



Prudential

Group Disability Insurance

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

Employer Statement

1 Employer Information

Employer's Name		Control Number (required)	
<input type="text"/>		<input type="text"/>	
Street	Suite	STD Branch (required)	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
City	State	ZIP Code	LTD Branch (required)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Employer's Telephone Number	Extension	E-mail Address	
<input type="text"/>	<input type="text"/>	<input type="text"/>	

2 Employee Information

First Name	MI	Last Name
<input type="text"/>	<input type="text"/>	<input type="text"/>
Address 1	Social Security Number	
<input type="text"/>	<input type="text"/>	
Address 2	Telephone Number	
<input type="text"/>	<input type="text"/>	
City	State	ZIP Code
<input type="text"/>	<input type="text"/>	<input type="text"/>
		Gender <input type="checkbox"/> Male <input type="checkbox"/> 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 <input type="checkbox"/> Salaried Employee <input type="checkbox"/> Hourly Employee <input type="checkbox"/> Other
<input type="checkbox"/> LTD Core	<input type="checkbox"/> LTD Supplemental	
<input type="checkbox"/> TDB (NJ)	<input type="checkbox"/> DBL (NY) <input type="checkbox"/> VDI (CA)	
Employee Work State <input type="text"/>		
Coverage Effective Date if applicable (date the employee became covered under group disability policy regardless of carrier). STD: <input type="text"/> LTD: <input type="text"/>		
Date Hired (MM DD YYYY)	Coverage Termination Date (MM DD YYYY)	Last Date Employer Paid Compensation* (MM DD YYYY)
<input type="text"/>	<input type="text"/>	<input type="text"/>
Date First Absent (MM DD YYYY)	Date Last Worked (MM DD YYYY)	Date Work Was Resumed (MM DD YYYY)
<input type="text"/>	<input type="text"/>	<input type="text"/>
Normal Earnings Prior to this Absence (exclude bonus, overtime, etc.) \$ <input type="text"/> PER	If employee does not work Monday through Friday, check days worked: <input type="checkbox"/> Varies <input type="checkbox"/> Thursday <input type="checkbox"/> Monday <input type="checkbox"/> Friday <input type="checkbox"/> Tuesday <input type="checkbox"/> Saturday <input type="checkbox"/> Wednesday <input type="checkbox"/> Sunday	Year To Date Total Taxable Wages \$ <input type="text"/> As of: (MM DD YYYY) <input type="text"/>
<input type="checkbox"/> Hour <input type="checkbox"/> Week <input type="checkbox"/> Bi-Weekly (every two weeks) # of hrs worked <input type="checkbox"/> Month <input type="checkbox"/> Year <input type="checkbox"/> Other	How was the STD 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? <input type="checkbox"/> Yes <input type="checkbox"/> No Has either percentage changed within the last 3 years? <input type="checkbox"/> Yes <input type="checkbox"/> No	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? <input type="checkbox"/> Yes <input type="checkbox"/> No Has either percentage changed within the last 3 years? <input type="checkbox"/> Yes <input type="checkbox"/> No





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3 Other Income, Deductions, and Workers' Compensation Information

Please indicate any applicable deductions such as Local Tax, State Income Tax, Medical, Dental, Life and/or 401(K), that should be withheld from the employee's benefits, if approved. Please also indicate if the employee is receiving, or is eligible to receive, benefits from any other sources because of this absence, such as Salary Continuance/Sick Pay, Workers' Compensation, Social Security Disability or Retirement Benefits, Statutory Benefits, Automobile Liability, Retirement or Pension Plan. **Please send copies of any letters or notices approving or denying benefits.** If the employee has filed for or is receiving Pension/Retirement benefits, Paid Family Leave, or Unemployment Benefits, please enter this information in the line marked "Other".
*If the Last Date Employer Paid Compensation is after the employee's last day worked, please enter the payment type and amount in the table below.

Source	Applied for		Amount	Frequency		Date Benefit Begins		Date Benefit Ends																								
	Yes	No																														
Salary Continuance/ Sick Pay	<input type="checkbox"/>	<input type="checkbox"/>	<table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>							<input type="checkbox"/> Weekly	<input type="checkbox"/> Monthly	<table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>							<table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>							<table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>						
State Disability Benefits	<input type="checkbox"/>	<input type="checkbox"/>	<table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>							<input type="checkbox"/> Weekly	<input type="checkbox"/> Monthly	<table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>							<table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>							<table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>						
Social Security	<input type="checkbox"/>	<input type="checkbox"/>	<table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>							<input type="checkbox"/> Weekly	<input type="checkbox"/> Monthly	<table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>							<table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>							<table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>						
Workers' Compensation	<input type="checkbox"/>	<input type="checkbox"/>	<table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>							<input type="checkbox"/> Weekly	<input type="checkbox"/> Monthly	<table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>							<table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>							<table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>						
Medical Deduction	<input type="checkbox"/>	<input type="checkbox"/>	<table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>							<input type="checkbox"/> Weekly	<input type="checkbox"/> Monthly	<table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>							<table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>							<table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>						
Dental Deduction	<input type="checkbox"/>	<input type="checkbox"/>	<table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>							<input type="checkbox"/> Weekly	<input type="checkbox"/> Monthly	<table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>							<table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>							<table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>						
Vision Deduction	<input type="checkbox"/>	<input type="checkbox"/>	<table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>							<input type="checkbox"/> Weekly	<input type="checkbox"/> Monthly	<table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>							<table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>							<table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>						
Life Deduction	<input type="checkbox"/>	<input type="checkbox"/>	<table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>							<input type="checkbox"/> Weekly	<input type="checkbox"/> Monthly	<table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>							<table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>							<table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>						
Other	<input type="checkbox"/>	<input type="checkbox"/>	<table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>							<input type="checkbox"/> Weekly	<input type="checkbox"/> Monthly	<table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>							<table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>							<table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>						

If you entered information in "Other", please specify what benefit this represents _____

Has the employee indicated that the absence is work related? ☐ Yes ☐ No Has a Workers' Compensation claim been filed? ☐ Yes ☐ No

4 Job Information

Occupation

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DOT Job Code _____

What Job Category best describes the employee's essential job duties? (Please check the appropriate box)

<input type="checkbox"/> Sedentary	<input type="checkbox"/> Light	<input type="checkbox"/> Medium	<input type="checkbox"/> Heavy	<input type="checkbox"/> Very Heavy
Negligible weight, Mostly sitting	Up to 10 lbs. frequently, Up to 20 lbs. occasionally, and/or Frequent Walk/Stand, and/or Constant Push/Pull	Up to 25 lbs. frequently, Up to 50 lbs. occasionally	25 to 50 lbs. frequently, 50 to 100 lbs. occasionally	More than 50 lbs. frequently, 100 lbs. occasionally

☐ **Other** (Please describe)

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As the employer, would you be able to accommodate modified duty to facilitate early return to work? ☐ Yes ☐ No

If Yes, please explain (reduced hours, job modification, etc.):

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5 Life Insurance

Is employee covered under a Prudential Group Life Insurance Policy? ☐ Yes ☐ No

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6 Fraud Notice

I have read and understand the terms and requirements of the fraud warnings included as part of this form. I certify that the above statements are true.

Employer
Signature **X**

Date (MM DD YYYY)

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For residents of all states and jurisdictions 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.

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

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.

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. This notice ONLY applies to accident and disability income coverage.





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.

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/she 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.

