date (MM DD YYYY): Last Date Employer Paid Compensation (MM DD YYYY):

Date First Absent (MM DD YYYY): Date Last Worked (MM DD YYYY): Date Work Was Resumed (MM DD YYYY):

Normal Earnings Prior to this Absence (exclude bonus, overtime, etc.)

\$, . PER

Hour Week Bi-Weekly (every two weeks)

Month Year Other _____

If employee does not work Monday thru Friday, check days worked:

Varies Wednesday Saturday

Monday Thursday Sunday

Tuesday Friday

Is the employee subject to FICA Withholding?

Yes No

If "No" indicate reason

How was the **STD** premium paid for the plan year in which the disability occurred? _____% paid by employer

How was the **LTD** premium paid for the plan year in which the disability occurred? _____% paid by employer

Was the premium amount paid by the employer included in the employee's W-2? Yes No

Was the premium amount paid by the employer included in the employee's W-2? Yes No

Has either percentage changed within the last 3 years? Yes No

Has either percentage changed within the last 3 years? Yes No



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Attending Physician Statement

1 Employee Information

Employer's Name Control Number (required)

Employee First Name MI Last Name

Social Security Number Date of Birth (MM DD YYYY) Gender Male Female

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

Employee Signature _____ Date (MM DD YYYY)

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

2 To Be Completed By Attending Physician

Clinical Diagnosis **ICD-9 Code is Required** Primary: Secondary: Secondary:
 Pregnancy EDC (MM DD YYYY) Actual Delivery Date (MM DD YYYY)
 Date of Surgical Procedure (MM DD YYYY)

Relevant tests and surgical procedure (s) performed (please be specific):

Current Medications, Treatment and Prognosis:

First Visit (MM DD YYYY) Last Visit (MM DD YYYY) Next Visit (MM DD YYYY)

Was Claimant hospital confined? Yes No
 If yes, please provide name and address of hospital
 From (MM DD YYYY) To (MM DD YYYY)

Check all that apply to this disability:
 Work Related Yes No Accident Yes No Sickness Yes No Maternity Yes No Motor Vehicle Accident Yes No If MVA, what State did it occur?

Other Treating Physicians or Consultants
 First Name Last Name
 Specialty Telephone Number



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2
Attending Physician Information (Cont'd.)

Other Treating Physicians or Consultants

First Name	Last Name
<input type="text"/>	<input type="text"/>
Specialty	Telephone Number
<input type="text"/>	<input type="text"/>

First Name	Last Name
<input type="text"/>	<input type="text"/>
Specialty	Telephone Number
<input type="text"/>	<input type="text"/>

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

Date when significant loss of function occurred: (MM DD YYYY) Return to Work Target Date (MM DD YYYY) Full Time Part Time With Limitations (functions lost)

Please describe Return to Work Plan and provide any corresponding Limitations:

Please describe any Medical Obstacles to Return to Work:

Nature of Medical Impairment (i.e., loss of function):

Are there any Non-Medical Factors which have a significant impact on Functional Abilities (i.e., interpersonal, financial family)?

3
Physician Information

First Name	MI	Last Name
<input type="text"/>	<input type="text"/>	<input type="text"/>
Primary Telephone Number	Fax Number	
<input type="text"/>	<input type="text"/>	
Office Address	Suite	
<input type="text"/>	<input type="text"/>	
City	State	ZIP Code
<input type="text"/>	<input type="text"/>	<input type="text"/>
Specialty		
<input type="text"/>		

4
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Physician Signature _____ Date (MM DD YYYY)



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Group Disability Insurance Employee Tax Notice

1 Employee Information

First Name	MI	Last Name
<input type="text"/>	<input type="text"/>	<input type="text"/>
Social Security Number	Employee Phone Number	
<input type="text"/>	<input type="text"/>	
Email Address		
<input type="text"/>		
Employer's Name	Control Number	
<input type="text" value="State of New Jersey"/>	<input type="text" value="0014800"/>	

***Notice to all parties completing this form: It is fraudulent to fill out this form with information you know to be false or to omit important facts. Criminal and/or civil penalties can result from such acts.**

2 Federal and State Withholding

Benefits provided under your Group Disability Income Plan may be subject to federal, state and local taxation. Contact your employee benefits representative or disability plan trustee for details on your rights and obligations under the various tax codes.

If you wish to have Federal Income Tax (FIT) withheld from any payments you may receive, indicate the amount to be withheld (\$20 weekly minimum for STD/\$88 monthly minimum for LTD) below and sign the authorization. Withholding requests may also be submitted on IRS Form W-4S. Withholding requests must be stated in whole dollar amounts. FIT will not be withheld if the disability benefit is not taxable.

I request voluntary Federal Income Tax withholding from each payment, as authorized under section 3402(c) of the Internal Revenue Code, in the amount(s) of:

For STD .00 weekly (\$20.00 minimum)

For LTD .00 monthly (\$88.00 minimum)

3 Employee Signature

X _____ Date (MM DD YYYY)

Employee Signature



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Group Disability Insurance Authorization

1 Claimant's Information

First Name	MI	Last Name
<input type="text"/>	<input type="text"/>	<input type="text"/>
Social Security Number	Employee Phone Number	Control Number
<input type="text"/>	<input type="text"/>	<input type="text" value="0014800"/>

2 Authorization for Release of Information to Prudential Insurance Company

This Authorization is intended to comply with the HIPAA Privacy Rule

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 to me or on my behalf ("My Providers") to disclose my entire medical record and any other health information concerning me 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, but excludes psychotherapy notes.

I authorize any insurance company, employer, the Social Security Administration, or other person or institutions to provide any information, data or records relating to my Social Security, Workers' Compensation, credit, financial, earnings, activities or employment history to Prudential.

Unless limits* are shown below, this form pertains to all of the records listed above.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct My Providers to release and disclose my 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 have or have 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: P.O. Box 13480, 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 any 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 the entire 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 receive a copy of this authorization.

*Limits, if any:

Date (MM DD YYYY)

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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X
 Employee Signature (indicate how related if signed by other than claimant)

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.

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Group Disability Insurance Electronic Funds Transfer Authorization

1 Enrollment

To enroll in Prudential's Electronic Funds Transfer (EFT) payment service, please provide the following information. If you elect to have Prudential deposit the funds in your savings account, you must first check with your bank to obtain the correct bank transit routing number and account number for electronic deposit. Please note that a deposit slip does not contain acceptable banking information. If you have any questions, please call us toll free at 800-842-1718.

***Please note that not all policies are designed to participate in the Electronic Funds Transfer option. Contact your employee benefits representative or disability plan trustee for details.**

2 Claimant Information

Employer's Name

S t a t e o f N e w J e r s e y

Claimant's First Name

MI

Last Name

Social Security Number

Primary Phone Number

3 Banking Information

Bank Name

Branch Phone Number

Type of Account (SELECT ONE)

Savings

Checking

Bank Transit Routing Number

Bank Account Number

(NINE DIGIT BANK TRANSIT ROUTING NUMBER)

(BANK ACCOUNT NUMBER)

4 Payment Plan Agreement

I authorize the Prudential Insurance Company of America to make electronic fund deposits of my disability benefit payment to my account. I understand that any deposit made to an inactive account will be returned to Prudential and reissued as a manual check. In addition, if any overpayment of such disability benefits is credited to my account in error, I authorize Prudential to withdraw any payments necessary in order to assure the accuracy of my claim payments.

I can cancel this authorization at any time by giving Prudential written notice. Any notice hereunder will not be deemed effective until Prudential has received my written notice.

Account Owner

First Name

MI

Last Name

Street

Suite

City

State

ZIP Code

Date Signed (MM DD YYYY)

X

Signature



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5 **Instructions for completing Section 3, "Banking Information"**

This will help you identify the necessary bank information to initiate electronic withdraws. The nine-digit transit routing number is how we recognize the bank you do business with.

Record all banking information on page 1 of the form in Section 3, "Banking Information". Please call your bank to confirm that the information you are supplying is correct.

<p>Customer XYZ XYZ Street City, State, ZIP</p>	<p>Check No. 1246</p>	
<p>PAY TO THE ORDER OF _____</p>	<table border="1" style="margin-left: auto; margin-right: auto;"> <tr> <td style="text-align: center; width: 40px;">\$</td> </tr> </table> <p>Dollars</p>	\$
\$		
<p>Bank XYZ UXYZ Street City, State, ZIP</p>		
<p>A27202754 006666D6666C 1246</p>		

↑ This is the bank transit routing number. It is always 9 digits and appears between the: symbols. Record this number in the boxes provided in Section 3, "nine-digit bank transit routing number."

↑ This is your bank account number. It varies in number of digits and may include dashes or spaces. The < symbol indicates the end of the account number. Record the account number in the boxes provided in Section 3, "Bank Account Number" and include any dashes and spaces that are within the account number. If there are any digits to the right of the < symbol (which do not represent the check sequence number), record them in the boxes provided.

↑ This is the check sequence number. It may be on either end of your check. Please do not include this on the authorization form.

*This page is **Instructions Only**: It is not necessary to return this page with your EFT Authorization.*



ALTERNATE BENEFIT PROGRAM

INFORMATION FOR NEW APPLICANTS

A *Carrier Election and Allocation* form must be completed to identify the investment carrier(s) with which you want your contributions invested.

- **If you are eligible for immediate vesting**, the employer contributions become your property immediately upon investment in your account. **You may elect any number of investment carriers and designate the percentage (in whole numbers) of the total contributions they each should receive.**
- **If you are not eligible for immediate vesting**, the employer contributions do not become your property until the beginning of the 13th month of your employment. **You may elect only one investment carrier.**

If you do not file a *Carrier Election and Allocation* form, the ABP Administrator will enroll you with the investment carrier selected as the default carrier for the current plan.

You must file an application directly with the investment carrier(s) you have elected or with the default investment carrier if you fail to complete this form. If you fail to do so, you may lose possible revenue from your contributions. Additionally, the carrier(s) you elected will return your contributions to your employer and the ABP administrator will enroll you with the default investment carrier.

INFORMATION FOR VESTED ABP MEMBERS

ABP members may change their investment carrier election and/or allocation once each quarter of the calendar year.