

The Prudential Insurance Company of America

Waiver of Premium Unit P.O. Box 70183, Philadelphia, PA 19176 Tel 800-524-0542 Fax 877-862-0269

Authorization to Release Information

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

For the purposes of evaluation of a claim for insurance benefits, I authorize all physicians, hospitals, clinics, medical providers, health plans, other health care providers, laboratories, insurance companies, pharmacies, pharmacy benefit managers, employers, investigative consumer reporting agencies and other agencies, including governmental organizations and the Social Security Administration, to provide to Prudential the Claimant's entire medical record (excluding psychotherapy notes), employment record, pharmacy record, insurance claim record, and insurance policy information. Upon the presentation of the original or photocopy of this signed authorization, I request the Social Security Administration to release to Prudential any and all information regarding earnings and any other information that may determine eligibility for benefits under the Social Security Act.

I authorize the entities listed above to permit Prudential or its authorized representative to obtain a copy of the entire medical record, including but not limited to, treatment for communicable diseases such as the human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS), drug and alcohol use and all other information relative to the physical health, mental health, dental care, or employment pertaining to Claimant.

For the purpose of processing and payment of claims in an efficient and prompt manner, I authorize Prudential to consolidate and disclose completed claim forms and documents to appropriate associates for each and every one of Prudential Financial, Inc.'s affiliates or business units for which a claim for payment or distribution is made.

First name		MI	Last name		
Claim number (if available)	Social Security number (last 4 digits)	Employee pho	ne number	Date of birt (mm/yy)	th
Control number or Polic	y number				
This authorization will remain va shorter duration. This authoriclaim process and may deny be other than its reinsurers or services A copy of this authorization for	ization can be revoked by givenefits if this form is unsignerice providers without writter	ving written notice ed or revoked. Pro authorization, u	e to Prudential. Pru udential will not rel nless required or al	idential may be un ease this informati lowed by law or ord	able to complete the on to any other entity dered by a court of law.
I understand that I have the rig Prudential at P.O. Box 70183, providers have relied on this Au or to contest the policy itself. I longer covered by federal rules	Philadelphia PA 19176. I uthorization or to the extent understand that any information	understand that a that Prudential ha ation that is discl	revocation is not e as a legal right to co osed pursuant to th	ffective to the exte ontest a claim und	ent that any of my medical ler any insurance policy,
Once disclosed to Prudential, the but will be protected by other authorization, I hereby revoke a release of the Claimant's entire	applicable federal and state any prior restriction on disclo	laws relating to the sure of medical	ne protection of per records provided to	sonal information.	For purposes of this
X Signature				month day	year
X					
Witness					
Relationship					
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