TO: Staff Members

RE: FMLA Paperwork-Employee Illness

Short & Long Term Disability Forms

Attached are forms you will need to complete and return to Melissa Goodroe, Benefits Coordinator, when applying for Family and Medical Leave. ***Please use this form as your "check-off list" to make sure all forms are submitted at the appropriate time.***

_____*Family and Medical Leave Request Form.* Submit at least 30 days prior to foreseeable leave. If leave is not foreseeable, submit as soon as possible.

_____*Physician's Statement and Certification Form.* This form must be submitted with the *Request for Family and Medical Leave Form.*

_____*Certification of Health Care Provider for Employee's Serious Health Condition.* This form must be submitted with the *Family and Medical Leave Request Form & the Physician's Statement and Certification Form.*

_____*Short/Long Term Disability Forms (If applicable).* Submit once application is completed by employee and his/her physician.

_____*Physician's Return to Work Statement.* Submit prior to returning back to work.

Please note that incomplete forms will be returned for completion

Request for Family and Medical Leave Form
Colquitt County Schools
P. O. Box 2708
Moultrie, GA 31776-2708

Employees of the Colquitt County Board of Education who have been employed for 12 months or more and who worked at least 1250 hours during that time, are entitled to 12 weeks of unpaid leave per year in connection with: Birth and first year care of a child, adoption or foster parent placement of a child, illness of an employee's spouse, child, or parent with respect to a serious health condition, defined as one that require in-patient care in a hospital, hospice or residential medical care facility, or which required continuing treatment by a health care provider, or the employee's own illness.
In accordance with FMLA, County Board of Education policy, GBRIG, as of April 1999, an employee is not eligible for unpaid leave under this policy until any paid leave provided to the employee under other Board polices has been taken.
The employee must provide a minimum of 30 day advance notice when the leave is foreseeable.

Name _____ Social Security _____

Position _____ School/Facility _____

Date Submitted: _____ Expected Date of Return: _____

Please select the following reason(s) and the estimated time period of absence:
The Board of Education requires that a request for leave be supported by medical documentation from the appropriate health care provider of the eligible employee or of the son, daughter, spouse, or parent of the employee.

REASONS	FROM	TO	NUMBER OF WORK DAYS DURING PERIOD
Employee's Own Illness or Disability			
Illness or Disability of Family Member			
Childbirth			
Adoption or Foster Parent Placement of a Child			

It is requested that my absences be reported as follows:
(Check all that applies)
_____ABSENT WITHOUT PAY _____SICK LEAVE _____VACATION
Is a substitute required? Yes____ No____

I expect to return to work on _____(Date)

Signature of employee: _____
Upon the employee's return to work, the Board of Education requires the employee to provide certification by his or her health care provider that the employee is able to resume work.

CENTRAL OFFICE USE ONLY

Name of long term substitute_____Level of Pay_____

Paid Days Remaining_____ Remaining Days Unpaid_____

Director of Human Resources
Signature_____Date_____

Physician's Statement and Certification Form
COLQUITT COUNTY SCHOOLS
P.O. Box 2708
Moultrie, GA 31776-2708

I. EMPLOYEE IDENTIFICATION.

SSN: ☐☐☐—☐☐—☐☐☐☐

Last Name | First | Initial

Apartment/Box/Route

Street Address

City, State | Zip Code 5-digit + 4-digit

County of Residence | Daytime Telephone Number

II. PATIENT IDENTIFICATION.

Does this certification relate to the employee? ☐ Yes ☐ No

_____ OR _____

Does this certification relate to a seriously ill family member? ☐ Yes ☐ No

If the certification relates to a family member, answer the following:

Last Name | First | Initial

Relationship to Employee	Date of Birth		
	Month	Day	Year

III. PHYSICIAN'S STATEMENT. Complete for the patient identified in Section II

- If the patient is the employee, will the patient be able to perform normal job duties during the period of disability? ☐ Yes ☐ No
- If the patient is not the employee, is the employee's presence necessary or beneficial to the care of the patient? ☐ Yes ☐ No
- If the disability is due to pregnancy, please give expected date of delivery. _____
- If the disability period exceeds two weeks prior to delivery or six weeks after delivery, please give detailed medical information that supports the additional period of disability.
- Describe the disability – give diagnosis or detailed statement of patient's physical condition. (Attach additional sheets if necessary.)

_____

_____

_____

_____

_____

_____

_____

IV. PHYSICIAN'S CERTIFICATION.

Physician's Name

Group Name

Suite | Telephone Number

Street Address

City, State, Zip

Date Disability Begins			Estimated Date Disability Ends		
Month	Day	Year	Month	Day	Year

I certify that the above named Patient is under my care. Adjustments in the dates may be necessary at a later date.

_____ _____

Physician's Signature (No Stamps, Please) | Date

Certification of Health Care Provider for Employee's Serious Health Condition (Family and Medical Leave Act)

U.S. Department of Labor
Wage and Hour Division

DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT

OMB Control Number: 1235-0003
Expires: 5/31/2018

SECTION I: For Completion by the EMPLOYER

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave due to a serious health condition to submit a medical certification issued by the employee's health care provider. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

Employer name and contact: Colquitt Co. Bd. of Ed - Mr. James Harrell, HR Director

Employee's job title: _____ Regular work schedule: _____

Employee's essential job functions: _____

_____

Check if job description is attached:

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 29 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. § 825.305(b).

Your name: _____
First Middle Last

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the employee is seeking leave. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b). Please be sure to sign the form on the last page.

Provider's name and business address: _____

Type of practice / Medical specialty: _____

Telephone: (_____)_____ Fax:(_____)_____

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed above has requested leave under the FMLA to care for your patient. Answer, fully and completely, all applicable parts below. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the patient needs leave. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), or genetic services, as defined in 29 C.F.R. § 1635.3(e). Page 3 provides space for additional information, should you need it. Please be sure to sign the form on the last page.

Provider's name and business address: _____

Type of practice / Medical specialty: _____

Telephone: (_____) _____ Fax: (_____) _____

PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____

   Probable duration of condition: _____

   Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?
   ___No ___Yes. If so, dates of admission: _____

   Date(s) you treated the patient for condition: _____

   Was medication, other than over-the-counter medication, prescribed? ___No ___Yes.

   Will the patient need to have treatment visits at least twice per year due to the condition? ___No ____ Yes

   Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?
   ____ No ____Yes. If so, state the nature of such treatments and expected duration of treatment:

   _____

   _____

2. Is the medical condition pregnancy? ___No ___Yes. If so, expected delivery date: _____

3. Describe other relevant medical facts, if any, related to the condition for which the patient needs care (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

_____

_____

_____

_____

PART B: AMOUNT OF CARE NEEDED: When answering these questions, keep in mind that your patient's need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care;

4. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery? ___No ___Yes.

   Estimate the beginning and ending dates for the period of incapacity: _____

   During this time, will the patient need care? __ No __ Yes.

   Explain the care needed by the patient and why such care is medically necessary:

   _____

   _____

   _____

   _____

   _____

5. Will the patient require follow-up treatments, including any time for recovery? ___No ___Yes.

   Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

   _____

   Explain the care needed by the patient, and why such care is medically necessary: _____

   _____

6. Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery? __ No __ Yes.

   Estimate the hours the patient needs care on an intermittent basis, if any:

   _____ hour(s) per day; _____ days per week from _____ through _____

   Explain the care needed by the patient, and why such care is medically necessary:

   _____

   _____

   _____

   _____

CONTINUED ON NEXT PAGE

7. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? ____No ____Yes.

Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

Frequency: _____ times per _____ week(s) _____ month(s)

Duration: _____ hours or ___ day(s) per episode

Does the patient need care during these flare-ups? ____ No ____ Yes

Explain the care needed by the patient, and why such care is medically necessary: _____

_____

_____

_____

_____

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

_____

_____

_____

_____

_____

_____

_____ _____

Signature of Health Care Provider **Date**

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave , NW, Washington, DC 20210.
DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.

COLQUITT COUNTY SCHOOLS
Physicians Return to Work Statement

Name of Patient: _____

Date of Extended Leave: _____

I hereby certify that I have examined the above-named patient and find that he/she (is – is not) in such physical condition as to be able to discharge his/her normal job requirements on or after _____ (date).

Signed: _____ Date: _____
Physician

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

Disability Claim Instructions

Submitting a Claim

The first three steps are required.

1. Notify your employer of your absence. Inform your employer that you'll be filing a disability claim. Ask your employer to complete the **Employer's Statement** and submit it to Prudential.
2. Complete all sections of the **Employee's Statement** and submit it to Prudential.

(If you prefer, you may complete and submit the Employee's Statement online. Go to www.prudential.com/mybenefits. Your online submission will save time at the beginning of your claim-filing process.)

3. Ask your doctor to complete the Attending Physician's Statement and submit it to Prudential.

Check with your Benefits Office to see if there are any additional requirements.

Steps 4 through 6 are voluntary.

4. Complete all sections of the **Group Disability Insurance Authorization**.

(If additional medical information is needed to review your claim, submitting this form now may reduce the time needed to reach a decision.)

[redacted]

6. If you want electronic fund deposits of your disability benefit payments — read and complete the **Group Disability Insurance Electronic Funds Authorization**.

Prudential considers a claim to be filed when the **Employer's Statement, Employee's Statement,** and **Attending Physician's Statement** have been submitted, and specific elimination period requirements have been met — as specified below.

- **If you have Short-Term Disability (STD) coverage** with Prudential, your claim for STD benefits will be considered filed, when you meet **both** of these two criteria. **1** We receive the Employee's Statement, the Employer's Statement, and the Attending Physician's Statement. **2** Your STD elimination period has started.
- **If you have Long-Term Disability (LTD) coverage** with Prudential, your claim for LTD benefits will be considered filed, when you meet **both** of these two criteria. **1** We receive the Employee's Statement, the Employer's Statement, and the Attending Physician's Statement. **2** The date is 45 days before the end of your LTD elimination period.
- **If you have both STD and LTD coverages** with Prudential, and you have filed a claim for STD, there is no need to resubmit the statements noted above for the LTD portion of your claim.

  Your claim for LTD benefits, in this case, will be considered filed, when you meet **both** of these two criteria. **1** We receive the Employee's Statement, the Employer's Statement, and the Attending Physician's Statement. **2** The date is 45 days before the end of your LTD elimination period.

  Note: If you are approved for STD benefits at a later date, your LTD claim will be considered filed on the date of the STD approval.

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

Employee Statement

1 Employer Information

Employer Name: Colquitt County Board of Education

Control Number: 53009

Location/Division:

2 Employee Information

First Name | MI | Last Name

Address 1 | Social Security Number

Address 2 | Telephone Number

City | State | ZIP Code

Birth Date | Gender ☐ Male ☐ Female | Marital Status ☐ Unmarried ☐ Married ☐ Divorced ☐ Widowed

Email Address | Work Telephone Number

Date Last Worked (MM DD YYYY) | Date First Absent (MM DD YYYY) | Date First Treated for this Condition (MM DD YYYY)

Date Expected to Return to Work (MM DD YYYY) | Spouse's Date of Birth (MM DD YYYY) | Is Spouse Employed? ☐ Yes ☐ No

Education: Highest Grade Completed | Number of Children Under 18 | Youngest Child's Date of Birth (MM DD YYYY)

3 Job Information

Occupation | DOT Job Code

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

☐ Sedentary	☐ Light	☐ Medium	☐ Heavy	☐ 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)

Prudential

Employee Social Security Number

4 Primary Care Physician

Physician First Name | MI | Physician Last Name

Primary Telephone Number | Fax Number

Office Address | Suite

City | State | ZIP Code

Specialty

5 Medical Information

All Other Physicians You Have Consulted for this Condition (Attach an additional sheet if necessary)

Physician First Name | Physician Last Name

Specialty | Telephone Number

Physician First Name | Physician Last Name

Specialty | Telephone Number

Physician First Name | Physician Last Name

Specialty | Telephone Number

What medical condition is preventing you from working?

How does this condition interfere with your ability to perform your job?

Have you ever been hospitalized for this condition? ☐ Yes ☐ No ☐ Inpatient ☐ Outpatient

If Hospitalized Give Dates (MM DD YYYY)

From | To

If You are Pregnant:

Estimated Delivery Date: (MM DD YYYY) | Actual Delivery Date (MM DD YYYY)

Name of Your Health Insurance Company | Telephone Number

Prudential

Employee Social Security Number

6 Other Income and Workers' Compensation Information

What other income are you entitled to receive as a result of your disability? Please complete the chart below. Other Income type examples include but are not limited to: Individual Disability Benefits, Paid Family Leave, Third Party Liability payments, Unemployment Benefits, any other income.

Please send copies of any letters or notices approving or denying benefits.

Source	Applied for Yes	Applied for No	Amount	Frequency	Date Benefit Begins	Date Benefit Ends
Salary Continuance/ Sick Pay	☐	☐	.	☐ Weekly ☐ Monthly		
State Disability Benefits	☐	☐	.	☐ Weekly ☐ Monthly		
Social Security	☐	☐	.	☐ Weekly ☐ Monthly		
Workers' Compensation	☐	☐	.	☐ Weekly ☐ Monthly		
Automobile Liability Insurance	☐	☐	.	☐ Weekly ☐ Monthly		
Disability Paid by another carrier	☐	☐	.	☐ Weekly ☐ Monthly		
Pension/Retirement	☐	☐	.	☐ Weekly ☐ Monthly		
Other Income	☐	☐	.	☐ Weekly ☐ Monthly		

Are you currently working in any capacity? ☐ Yes ☐ No If yes, please explain _____

Check all that apply to this disability:

Accident ☐ Yes ☐ No

Sickness ☐ Yes ☐ No

Maternity ☐ Yes ☐ No

Motor Vehicle Accident ☐ Yes ☐ No

If MVA, in what State did it occur? ☐☐

No Fault is involved, please provide Name, Address, Phone number of carrier, and your claim number:

Is this condition work related? ☐ Yes ☐ No If Yes, do you intend to file a Workers' Compensation claim? ☐ Yes ☐ No

7 Correspondence Preference

The Prudential website is a quick, secure way to review the status of your claim and view/print all claim related correspondence.

You have the option to view your correspondence electronically. If you select 'Yes' below, you will receive an e-mail from Prudential instructing you to log onto our website and to accept the web disclosure authorization. Once you enroll in E-Delivery, claim correspondence will only be available on our website, and paper correspondence will no longer be mailed. You will be notified via e-mail when new correspondence is available. You can change your preference at any time on our website.

☐ Yes, I prefer to receive my correspondence electronically. I understand that all future correspondence related to this claim will be posted to the Prudential website and paper correspondence will no longer be mailed to me.

☐ No, I prefer my correspondence to be mailed to me.

8 Fraud Notice

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.

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.

Claimant Signature X _____ Date (MM DD YYYY) ☐☐ ☐☐ ☐☐☐☐

Prudential

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.

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 or misleading 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/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.

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

Group Disability Insurance
Electronic Funds Transfer Authorization

1 Enrollment

To enroll in Prudential's Electronic Funds Transfer (EFT) payment service, please provide the following information. If you elect to have Prudential deposit the funds in your savings or checking account, you must first check with your bank to obtain the correct bank transit routing number and account number for electronic deposit. Please note that a deposit slip does not contain acceptable banking information. If you have any questions, please call us toll free at 800-842-1718.

***Please note that not all policies are designed to participate in the Electronic Funds Transfer option. Contact your employee benefits representative or disability plan trustee for details.**

2

Employer's Name

Control Number (required)

Claimant's First Name

MI

Last Name

Claim Number

Social Security Number

Primary Phone Number

3 Banking Information

Bank Name

Branch Phone Number

Type of Account (Select One)

☐ Savings ☐ Checking

Bank Transit Routing Number

(NINE-DIGIT BANK TRANSIT ROUTING NUMBER)

Bank Account Number

(BANK ACCOUNT NUMBER)

4 Payment Plan Agreement

I authorize the Prudential Insurance Company of America to make electronic fund deposits of my disability benefit payment to my account. I understand that any deposit made to an inactive account will be returned to Prudential and reissued as a manual check. In addition, if any overpayment of such disability benefits is credited to my account in error, I authorize Prudential to withdraw any payments necessary in order to assure the accuracy of my claim payments.

I can cancel this authorization at any time by giving Prudential written notice. Any notice hereunder will not be deemed effective until Prudential has received my written notice.

Account Owner
First Name

MI

Last Name

Street

Apartment

City

State

ZIP Code

Date Signed (MM DD YYYY)

X
Signature

Prudential

Claimant's Social Security Number

5 **Instructions for Completing Section 3, "Banking Information"**

This will help you identify the necessary bank information to initiate electronic withdrawals. The nine-digit transit routing number is how we recognize the bank you do business with.

Record all banking information on page 1 of the form in Section 3, "Banking Information". Please call your bank to confirm that the information you are supplying is correct.

Customer XYZ
XYZ Street
City, State, ZIP

Check No. 1246

PAY TO THE ORDER OF _____ $ _____

Dollars

_____

Bank XYZ
UXYZ Street
City, State, ZIP

A27202754 006666D66666C 1246

This is the bank transit routing number.

It is always nine digits and appears between the ":" symbols.

Record this number in the boxes provided in Section 3, "nine-digit bank transit routing number."

This is your bank account number. It varies in number of digits and may include dashes or spaces.

The "<" symbol indicates the end of the account number.

Record the account number in the boxes provided in Section 3, "Bank Account Number" and include any dashes and spaces that are within the account number.

If there are any digits to the right of the "<" symbol (which do not represent the check sequence number), record them in the boxes provided.

This is the check sequence number. It may be on either end of your check. Please do **not** include this on the authorization form.

*This page consists only of **Instructions**: It is not necessary to return this page with your EFT Authorization.*

Prudential

Group Disability Insurance

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Disability Management Services
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Tel: 800-842-1718 Fax: 877-889-4885
www.prudential.com/mybenefits

Group Disability Insurance Authorization

1 Claimant's Information

First Name | MI | Last Name

Claim Number | Social Security Number (Last four digits) | Employee Phone Number

Date of Birth (mm yyyy) | Control Number: 53009

2 Authorization for Release of Information to The Prudential Insurance Company

This authorization is intended to comply with the HIPAA Privacy Rule.

I authorize and instruct any health plan, physician, health care professional, medical professional, hospital, clinic, laboratory, pharmacy, clearinghouse, data warehouse, or other organization that aggregates and maintains pharmacy data, MIB, Inc. (formerly known as the Medical Information Bureau), medical facility, or other health care provider or insurance company or producer that has provided treatment, payment, or services to me or on my behalf ("My Providers") to disclose my entire medical record and any other information concerning me or my mental or physical health 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 any insurance company, employer, the Social Security Administration, or other person or institutions to provide any information, data, or records relating to my Social Security, Workers' Compensation, credit, financial, earnings, activities, or employment history to Prudential.

For purposes of this Authorization, I acknowledge that any agreements I have made with My Providers that restricts the disclosure of my protected health information as described above do not apply to this Authorization and I instruct My Providers to release and disclose my entire medical record without restriction, including any restrictions on healthcare items or services for which a healthcare provider has been paid out of pocket in full.

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 or benefits I have or have 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: P.O. Box 13480, Philadelphia, PA 19176. I understand that a revocation is not effective to the extent that any of My Providers or Prudential has relied on this Authorization or to the extent that Prudential has a legal right to contest a claim under any insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and will no longer be protected by the HIPAA Privacy Rule governing privacy and confidentiality of health information.

I understand that if I refuse to sign this Authorization to release the entire 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 receive a copy of this Authorization.

Authorization for Release of Information to The Prudential Insurance Company

X _____ Date (mm dd yyyy)

Employee Signature (indicate how related if signed by other than claimant)

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/forphysicians

Attending Physician Statement

1 Employee Information

Employer's Name

Control Number (required) 53009

Employee First Name | MI | Last Name

Claim Number | Social Security Number | Date of Birth (MM DD YYYY) | Gender ☐ Male ☐ Female

I hereby authorize the release of information requested on this form by the below named physician for the purpose of claim processing.

Employee Signature X

Date (MM DD YYYY)

The Employee is responsible for the completion of this form without expense to Prudential.

2 To Be Completed by Attending Physician

Clinical Diagnosis **ICD Code is Required**

Primary:

Secondary:

Secondary:

Pregnancy EDC (MM DD YYYY)

Actual Delivery Date (MM DD YYYY)

Date when significant loss of function occurred: (MM DD YYYY)

Do you feel the claimant is competent to endorse checks and direct the use of proceeds? ☐ Yes ☐ No

Return to Work Target Date (MM DD YYYY)

☐ Full-Time ☐ Part-Time ☐ With Limitations (functions lost)

Please describe Return to Work Plan and provide any corresponding Limitations:

Please describe any Medical Obstacles to Return to Work:

Nature of Medical Impairment (i.e., loss of function):

Are there any Non-Medical Factors which have a significant impact on Functional Abilities (i.e., interpersonal, financial, family)?

Check all that apply to this disability:

Work Related	Accident	Sickness	Maternity	Motor Vehicle Accident	If MVA, in what State did it occur?
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	

Other Treating Physicians or Consultants:

First Name | Last Name

Specialty | Telephone Number

Prudential

Employee First Name | MI | Last Name

Claim Number | Date of Birth (MM DD YYYY) | Employee's Social Security Number

2 Attending Physician Information (Cont'd)

Other Treating Physicians or Consultants

First Name | Last Name

Specialty | Telephone Number

Date of Surgical Procedure (MM DD YYYY)

Relevant tests and surgical procedure (s) performed (please be specific):

Current Medications, Treatment, and Prognosis:

First Visit (MM DD YYYY) | Last Visit (MM DD YYYY) | Next Visit (MM DD YYYY) | Was Claimant hospital confined? ☐ Yes ☐ No

If yes, please provide name and address of hospital:

From (MM DD YYYY)

To (MM DD YYYY)

3 Physician Information

First Name | MI | Last Name

Primary Telephone Number | Fax Number

Office Address | Suite

City | State | ZIP Code

Specialty

4 Fraud Notice

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)