ABP Long Term Disability Insurance

NJDPB
Pensions & Benefits
Explore Your Benefits

Alternate Benefit Program (ABP)

APPLICATION INSTRUCTIONS

This Packet Contains:

Prudential Group Disability Insurance Application

— Employee Statement
— Employer Statement
— Attending Physician Statement
— Employee Tax Notice
— Insurance Authorization
— Electronic Funds Transfer Authorization

ABP Carrier Election and Allocation Form

1. An ABP member wishing to apply for a Long Term Disability begins the process by completing the *Disability Insurance Application* and *Carrier Election and Allocation* form — accurately providing all requested information and submitting the complete packet to his or her employer.

2. The employer then provides the employee's salary information for the final 12 months prior to the month in which the disabling event occurred, and sends the completed applications and forms to:

   The Division of Pensions & Benefits
   Alternate Benefit Program
   P.O. Box 295
   Trenton, NJ 08625-0295

3. The New Jersey Division of Pensions & Benefits (NJDPB) then forwards the employee's application to Prudential for initial processing.

4. ABP Long Term Disability 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.

5. 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.

6. If approved, the NJDPB will notify the State Health Benefits Program/School Employees' Health Benefits Program, who will send out information regarding retired health benefits.

For additional information or if you have questions, contact Prudential at 1-800-842-1718 or write to the ABP at the address listed above.

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

The State Treasurer of New Jersey Employee Statement

1 Employer Information

Employer Name

Control Number 1 4 8 0 0

Location/Division

Branch Number

2 Employee Information

First Name MI Last Name

Address 1

Social Security Number

Address 2

Telephone Number

City State ZIP Code

Birth Date (MM DD YYYY)

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

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

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)

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.

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

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The State Treasurer of New Jersey
Employer Statement/Certification Form

1 Employer Information

Employer's Name

Control Number (required) 14800

Street

Suite

City

State

ZIP Code

LTD Branch (required)

Employer's Telephone Number

Extension

E-mail Address

2 Employee Information

First Name

MI

Last Name

Address 1

Social Security Number

Address 2

Telephone Number

City

State

ZIP Code

Gender ☐ Male ☐ Female

Employment Status
☐ Salaried Employee
☐ Hourly Employee
☐ Other_____

Coverage Effective Date/Enrollment Date (date the employee became covered under group disability policy regardless of carrier).
LTD:

Date Hired (MM DD YYYY)

Coverage Termination Date (MM DD YYYY)

Last Date Employer Paid Compensation* (MM DD YYYY)

Date First Absent (MM DD YYYY)

Date Last Worked (MM DD YYYY)

Date Work Was Resumed (MM DD YYYY)

Normal Earnings Prior to this Absence (exclude bonus, overtime, etc.)
$,, . PER
☐ Hour ☐ Week ☐ Bi-Weekly (every two weeks)
_____ # of hrs worked
☐ Month ☐ Year ☐ Other _____

If employee does not work Monday through Friday, check days worked:
☐ Varies ☐ Thursday
☐ Monday ☐ Friday
☐ Tuesday ☐ Saturday
☐ Wednesday ☐ Sunday

Year To Date Total Taxable Wages
$,, .
As of: (MM DD YYYY)

How was the **LTD** premium paid for the plan year in which the disability occurred? _____ % paid by employer

Was the premium amount paid by the employer included in the employee's W-2? ☐ Yes ☐ No

Has either percentage changed within the last 3 years? ☐ Yes ☐ No

Prudential

Employee's Social Security Number

3 Other Income, Deductions, and Workers' Compensation Information

Please indicate any applicable deductions such as Local Tax, State Income Tax, Medical, Dental, Life and/or 401(K), that should be withheld from the employee's benefits, if approved. Please also indicate if the employee is receiving, or is eligible to receive, benefits from any other sources because of this absence, such as Salary Continuance/Sick Pay, Workers' Compensation, Social Security Disability or Retirement Benefits, Statutory Benefits, Automobile Liability, Retirement or Pension Plan. If the employee has filed for or is receiving Pension/Retirement benefits, Paid Family Leave, or Unemployment Benefits, please enter this information in the line marked "Other". **Please send copies of any letters or notices approving or denying benefits.** *If the Last Date Employer Paid Compensation is after the employee's last day worked, please enter the payment type and amount in the table below.

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		
Medical Deduction	☐	☐	.	☐ Weekly ☐ Monthly		
Dental Deduction	☐	☐	.	☐ Weekly ☐ Monthly		
Vision Deduction	☐	☐	.	☐ Weekly ☐ Monthly		
Life Deduction	☐	☐	.	☐ Weekly ☐ Monthly		
Other	☐	☐	.	☐ Weekly ☐ Monthly		

If you entered information in "Other", please specify what benefit this represents _____

Has the employee indicated that the absence is work related? ☐ Yes ☐ No Has a Workers' Compensation claim been filed? ☐ Yes ☐ No

4 Job Information

Occupation

What Job Category best describes the employee'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)

As the employer, would you be able to accommodate modified duty to facilitate early return to work? ☐ Yes ☐ No

If Yes, please explain (reduced hours, job modification, etc.):

5 Life Insurance

Is employee covered under a Prudential Group Life Insurance Policy? ☐ Yes ☐ No

If Yes, what is the face amount? $, , .

Prudential

Employee's Social Security Number

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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.

Employer/ Certifying Officer Signature X _____

Date (MM DD YYYY)

For residents of all states 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.

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Prudential

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Prudential

Group Disability Insurance

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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

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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)

FP-0777-0418

State of New Jersey • Department of the Treasury

DIVISION OF PENSIONS & BENEFITS — DEFINED BENEFIT & DEFINED CONTRIBUTION BUREAU

P.O. Box 295, Trenton, NJ 08625-0295

ALTERNATE BENEFITS PROGRAM (ABP) CARRIER ELECTION AND ALLOCATION

Name _____
Last *First* *MI*

Social Security Number _____ ABP Number _____
if assigned

Address _____
Street

_____
City *State* *Zip*

Daytime Telephone Number (_____) _____

AUTHORIZED INVESTMENT CARRIERS

If you are vested, select any number of investment carriers and allocate the percentage of your contributions to each one, totaling 100 percent. Percentages must be whole numbers. **You must establish a valid account directly with the carrier(s) you select.**

Check One: ☐ Initial Election ☐ Subsequent Election

____	AXA Financial (Equitable)	_____ %
____	MassMutual Retirement Services (The Hartford)	_____ %
____	ING/VOYA Financial Services	_____ %
____	MetLife (formerly Travelers/CitiStreet)	_____ %
____	Prudential	_____ %
____	TIAA-CREF	_____ %
____	VALIC	_____ %
		100%

I elect to allocate my total employee and employer tax sheltered contributions as indicated above. This allocation becomes effective within 30 days of receipt of a properly completed form. I have read and understand the information on the back of this application about my ABP membership.

Employee Signature _____ Date _____

Certifying Officer Signature _____ Date _____

Certifying Officer's Phone Number (_____) _____

ABP

INFORMATION FOR NEW APPLICANTS

A *Carrier Election and Allocation* form must be completed to identify the investment carrier(s) with which you want your contributions invested.

- **If you are eligible for immediate vesting,** the employer contributions become your property immediately upon investment in your account. You may elect any number of investment carriers and designate the percentage (in whole numbers) of the total contributions they each should receive.
- **If you are not eligible for immediate vesting,** the employer contributions do not become your property until the beginning of the 13th month of your employment. You may elect only one investment carrier.

If you do not file a *Carrier Election and Allocation* form, the ABP Administrator will enroll you with the investment carrier selected as the default carrier for the current plan.

You must file an application directly with the investment carrier(s) you have elected or with the default investment carrier if you fail to complete this form. If you fail to do so, you may lose possible revenue from your contributions. Additionally, the carrier(s) you elected will return your contributions to your employer and the ABP administrator will enroll you with the default investment carrier.

INFORMATION FOR VESTED ABP MEMBERS

ABP members may change their investment carrier election and/or allocation once each quarter of the calendar year.