



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

Reimbursement Agreement

1 Claimant Information

First Name

MI

Last Name

Claim Number

Claimant Social Security Number

As an individual covered under a Prudential Group Plan, I have filed a claim for Disability (Short Term Disability and/or Long Term Disability) benefits.

With respect to Social Security benefits: I understand that benefits payable under this Group Plan are to be reduced by any benefits under the Social Security Act that I or members of my family receive or would be entitled to receive as a result of my disability, for that same period.

Should my claim for benefits be approved, I request that Prudential postpone making the reduction of benefits described in the second paragraph of this Agreement until I actually am awarded Social Security benefits or complete the Social Security application process described below.

I agree to make timely and diligent pursuit of Social Security benefits through each level of appeal up to and including the Administrative Law Judge level.

These steps may include:

1. Application for such benefits;
2. Appeal at the reconsideration level, if benefits are denied;
3. Appeal at the Administrative Law Judge level, if benefits are denied.

I understand that I must provide Prudential with written proof that I have completed the process above. I also understand that I must provide Prudential with a signed Social Security Authorization form, upon request. Failure to complete this process and provide proof of same will result in Prudential (1) estimating my monthly Social Security benefits and (2) using that amount to determine my adjusted benefits.

I promise to notify Prudential immediately if I am awarded Social Security benefits. I understand that I must notify Prudential immediately of any changes in my or my eligible family member's monthly Social Security benefits.

If any benefits under the Social Security Act are awarded retroactively, I understand that an overpayment of my Short Term and/or Long Term Disability Benefits may result. I understand and agree that all or a portion of those retroactive Social Security benefits must be immediately repaid to Prudential in accordance with the terms of the Group Plan.

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Prudential

Reimbursement Agreement

First Name

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MI

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Last Name

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Claim Number

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Claimant Social Security Number

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To assist in the recovery of these overpaid benefits, I acknowledge that I may authorize Prudential to recover the funds through Prudential's Direct Withdrawal service by completing the Direct Withdrawal Authorization Form. I understand that I am not required to authorize Prudential to recover funds through Prudential's Direct Withdrawal service, but that regardless of whether I provide such authorization, I will still be required to reimburse Prudential for any overpayments of Disability Benefits.

With respect to all other Deductible Sources of Income outlined in the Group Plan, including Workers' Compensation, Pension or Retirement, or similar coverage: I agree to repay Prudential immediately the amount paid to me under this Group Plan in excess of the amount to which I would have been entitled under the terms of the Plan if I subsequently receive an award of other Deductible Sources of Income by judgment, settlement or otherwise.

I also understand that benefits payable under this Group Plan are to be reduced by the amount I receive, due to my disability, from a third party (after subtracting reasonable attorney's fees) by judgment, settlement or otherwise.

I understand that I must notify Prudential immediately of any changes in the monthly benefits provided to me or my family by any other Deductible Sources of Income outlined in the Group Plan.

With respect to any overpayment of my Disability Benefits from Prudential, I hereby assign, transfer and set over to Prudential, to the extent of any excess so paid under this Agreement, the amount of future benefits which may become payable under this Group.

Employee
Signature

X

Name of
Employee
(Print)

X

Date (MM DD YYYY)

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"R/A #1 (Family)"

