RD-0988-0418

State of New Jersey • Department of the Treasury
DIVISION OF PENSIONS & BENEFITS
P.O. Box 295, Trenton, NJ 08625-0295

DEFINED CONTRIBUTION RETIREMENT PROGRAM (DCRP)
PUBLIC EMPLOYEES' RETIREMENT SYSTEM (PERS)
TEACHERS' PENSION AND ANNUITY FUND (TPAF)

LONG-TERM DISABILITY INSURANCE FOR MEMBERS OF DCRP AND TIER 4 & 5 MEMBERS OF PERS/TPAF

ATTENDING PHYSICIAN STATEMENT — INSTRUCTIONS

Actively contributing DCRP members and PERS or TPAF members enrolled in Tier 4 or 5 (on or after May 21, 2010) are eligible for employer-paid long-term disability insurance coverage administered by Prudential.

1. The application process begins by completing the *Long-Term Disability Insurance Application.* The application is made up of the *Employee Statement,* the *Attending Physician Statement,* and the *Employer Statement.*

2. When completing the application, enter the Control Number **14800** for DCRP, PERS, and TPAF Long-Term Disability Insurance and the Branch Number that corresponds to your employer type: **00043** for DCRP Local Government; **00044** for DCRP State; **00045** for PERS Local Government/Education; **00046** for PERS State; or **00047** for TPAF.

3. Complete the *Employee Statement* providing all requested information about the applicant, their job, and the disabling condition.

4. Provide the *Attending Physician Statement* to the treating physician(s) for completion.

5. The employer completes the *Employer Statement* which includes information about the employee's occupation, coverage effective date, and the employee's salary information for the final 12 months prior to the month in which the disabling event occurred.

6. Submit all sections of the completed application to Prudential, using the address provided.

   Prudential Insurance Company of America
   Disability Management Services
   P.O. Box 13480
   Philadelphia, PA 19176

7. Prudential notifies the Division of Pensions & Benefits (NJDPB) that a claim is pending and begins initial processing.

8. Processing times vary. If any required information is missing from the application, Prudential will contact the employee or the employer to obtain the necessary information.

9. When all required information has been obtained, Prudential makes a determination as to whether or not the disability is approved and notifies the employee directly. The employer and the NJDPB are also notified of the determination.

PERS and TPAF members see the *Long Term Disability for PERS and TPAF Tiers 4 and 5* Fact Sheet for additional information.
For questions contact Prudential Disability Management at 1-800-842-1718
or at: ***www.prudential.com/mybenefits***
(Registration with the Prudential website is required for first-time users.)

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

The State Treasurer of New Jersey

Attending Physician Statement

1 Employee Information

Employer's Name

Control Number (required) 14800

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)