Prudential

Group Insurance
The Prudential Insurance Company of America
c/o Transaction Applications Group, Inc. as
Third Party Administrator
PO Box 83408
Lincoln, NE 68501-3408
Phone: 877-920-4778
Secure Fax: 844-581-2757

Critical Illness Insurance Claim Form Instruction Sheet

How to Complete and Submit a Claim Form

1. If submitting a claim for a covered condition, complete and sign the claimant statement portion of the form and have the attending physician complete and sign the attending physician portion of the form. The attending physician must provide copies of your office records, consultation reports, and hospitalization summaries for your claim to be reviewed.
2. If submitting a claim for an additional covered benefit only (National Cancer Institute Transportation, Lodging, Wellness), sufficient proof of benefit must be provided for the claim to be reviewed. For the National Cancer Institute Benefit, please provide a copy of the explanation of benefits documentation from your visit. For the Transportation Benefit, please provide copies of receipts for travel or provide mileage if traveled by personal car. For the Lodging Benefit, please provide copies of receipts for lodging. Please note the availability of additional covered benefits depends upon your employer/member contract.
3. Return the completed form with the required documents to:
   The Prudential Insurance Company of America
   c/o Transaction Applications Group, Inc. as Third Party Administrator
   PO Box 83408
   Lincoln, NE 68501-3408
   Phone: 877-920-4778
   Secure Fax: 844-581-2757
4. Your claim will be reviewed timely. If you would like to receive your claim benefit even more promptly, The Prudential Insurance Company of America (Prudential) can automatically deposit the proceeds of your claim into your bank account. If you wish to elect this option, please complete and return our Electronic Funds Transfer Authorization form.

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Critical Illness Insurance Claim Form

Critical Illness Insurance—Claimant's Statement

If someone other than the claimant has completed this form or part of this form, please give full name and relationship to claimant, if any, and attach Power of Attorney (POA) if applicable.

1 Insured/ Claimant Information

Insured First Name _____ Insured Last Name _____

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

Email Address _____ Telephone Number _____

Address _____ Suite _____

City _____ State _____ ZIP Code _____

Employer/Association _____ Control Number _____

☐ **Please check if the insured is the claimant; if not, please complete claimant information.**

Claimant First Name _____ Claimant Last Name _____

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

Relationship to Insured _____

2 Covered Condition Information

Are you submitting a claim for:

☐ The occurrence of a covered condition

☐ For an additional covered benefit (National Cancer Institute, Transportation, Lodging, Wellness)

If you are submitting the occurrence of a covered condition, please continue completion of Section 2.
If you are submitting a claim for an additional covered benefit, please skip to Section 3.

Please select the condition you are claiming for:

☐ Heart Attack ☐ Stroke ☐ Cancer ☐ Renal (Kidney) Failure

☐ Major Organ Transplant/Failure ☐ Coronary Artery Bypass Surgery/Severe Coronary Artery Disease

☐ Cancer in Situ ☐ Other Conditions (may vary by contract)

_____

_____

Prudential

Claimant First Name | Claimant Last Name

2 Covered Condition Information (Continued)

What is the name and address of the doctor who provided the diagnosis?

First Name | Last Name

Address | Suite

City | State | ZIP Code

Telephone Number

Please give names, addresses, and telephone numbers of all doctors and hospitals who have treated you for this condition. (Please include dates.)

Physician's/Provider's Name

Address | Suite

City | State | ZIP Code

Telephone Number | Date Admitted

Physician's/Provider's Name

Address | Suite

City | State | ZIP Code

Telephone Number | Date Admitted

Physician's/Provider's Name

Address | Suite

City | State | ZIP Code

Telephone Number | Date Admitted

If not already provided above, please give the name, address, and phone number of your primary care family physician.

First Name | Last Name

Address | Suite

City | State | ZIP Code

Telephone Number

Prudential

Claimant First Name | Claimant Last Name

3 Additional Benefits Claims

Please note that sufficient proof of benefit must be provided to Prudential in order to accurately process your payment. Please also note the availability of additional covered benefits depends upon your employer/member contract.

- ☐ For National Cancer Institute Benefit, please provide a copy of the explanation of benefits documentation from your visit.
- ☐ For Transportation Benefit, please provide copies of receipts for travel or provide mileage here if traveled by personal car. _____
- ☐ For Lodging Benefit, please attach copies of receipts for lodging.
- ☐ For Wellness Benefit, please provide proof that health screening test was performed while claimant was not confined in a hospital.

4 Declaration/ Release

I authorize The Prudential Insurance Company of America (Prudential) or its reinsurers to acquire from and authorize any hospital, physician, medical practitioner, clinic, medically related facility, insurance company, the Medical Information Bureau, Inc. (MIB), or consumer reporting agency to release to Prudential any information regarding me or my past or present health for the purpose of evaluating my claim for insurance benefits. I also authorize Prudential or its reinsurers to disclose all such information to any doctor, the Medical Information Bureau, Inc., or any other insurance company in order to evaluate a claim.

This authorization shall remain valid for a period of two (2) years from the date noted below. A photocopy of this authorization will be as valid as the original. A copy of the authorization is available to you or your representative upon request to Prudential.

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 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.

Signature of Claimant _____

Name _____ Date _____

City _____ State _____

Tax Information:
You should consult with your tax advisor regarding the possible tax implications of the receipt of benefits under Prudential's Critical Illness Insurance, including the potential impact on certain other coverage or benefits that you might have or that you might obtain, such as a Health Savings Account (HSA). Benefit payments under this coverage may be considered taxable income to the extent you pay premiums on a pre-tax basis or your employer pays premiums without including them in your income. Prudential reports taxable income to you and the IRS as required on Form 1099-MISC. Every tax situation is unique.

5 To Be Completed by the Benefits Administrator

Coverage Effective Date: (MM DD YYYY) _____ Claim Submission Date: (MM DD YYYY) _____

Employee/Member Coverage Amount: $ _____

Spouse Coverage Amount: $ _____

Child Coverage Amount: $ _____

Claim Branch: _____

Prudential

Claimant First Name

Claimant Last Name

6

Authorization for Release of Information to The Prudential Insurance Company of America

This Authorization is intended to comply with the HIPAA Privacy Rule

Name of Insured:

First Name | MI | Last Name

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 pertaining to:

First Name | MI | Last Name

Print Name of Deceased or Claimant

Date of Birth (MM DD YYYY)

or on my (his/her) behalf ("My Providers") to disclose my (his/her) entire medical record for me or my dependents and any other health information concerning me (him/her) 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 all non-health organizations, any insurance company, employer, or other person or institutions to provide any information, data, or records relating to credit, financial, earnings, travel, activities, or employment history to Prudential.

By my signature below, I acknowledge that any agreements I (he/she) have made to restrict my (his/her) protected health information do not apply to this authorization and I instruct My Providers to release and disclose my (his/her) 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 (he/she) have (has) or have (has) 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: **PO Box 83408, Lincoln, NE 68501-3408**. 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 an 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 my complete 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 request and receive a copy of this authorization.

Date (MM DD YYYY)

X

Signature of Insured/Claimant or Personal Representative

Description of Personal Representative's Authority or Relationship to Insured/ Claimant

Prudential

Critical Illness Insurance Claim Form

Critical Illness Insurance—Attending Physician's Statement

Claimant First Name

Claimant Last Name

7 To Be Completed by the Attending Physician

The above named is insured with Prudential Critical Illness Insurance against the happening of certain contingent events associated with his/her health. A claim has been submitted in connection with the above condition and, to enable us to assess the claim, we would be grateful for your cooperation in the completion of this form.

Are you the claimant's (our claimant's) usual medical attendant? Yes ☐ No ☐

If yes, please provide copies of your office records (including ECG tracings, exercise stress tests, enzyme and protein assays, isotope imaging, coronary and LV angiography), consultation reports, and hospitalization summaries.

If no, please provide the full name and the address of this claimant's usual medical attendant:

_____

_____

Please select the condition for which you diagnosed the claimant:

☐ Heart Attack ☐ Stroke ☐ Cancer ☐ Renal (Kidney) Failure

☐ Major Organ Transplant/Failure ☐ Coronary Artery Bypass Surgery/Severe Coronary Artery Disease

☐ Cancer in Situ ☐ Other Conditions (may vary by contract)

_____

When were you first consulted for symptoms of this condition? (MM DD YYYY) _____

On what date did you diagnose this condition? (MM DD YYYY) _____

When did symptoms of this condition begin? (MM DD YYYY) _____

Please describe the symptoms the claimant presented:

_____

Please give details of anything else in the claimant's habits or personal medical history that would have contributed to his/her condition.

_____

_____

_____

Please provide copies of your office records, consultation reports, and hospitalization summaries for claim to be reviewed.

Prudential

Claimant First Name | Claimant Last Name

7 To Be Completed by the Attending Physician (Continued)

Please give details of the claimant's habits in relation to cigarette smoking, including, to your knowledge, how many cigarettes the claimant has smoked in the past and currently smokes.

Please give the name and address of all consultants, specialists, or hospitals to which your claimant has been referred or attended for this condition.

If there is any further information which, in your opinion, will assist us in assessing this claim, please give details.

The following questions are specific to certain conditions and are required to be completed if the claimant is requesting consideration on any of the conditions listed here.

MYOCARDIAL INFARCTION

To the best of your knowledge, has the claimant had a prior myocardial infarction? Yes ☐ No ☐

If yes, please give details and dates:

Has surgery been performed? Yes ☐ No ☐

If yes, please give date of surgery:

If no, is surgery planned? Yes ☐ No ☐

If surgery is not planned, why not?

Did myocardial infarction occur during a surgical procedure? Yes ☐ No ☐

Was heart attack a result of alcohol or drug abuse? Yes ☐ No ☐

What treatment has been recommended for condition?

Please provide copies of your office records, consultation reports, and hospitalization summaries for claim to be reviewed.

Prudential

Claimant First Name | Claimant Last Name

7 To Be Completed by the Attending Physician (Continued)

STROKE/CEREBROVASCULAR ACCIDENT

To the best of your knowledge, has the claimant had a stroke/cerebrovascular accident before? If yes, please give details and dates: Please describe this initial episode.

Is the neurological sequelae anticipated to last more than 30 days? Yes ☐ No ☐

What is the sequelae and is it expected to be permanent?

Has there been an infarction of brain tissue, hemorrhage, or embolization from an extra-cranial source? Yes ☐ No ☐

Did the claimant experience a transient ischemic attack (TIA)? Yes ☐ No ☐

CORONARY BYPASS SURGERY

To the best of your knowledge, has the claimant had prior coronary bypass surgery? If yes, please give details and dates: What type of surgery has been performed and when? If coronary artery bypass grafting, please state the number of sites and grafts.

RENAL (KIDNEY) FAILURE

What were the first symptoms that were demonstrated from the time in question?

Has the renal disease reached end-stage? Yes ☐ No ☐

Is the claimant currently undergoing regular peritoneal dialysis or hemodialysis? Yes ☐ No ☐

Has renal transplantation been performed? Yes ☐ No ☐ If yes, please give date of surgery: _____

If no, is surgery planned? Yes ☐ No ☐ If surgery is not planned, why not?

Is there any history of renal dysfunction or drug or alcohol abuse in this claimant's history? Yes ☐ No ☐

CANCER

Please indicate the location and staging of this claimant's cancer:

Please describe the symptoms:

Is there a history of lumps, moles, tumors, or previous cancer in this claimant's medical history? Yes ☐ No ☐

If yes, please provide details and dates:

Please provide copies of your office records, consultation reports, and hospitalization summaries for claim to be reviewed.

Prudential

Claimant First Name | Claimant Last Name

7 To Be Completed by the Attending Physician (Continued)

TO BE COMPLETED FOR OTHER CONDITIONS

To the best of your knowledge, has this claimant had any precursors for this condition? Yes ☐ No ☐

If yes, please give details and dates:

Please describe the symptoms:

Has surgery been performed? Yes ☐ No ☐ If yes, please give date of surgery: _____

If no, is surgery planned? Yes ☐ No ☐

If surgery is not planned, why not? _____

Please give names, addresses, and telephone numbers of all doctors and hospitals who have treated the claimant for this condition (please include dates):

Physician's/Provider's Name

Address | Suite

City | State | ZIP Code

Telephone Number | Date Admitted

Physician's/Provider's Name

Address | Suite

City | State | ZIP Code

Telephone Number | Date Admitted

Physician's/Provider's Name

Address | Suite

City | State | ZIP Code

Telephone Number | Date Admitted

Prudential

Claimant First Name

Claimant Last Name

8 Physician Verification

First Name

Last Name

Address

Suite

City

State

ZIP Code

Telephone Number

Specialty

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)

Prudential

For residents of all states 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.

Prudential

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 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.

IMPORTANT INFORMATION

LOUISIANA RESIDENTS — The Louisiana Department of Insurance is located at 1702 N. 3rd Street, Baton Rouge, LA 70802 and can be reached by calling 800-259-5300. Written inquiries can be sent to the Louisiana Department of Insurance, Post Office Box 94214, Baton Rouge, LA 70804.