Group Life insurance claim form

FOR CONTRACT HOLDERS

This form is to be completed by the Employer/Plan Administrator.

How to complete this form

1 Complete all relevant sections.

Section 1 must be completed if the claim is for an employee/member, or for a dependent of an employee/member. Please be sure to complete the 'Relationship to Employee/Member' block.

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

2 Check your form, and return it to us with the required documents.

Once the form is complete, please check it has been signed and dated. Then, please return the form with the required documents specified on the right. Instructions to return your form can be found on page 6

3 Ensure beneficiaries have received the separate Beneficiary Group Life insurance claim form.

Please ask each beneficiary to complete and return their form to us.

Need some help?

If you have any questions, please call a Group Life Claim Beneficiary Advocate at **800-524-0542**. Lines are open 8:00 a.m. to 8:00 p.m. ET.

Required documents (if available)

Please check to indicate that each document has been included with the completed form.

- ☐ A copy of the death certificate.
- ☐ A copy of the employee's/member's enrollment card.
- ☐ A copy of the most recent beneficiary designation and any beneficiary changes.
- ☐ 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.
- ☐ If an accidental death claim is being filed, attach supporting information, such as a police report or newspaper clippings.
- ☐ 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:** attach 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 loss, such as a trip itinerary, travel tickets, etc. testamentary.
  - **C. no longer living:** attach a copy of the death certificate.
- ☐ If a Business Travel Accident (BTA) claim is being filed, submit documentation further substantiating the loss, such as trip itinerary, travel tickets, etc.

PART 01
Deceased's information

(*) indicates required information

1.1 Deceased details*

First name:

Middle initial:

Last name:

Social Security number:

Date of birth: mm–dd–yyyy

Date of death: mm–dd–yyyy

State of residence:

Relationship to employee/member:

1.2 Was the deceased known by other names?*

◯ **Yes** → Please give details of other names:

First name:

Last name:

◯ No

1.3 Did deceased have accidental death coverage?*

◯ **Yes** → Please give details of other names:

First name:

Last name:

◯ No

PART 02
Employee/Member information

(*) indicates required information

2.1 Employee/Member details*

Is the employee/member the same as the deceased?

◯ **Yes** → **Go to question 2.2**

◯ No

First name:

Middle initial:

Last name:

Social Security number:

Date of birth: mm–dd–yyyy

State of residence:

2.2 Employment details*

Date last worked: mm–dd–yyyy

Date of employment: mm–dd–yyyy

◯ Hourly ◯ Non-union ◯ Salary ◯ Part time

◯ Union ◯ Full time

Occupation

Where employed:

Street:

City:

State: Zip

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

◯ Disability ◯ Resigned ◯ Leave of absence ◯ Retired

◯ Vacation ◯ Temporary layoff ◯ Terminated

◯ **Other** → Please specify:

PART 03
Employer/Association information

(*) indicates required information

3.1 Employer/Association details*

Name:	
Street:	
City:	
State:	Zip
Telephone number:	

3.2 Employer/Association representative details

First name:	
Last name:	

PART 04
Insurance coverage

(*) indicates required information

4.1 Group coverage details* (Select all that apply)

Group Coverage	Control #	Amount	Effective date of coverage mm–dd–yyyy	Branch
☐ Basic Term Life		$		
☐ Optional Term Life		$		
☐ Dependent Term Life		$		
☐ Dependent Optional Term Life		$		
☐ Group Universal Life		$		
☐ Group Variable Universal Life		$		
☐ Dependent Group Universal Life		$		
☐ Accidental Death		$		
☐ Group Universal Accidental Death		$		
☐ Dependent Accidental Death		$		
☐ Optional Accidental Death		$		
☐ Dependent Optional Accidental Death		$		
☐ Dependent Group Universal Accidental Death		$		
☐ Business Travel Accidental Death		$		
☐ Dependent Business Travel Accidental Death		$		

PART 04
Insurance coverage (continued)

(*) indicates required information

4.2 Salary amount on last day worked*

$

◯ Hour ◯ Week ◯ Month ◯ Year

Was insurance ever assigned?

◯ **Yes** → Please attach a copy of assignment and all related papers. For collateral assignment, please attach assignee's statement of indebtedness.

◯ No

4.3 Has insurance election increased in last two years?*

◯ **Yes** → Please specify:

Date of increase: mm–dd–yyyy

◯ No

4.4 Was evidence of insurability required to secure current coverage?*

◯ **Yes** Please specify:

Date last premium paid: mm–dd–yyyy

◯ No

4.5 Is there contributory insurance?*

◯ Yes

◯ No

4.6 Was insurance in force on date of death?*

◯ Yes

◯ **No** → Please specify:

Date of termination: mm–dd–yyyy

4.7 Was conversion privilege offered?*

◯ Yes

◯ No

4.8 Did the employee or the covered dependent suffer a loss as defined by the BTA contract?*

◯ **Yes** → An officer of the company must provide a written statement validating the circumstances of the accidental death.

◯ No

PART 05
Beneficiary information

(*) indicates required information

Is there beneficiary designation on file?*

◯ **Yes** → Please give beneficiary details below.

◯ **No** → Please list family point of contact information under Beneficiary #1.

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

5.1 Beneficiary #1*

First name:

Last name:

Relationship to deceased:

Social Security number:

Date of birth: mm–dd–yyyy

Street:

City:

State:

Zip

Telephone number:

If there are multiple beneficiaries, please provide their information next page →

PART 05
Beneficiary information (continued)

Please provide the following information about the beneficiary(ies).

5.2 Beneficiary #2

First name:	
Last name:	
Relationship to deceased:	
Social Security number:	
Date of birth: mm–dd–yyyy	

Street:	
City:	
State:	Zip
Telephone number:	

5.2 Beneficiary #3

First name:	
Last name:	
Relationship to deceased:	
Social Security number:	
Date of birth: mm–dd–yyyy	

Street:	
City:	
State:	Zip
Telephone number:	

5.2 Beneficiary #4

First name:	
Last name:	
Relationship to deceased:	
Social Security number:	
Date of birth: mm–dd–yyyy	

Street:	
City:	
State:	Zip
Telephone number:	

(*) indicates required information

PART 05
Beneficiary information (continued)

5.5 Completed by <name of representative of employer or benefit administrator>*

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person, or knowing that he or she 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 warnings (refer to page 7) included as part of this form. I certify that the above statements are true.

Your name*:		Signature*:	
Date*: mm–dd–yyyy			

Submit the form

Submit by mail

The Prudential Insurance Company of America
Beneficiary Services
P.O. Box 70182 Philadelphia, PA 19176

Submit by fax

844-625-7807

Claim fraud warnings

For residents of all states and jurisdictions except Alabama, Alaska, Arizona, Arkansas, California, Colorado, Delaware, the District of Columbia, Florida, Idaho, Indiana, Kentucky, Louisiana, Maine, Maryland, Minnesota, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Puerto Rico, Rhode Island, Tennessee, Texas, Utah, Vermont, Virginia, Washington and West Virginia; WARNING: Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person, or knowing that he or she 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.

ALASKA RESIDENTS – A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

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, MASSACHUSETTS, RHODE ISLAND and WEST VIRGINIA 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 AND TEXAS RESIDENTS – For your protection, California and Texas law requires the following to appear on this form. Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

COLORADO RESIDENTS – It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. 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 or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

DELAWARE RESIDENTS – Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

IDAHO RESIDENTS – Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement containing any false, incomplete, or misleading information is guilty of a felony.

INDIANA RESIDENTS – A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

KENTUCKY RESIDENTS – Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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, TENNESSEE, VIRGINIA, and WASHINGTON RESIDENTS – 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.

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.

MINNESOTA RESIDENTS – A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

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 includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NEW MEXICO 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 CIVIL FINES AND CRIMINAL 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.

OHIO RESIDENTS – Any person who, with 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 is guilty of insurance fraud.

OKLAHOMA RESIDENTS – WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete, or misleading information is guilty of a felony.

OREGON RESIDENTS – Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurance company, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

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.

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.

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.