Prudential
Group Life Insurance
Claim Form

This form may be used for both employee/member and dependent death claims.

Prudential

Instructions to the Employer/Plan Administrator for Submitting a Death Claim

<u>How to complete the Group Life Insurance Claim Form</u>

1. **Complete Sections A, B, C, D and E of the Group Contract Holder Statement portion of the Group Life Insurance Claim Form. In Section C, complete (C1) if the claim is for an employee/member, or (C2) if the claim is for a dependent of an employee.**

   For Dependent Life coverage on children, the employee is always the beneficiary. For Dependent Life coverage on spouses, the employee is usually the beneficiary, except for certain Group Universal Life and Group Variable Life Coverage, in which the employee may be able to specify other beneficiaries.

2. **Detach the Beneficiary Statement*and give it to each beneficiary due $5,000 or more in insurance proceeds. Ask each beneficiary to complete it and return it to you.**

   If there are multiple beneficiaries, each beneficiary should complete this form. It is only necessary for you to submit one Group Contract Holder Statement, regardless of the number of Beneficiary Statements completed. If you have difficulty obtaining forms from all beneficiaries, please submit the information you do have.

   If Accidental Death benefits are being claimed, ask one of the beneficiaries to complete the reverse side of the Beneficiary Statement*. If there is more than one beneficiary, it is only necessary to obtain one beneficiary's signature for this section.

   * If the beneficiary is an estate, a minor, or not competent to handle financial affairs, the Beneficiary Statement should be completed by the appropriate legal representative (executor, administrator or guardian). If no legal representative has been or will be court appointed, this section should be completed by the person who assumed the responsibility for the estate or beneficiary.

3. **Return both the Group Contract Holder Statement and the Beneficiary Statement with the required documents noted below to:**

   The Prudential Insurance Company of America
   Group Life Claim Division
   P.O. Box 1215
   Newark, NJ 07101-1215

   If you have any questions, please call our Group Life Claim Division at (800) 524-0542 and a Customer Service representative will assist you.

<u>Documents to submit to Prudential</u>

Submit the Group Contract Holder Statement, Beneficiary Statement(s) and the following attachments:

(1) A certified copy of the Death Certificate.

(2) A copy of the employee's enrollment card, if available.

(3) Any beneficiary changes, if applicable.

(4) The certificate of insurance, if available.

(5) Legal documentation of the beneficiary, for the following situations:

If the beneficiary is

(a) an estate, a minor, or not competent to handle financial affairs: attach a certified copy of the court order appointing the legal representative.
(b) a trust: include a letter verifying that the trust is still in effect. If the trust is testamentary, attach a certified copy of the will and a certified copy of letters of testamentary.
(c) no longer living: include a certified copy of his/her death certificate.

(6) If the insurance was assigned, attach a copy of the assignment and all related papers.
If it is a collateral assignment, attach the assignee's statement of indebtedness.

(7) If an Accidental Death claim is being filed, attach supporting information, such as a police report or newspaper clippings.

Group Life Insurance Claim Form

Please send the completed forms and all attachments to:

The Prudential Insurance Company of America
Group Life Claim Division
P.O. Box 1215
Newark, NJ 07101-1215

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Group Contract Holder Statement

To be completed by Employer/Plan Administrator

SECTION A: Employee/Member Information

1. Employee/member Social Security number	2. Name of employee/member Last	First	M.I.	3. State of residence	4. Sex
					☐ Male ☐ Female

SECTION B: Employer/Association Information

5. Name of employer/association	6. Control number
The State of Florida	LG-56001-FL
7. Employer address Street / City / State / Zip	8. Employer telephone number

9. Location name and address where employed
Street / City / State / Zip

SECTION C: Deceased Information

(C1) Please complete if the deceased was an employee/member.

10. Occupation	11. Employee pay status	12. Salary on last date worked
	☐ Salaried ☐ Hourly	$ ____ per ☐ Hour ☐ Week ☐ Month ☐ Year

13. If insurance is based on something other than earnings, please identify basis (i.e. job class, union, etc.)	14. Date of birth	15. Date employed

16. Effective date of coverage	17. Last day worked	18. Date of death

19. If not actively at work immediately prior to death, what was the reason?

☐ Disability ☐ Retired ☐ Temporary Layoff
☐ Resigned ☐ Vacation ☐ Discharge
☐ Leave of absence ☐ Other

20. Was insurance ever assigned?

☐ Yes ☐ No

(If "yes," please attach a copy of assignment and all related papers. For collateral assignment, please attach assignee's statement of indebtedness.)

21. Did employee have Accidental Death coverage?

☐ Yes ☐ No

22. Are Accidental Death benefits being claimed?

☐ Yes ☐ No

(If "yes," please include supporting documentation, such as newspaper clippings or police reports, and have the beneficiary complete and sign the release statement in Section 4 on the back of the Beneficiary Statement.)

(C2) Please complete if the deceased was a dependent of an employee.

23. Name of deceased dependent Last	First	M.I.	24. Dependent's Social Security number

25. Relationship to employee

☐ Spouse ☐ Son ☐ Daughter ☐ Other

26. Date of birth

27. Date of death

28. Effective date of dependent coverage

29. Dependent's marital status

☐ Single ☐ Married ☐ Divorced ☐ Legally separated

30. Was dependent employed? (If "Yes," please provide name of employer)

☐ Yes ☐ No

Please continue to Section D on page 4.

Group Contract Holder Statement (cont'd)

SECTION D: Insurance Coverage Information

31. Type of insurance and amount:

Branch Code:

- ☐ Basic Life $
- ☐ Supplemental Life $
- ☐ Group Universal Life $
- ☐ Group Variable Universal Life $
- ☐ Dependent Life $
- ☐ Accidental Death $
- ☐ Personal Accident Insurance (Voluntary Accidental Death) $
- ☐ Dependent Accidental Death $
- ☐ Business Travel Accident $

Total: $

32. Has insurance percentage increased in last two years?

☐ Yes ☐ No

If yes, give date:

33. Was evidence of insurability required to secure current coverage?

☐ Yes ☐ No

34. Date last premium paid

35. Was insurance in force on date of death? ☐ Yes ☐ No

If no, provide date:

☐ Insurance terminated

☐ Conversion privilege offered, if available

36. Is there contributory insurance? ☐ Yes ☐ No

If yes, please provide date until which employee is insured:

SECTION E: Payment Information

37. Mail payment to:

- ☐ Employer at address listed on previous page
- ☐ Beneficiary(ies) at address(es) listed below
- ☐ Other (please specify in cover letter)

38. If you are a client with draft privileges, please complete: Paid by draft no. M/D/Y Total draft amount $

39. Please provide the following information about the beneficiary(ies) (If the claim is for a dependent child, please list the employee as beneficiary).

Name of Beneficiary			
Date of birth			
Current address			
Social Security number			
Relationship to deceased			
Daytime telephone number			

40. Completed by *(name of representative of the employer or benefit administrator)*

Please print or type name   Date   Signature

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Group Life Insurance Claim Form

Beneficiary Statement

Each beneficiary due $5,000 or more in insurance proceeds should complete Sections 1, 2 and 3. If Accidental Death benefits are being claimed, Section 4 on the reverse should also be completed. Return the form to the Deceased's Employer/Plan Administrator.

SECTION 1: Information About the Deceased Person

Deceased's name (please print) Last	First	M.I.	Deceased's Social Security number

SECTION 2: Information About You, the Beneficiary

Beneficiary's name (please print) Last	First	M.I.	Beneficiary's date of birth

Beneficiary's address Street	City	State	Zip	Daytime telephone number

SECTION 3: Taxpayer Identification Number and Certification

IMPORTANT TAX INFORMATION

This information will help you complete the Tax Certification section below, which is required by the Internal Revenue Service. Please read it carefully. Prudential and its representatives cannot give tax or legal advice. You may wish to consult your tax or legal adviser for more information.

Citizenship. You must indicate if you are not a U.S. citizen or resident alien. In that case, you must state the country of which you are a citizen and submit a completed IRS Form W-8BEN.

Backup withholding. You must tell us if the IRS has notified you that you are subject to backup withholding because you did not report all your taxable interest and dividends on your tax return. **You are not subject to backup withholding if either (a) you did not receive such a notice from the IRS, (b) the IRS recently told you that you are no longer subject to a backup withholding order, or (c) you are exempt from such withholding.**

Taxpayer Identification Number and date of birth. You must include your Taxpayer Identification Number (TIN) and date of birth. The TIN for the certificate is:

- your Social Security number if you are an individual or the owner of a sole proprietorship;
- the Employer Identification Number (EIN) if you represent a trust, estate, corporation, partnership, or tax-exempt organization;
- the TIN of the grantor/trustee, or that of the actual owner of a trust-like entity not recognized as a legal or valid trust under state law.

TAX CERTIFICATION (see Important Tax Information above for additional information on this section.)
If this section is not completed, we may be required to withhold federal and state income tax.

Complete section (a) or (b) below:
(a) Under penalties of perjury, I certify that my correct Taxpayer Identification Number is:

Claimant/Assignee's Social Security number	-or-	Claimant/Assignee's Employer Identification number	Claimant's date of birth

Complete the following, if applicable
I am not subject to backup withholding for the reasons stated under "Backup Withholding" in the Important Tax Information section.
(Check the box only if you are subject to backup withholding)

☐ **I have been notified by the Internal Revenue Service that I am subject to backup withholding due to underreporting of interest or dividends.**

(b) ☐ **I am not a U.S. citizen or resident alien. I am a citizen of**
_______________ (attach completed IRS Form W-8BEN, if applicable)

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

X ______________________________
Claimant's signature Date

X ______________________________
Assignee's signature (if applicable) Date

Beneficiary Statement (cont'd)

For your protection, certain state laws require the following to appear on this form.

WARNING: Any person who knowingly and with intent to injure, defraud, or deceive 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 subjects such person to criminal and civil penalties.

In addition, any person who commits such a fraudulent act (or facilitates the act):

- may be prosecuted under state law (Alaska residents only).
- may be subject to fines and confinement in prison (Arkansas, California, and New Mexico residents only).
- **is subject to penalties that may include imprisonment, fines, denial of insurance, and civil damages (Colorado residents only). Also, any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement of award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.**
- is guilty of a felony (Delaware, Idaho, Indiana, and Oklahoma residents only).
- is guilty of a felony of the third degree (Florida residents only).
- may be subject to penalties including imprisonment, fines or denial of insurance benefits (Maine residents only).
- may be found guilty of insurance fraud (Maryland residents only).
- is subject to prosecution and punishment for insurance fraud as provided in RSA638:20 (New Hampshire residents only).
- 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 (New York residents only).

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits (Virginia residents only).

Any person who knowingly and with intent to defraud any insurance company or 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 subjects such person to criminal and civil penalties (Pennsylvania residents only).

SECTION 4: Accidental Death Release Statement (To be completed by a representative of the insured's estate or next of kin.)

"I hereby notify all physicians, hospitals, medical service providers, druggists, employers, and all other agencies or organizations (this includes other insurers, Blue Cross-Blue Shield and prepaid health plans) that I agree, for claim purposes, Prudential or its representatives may see, or get a copy of ALL RECORDS* which pertain to ______________________________

Print name of Deceased

Unless limits are shown below, this form pertains to all these records: medical and dental care, drug or alcohol use, prescribed drugs, employment and insurance coverage records. This information is for the sole use of Prudential or the group Contract Holder which will process the claim. Unless a law requires it, information will not be given in an identifiable form to any other persons unless I agree to its release in writing.

I can revoke this authorization by giving written notice to Prudential. The notice will not apply to information released before the date Prudential has the notice. If not revoked, this form will be valid while the claim is pending but not for more than one year from the date it is signed.
I agree that a photocopy of this form will be as valid as the original. Anyone signing this authorization may have a copy of it upon request."

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.

*Limits, if any: ______________________________

Date	Signed	Relationship
Date	Signed	