

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 Life Insurance Claim Form (Use for employee/member and dependent death claims)

How to complete and submit a Group Life Insurance Claim Form

1. Complete Sections 1, 2, 3, 4, and 5 of the Group Contract Holder Statement portion of the Group Life Insurance Claim Form. Section 1 must be completed if the claim is for an employee/member, or for a dependent of an employee. Please be sure to complete the "Relationship to Employee" block.

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

2. Detach the Beneficiary Statement* and give a copy to each beneficiary. 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 have.

*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 responsibility for the estate or beneficiary.

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

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

Documents to submit to Prudential

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, 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 a testamentary, attach a certified copy of the will and a certified copy of the testamentary.
 - (c) no longer living: include a copy of the 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.
8. If a Business Travel Accident (BTA) claim is being filed, attach information requested in (7) together with documentation further substantiating the loss, such as a trip itinerary, travel tickets, etc.



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Group Insurance Contract Holder Statement To be completed by Employer/Plan Administrator. Please complete all five sections.

1 Deceased's Information

First Name MI Last Name

Social Security Number Date of Birth (MM DD YYYY) Date of Death (MM DD YYYY)

Gender Male Female Relationship to Employee Employee Spouse Child Other State of Residence

Did employee have accidental death coverage? Yes No Date of Accident (MM DD YYYY) State of Accident

AKA: First Name Last Name

2 Employee/Member Information

First Name MI Last Name

Social Security Number Date of Birth (MM DD YYYY)

Date of Employment (MM DD YYYY) Hourly Union Part Time Date Last Worked (MM DD YYYY)
 Salary Non-union Full Time

Occupation Where Employed

If not actively at work immediately prior to death, what was the reason?
 Disability Leave of Absence Vacation Discharge
 Resigned Retired Temporary Layoff Other

Street Address (where employed) Apt.

City State ZIP Code

3 Employer/Association Information

Employer's Name

Street Suite

City State ZIP Code

Telephone Number



Deceased's Social Security Number

5 Payment Information

Mail payment to: Employer at address listed on page 2 Beneficiary(ies) at address(es) listed below Other (please specify in cover letter)

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

Name of Beneficiary Date of Birth (MM DD YYYY)

Social Security Number Relationship to Deceased Telephone Number

Residence: Street Apt.

City State ZIP Code

Name of Beneficiary Date of Birth (MM DD YYYY)

Social Security Number Relationship to Deceased Telephone Number

Residence: Street Apt.

City State ZIP Code

Name of Beneficiary Date of Birth (MM DD YYYY)

Social Security Number Relationship to Deceased Telephone Number

Residence: Street Apt.

City State ZIP Code

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

Please print or type name

Signature X

Date (MM DD YYYY)



Deceased's Social Security Number

5 **Payment Information Continued**

Mail payment to: Employer at address listed on page 2 Beneficiary(ies) at address(es) listed below Other (please specify in cover letter)

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

Name of Beneficiary Date of Birth (MM DD YYYY)

Social Security Number Relationship to Deceased Telephone Number

Residence: Street Apt.

City State ZIP Code

Name of Beneficiary Date of Birth (MM DD YYYY)

Social Security Number Relationship to Deceased Telephone Number

Residence: Street Apt.

City State ZIP Code

Name of Beneficiary Date of Birth (MM DD YYYY)

Social Security Number Relationship to Deceased Telephone Number

Residence: Street Apt.

City State ZIP Code

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

Please print or type name

Signature X Date (MM DD YYYY)



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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.

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.

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.

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.

