



The Prudential Insurance Company of America
Disability Management Services
P.O. Box 13480, Philadelphia, PA 19176
Tel: 800-842-1718 Fax: 877-889-4885
http://www.prudential.com/disability

Group Disability Insurance Authorization

1 Claimant's Information

Form fields for First Name, MI, Last Name, Social Security Number, Employee Phone Number, and Control Number.

2 Authorization for Release of Information to Prudential Insurance Company and Harvey Watt & Co.

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided treatment, payment, or services to me or on my behalf ("My Providers") to disclose my entire medical record and any other health information concerning me to the Prudential Insurance Company of America (Prudential) and/or Harvey Watt & Co. and their 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.

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

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.

Unless limits* are shown below, this form pertains to all of the records listed above.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct My Providers to release and disclose my entire medical record without restriction.

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 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 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 is no longer covered by federal rules 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.

*Limits, if any:

Empty box for limits, if any.

Date (MM DD YYYY)

Date input fields (MM DD YYYY)

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

NOTICE TO MONTANA RESIDENTS: You or your authorized representative are entitled to receive a copy of this Authorization, and upon request, a record of any subsequent disclosures of personal or privileged information.

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