Prudential

PRUDENTIAL XPRESS QUICKFORM

POLICY DELIVERY STATE: _____

DATE AUTHORIZATION (LIMITED INSURANCE AGREEMENT FOR PREPAID BUSINESS) SIGNED: _____

A. CASE DETAILS

1. General agency contract number: _____

B. PROPOSED INSURED (POLICYOWNER UNLESS OTHERWISE NAMED)

1. Name: _____
2. Social Security number: _____ 3. Gender: ☐ Female ☐ Male 4. Date of birth: _____
5. Date policy to Save Age? ☐ Yes ☐ No
6. Driver's license issuing state: _____ Number: _____ Expiration date: _____
   If None, why not? : _____
7. Residence address (No PO boxes): Street _____ Apt _____
   City _____ State _____ ZIP _____
8. If the mailing address is different than the residential address: _____ Apt _____
   City _____ State _____ ZIP _____
9. e-mail address: _____
10. Is the proposed insured a permanent, legal U.S. resident? ☐ Yes ☐ No
    If No, provide : Country of legal residence: _____ Length of U.S. residence: _____
    Type of visa: _____ Visa number: _____ Expiration date: _____
11. Earned annual income: $_____ Unearned annual income: $_____ Net worth: $_____
12. Is anyone dependent on the proposed insured for financial support? ☐ Yes ☐ No

C. CLIENT INTERVIEW (SEE INSTRUCTIONS FOR SCHEDULING GUIDELINES.) PHONE INTERVIEWS CONDUCTED M–F 9 A.M. TO 9 P.M.

1. Contact phone numbers : Home: _____
   Business: _____ Alternate: _____
   Preferred contact number: Check one: ☐ Home ☐ Business ☐ Alternate
2. Best time to call (select one): ☐ Morning ☐ Afternoon ☐ Evening
3. If the proposed insured is younger than 18 years old, who will be completing the callback?: ☐ Parent ☐ Guardian
   Name: _____
4. Special needs (hearing impaired, translator needed): _____
5. Do you plan on submitting, or have you recently submitted worksheets that are related to this one? ☐ Yes ☐ No
   If Yes, provide names : _____

D. PLAN OF INSURANCE

1. Amount of insurance applied for: $_____
2. Product applied for:
   - ☐ Term Essential®: ☐ 10 ☐ 15 ☐ 20 ☐ 30
   - ☐ Term Elite®: ☐ 10 ☐ 15 ☐ 20 ☐ 30
   - ☐ ROP Term: ☐ 15 ☐ 20 ☐ 30
   - ☐ PruTerm WorkLife 65℠ (includes Insured's Waiver of Premium Benefit)
   - ☐ PruLife® Founders Plus (PFP)
   - ☐ Other: _____
   - ☐ PruLife® Custom Premier II (PCP II)
   - ☐ VUL Protector℠ (VULP)
   - ☐ PruLife® Essential Universal Life (EUL)
   - ☐ PruLife® Universal Protector (UL Protector)
   - ☐ PruLife® Index Advantage (IAUL)
3. For **UL and VUL products only**: Death Benefit type:
   ☐ Type A (Level) ☐ Type B (Variable)–**N/A for UL Protector** ☐ Type C (Return of Premium)–N/A for **UL Protector & VULP**–Interest rate: _____%
4. For **UL and VUL products only**: Definition of life insurance:
   ☐ Cash Value Accumulation Test (CVAT) ☐ Guideline Premium Test (GPT)
5. Requested Optional Benefits (Not all benefits are available for all products.):
   - ☐ Waiver of Premium/Enhanced Disability Benefit
   - ☐ Acceleration of Death Benefit (Living Needs Benefit)
   - ☐ Accidental Death Benefit: Amount $_____
   - ☐ BenefitAccess Rider
     If applicable, **Select Max Monthly Benefit Percentage ☐ 2% or ☐ 4%**
   - ☐ Other Riders/Benefits (indicate amount where applicable): _____
   - ☐ Overloan Protection Rider
   - ☐ Child Rider: Amount $ _____
   - ☐ Automatic Premium Loan
   - ☐ Enhanced Cash Value Rider

E. PREMIUM

1. Send notices (check one): ☐ Policyowner ☐ Other recipient: _____
   Send notices (check one): ☐ Policyowner's residence ☐ Other address:
   Street _____ Apt _____
   City _____ State _____ ZIP _____
2. Premium payment mode: ☐ Annually ☐ Semiannually ☐ Quarterly ☐ Monthly – Electronic Funds Transfer (EFT)
3. **For non-term plans**, billed premium: $_____

F. BENEFICIARY DETAILS

If beneficiary is a trust, provide name of trust and trustee(s), date of trust and if trust is revocable or irrevocable. If beneficiary is a business, list name of business, city and state where located and the form of business.

Name: First	Middle	Last	Relationship to Proposed Insured	Age	Beneficiary Class Primary	Secondary/Contingent
					☐	☐
					☐	☐
					☐	☐
					☐	☐

G. INSURANCE HISTORY

1. Do you have any existing life insurance or annuities? ☐ Yes ☐ No
   Note: Existing coverage includes any life insurance policies that have been assigned, sold or transferred.
2. Will this insurance replace* any existing insurance or annuity? ☐ Yes ☐ No
3. List the following details for all existing coverage. (List only annuities to be replaced*, list all in force life insurance.):

	Insurance Company	Face Amount	Type	Product	To Be Replaced?*	1035 Exchange?
a.	_____	$_____	☐ Group ☐ Individual	☐ Annuity ☐ Life	☐ Yes ☐ No	☐ Yes ☐ No
	***If Replacement, policy number*:** _____					
b.	_____	$_____	☐ Group ☐ Individual	☐ Annuity ☐ Life	☐ Yes ☐ No	☐ Yes ☐ No
	***If Replacement, policy number*:** _____					
c.	_____	$_____	☐ Group ☐ Individual	☐ Annuity ☐ Life	☐ Yes ☐ No	☐ Yes ☐ No
	***If Replacement, policy number*:** _____					
d.	_____	$_____	☐ Group ☐ Individual	☐ Annuity ☐ Life	☐ Yes ☐ No	☐ Yes ☐ No
	***If Replacement, policy number*:** _____					
e.	_____	$_____	☐ Group ☐ Individual	☐ Annuity ☐ Life	☐ Yes ☐ No	☐ Yes ☐ No
	***If Replacement, policy number*:** _____					

*Replace or replaced means that the insurance being applied for may replace or cause a change in any existing insurance or annuity with any company, including the lapse or surrender of the existing policy, or the use of funds or values from the existing policy to pay for the new policy.

CA ONLY: Complete when requesting BenefitAccess Rider (BAR).

4. Will this rider replace any existing long-term care coverage presently in force? ☐ Yes ☐ No
   If Yes, provide name of Company being replaced. _____
5. Will this rider replace any existing Acceleration of Death Benefit coverage presently in force? ☐ Yes ☐ No
   If Yes, provide name of Company being replaced. _____

OH JUVENILE (AGE 0 - 17) ONLY:

6. Is the proposed owner considering the transfer or sale to an investor or other third party of: policy ownership; or, any interest in the policy benefits, either directly or indirectly as a beneficiary or owner of a trust or other entity? ☐ Yes ☐ No
   ***If Yes, provide details*:** _____
7. Has the proposed owner been offered any money or other considerations by any person or entity in connection with this application? ☐ Yes ☐ No
   ***If Yes, provide details*:** _____

All other states:

8. Is the proposed insured or proposed owner considering the transfer or sale to a life settlement company or other investor of: policy ownership; or, any interest in the policy benefits, either directly as a named beneficiary or indirectly as a beneficiary or owner of a trust or other entity? **In LA: If YES, always complete Section J (Policyowner Statement).** ☐ Yes ☐ No
   ***If Yes, provide details*:** _____

G. INSURANCE HISTORY (CONTINUED)

NY ONLY: Complete when requesting BenefitAccess Rider (BAR).

9. Do you have any other accident and health care insurance policy, accelerated death benefit policy or rider, long term care insurance, nursing home insurance, home care insurance or long term care insurance provided under the Partnership for Long Term Care Program as defined by New York law? ☐ Yes ☐ No

10. Is this rider intended to replace the coverage identified in #9 above? ☐ Yes ☐ No

11. List the following details for all existing coverage:

a. Company: _____ To Be Replaced?
Policy/Certificate Number: _____ Amount: _____ ☐ Yes ☐ No
Type of Benefit: ☐ Long Term Care Insurance provided under the Partnership for Long Term Care Program
☐ Accident and Health Care Insurance ☐ Accelerated Death Benefit Policy or Rider
☐ Long Term Care Insurance ☐ Nursing Home Insurance
☐ Home Care Insurance

b. Company: _____ To Be Replaced?
Policy/Certificate Number: _____ Amount: _____ ☐ Yes ☐ No
Type of Benefit: ☐ Long Term Care Insurance provided under the Partnership for Long Term Care Program
☐ Accident and Health Care Insurance ☐ Accelerated Death Benefit Policy or Rider
☐ Long Term Care Insurance ☐ Nursing Home Insurance
☐ Home Care Insurance

c. Company: _____ To Be Replaced?
Policy/Certificate Number: _____ Amount: _____ ☐ Yes ☐ No
Type of Benefit: ☐ Long Term Care Insurance provided under the Partnership for Long Term Care Program
☐ Accident and Health Care Insurance ☐ Accelerated Death Benefit Policy or Rider
☐ Long Term Care Insurance ☐ Nursing Home Insurance
☐ Home Care Insurance

H. TAX CERTIFICATION

1. Back-up withholding (select one):
☐ The policyowner is subject to backup withholding under Section 3406(a)(1)(C) of the Internal Revenue Code.
☐ The policyowner is **NOT** subject to backup withholding under Section 3406(a)(1)(C) of the Internal Revenue Code.

2. The policyowner is subject to FATCA reporting under Section 6038D. ☐ Yes ☐ No

3. The policyowner is a U.S. person (including a U.S. resident alien). ☐ Yes ☐ No

I. FINANCIAL DETAILS (COMPLETE FINANCIAL SUPPLEMENT WITH FACE AMOUNTS OF $5,000,000 OR MORE UP TO AGE 70, $2,500,000 OR MORE AGES 71-80, $1,000,000 OR MORE AGES 81 AND UP.)

Submit copies of material that supplements the information requested, such as loan commitments, written buy-sell agreements, audited financial statements or letters.

Financial Information

1. Source of Financial Information. (Check all that apply.):
☐ Proposed Insured ☐ Accountant/CPA ☐ Banker ☐ Attorney ☐ Producer ☐ Other: _____

2. Who determined the amount of insurance applied for? (Check all that apply.)
☐ Proposed Insured ☐ Accountant/CPA ☐ Banker ☐ Attorney ☐ Producer ☐ Other: _____

3. Current Annual Household Income:
a. Gross Compensation (e.g., Salary, Commissions, Bonuses, etc.): $_____
b. Other Income (e.g., Dividends, Interest, Net Real Estate Income, etc.): $_____
c. Total Annual Cash Income before taxes: $_____

4. Net Worth (excluding any business interest)
a. Liquid Assets (assets that can be easily changed to cash): $_____
b. Other Assets: $_____
c. Liabilities: $_____
d. Net Worth (excluding business): $_____

5. Business Related Assets: $_____

I. FINANCIAL DETAILS (CONTINUED)

6. Have either the Proposed Insured or owner filed for bankruptcy within the past five years? ☐ Yes ☐ No

If Yes, please provide details including whether bankruptcy was dismissed or discharged; type of bankruptcy (chapter); whether it was personal or business related; current status; single or multiple occurrences; any outstanding judgments, liens or garnishments, etc :

_____

Additional comments: _____

J. POLICYOWNER STATEMENT

OH ONLY: FOR UL AND VUL: COMPLETE IF PROPOSED INSURED IS AGE 18 OR ABOVE & FACE AMOUNT OF $50,000 AND ABOVE.
FOR TERM: COMPLETE IF PROPOSED INSURED IS AGE 70 OR ABOVE & FACE AMOUNT OF $1,000,000 AND ABOVE.
ALL OTHER STATES: COMPLETE IF PROPOSED INSURED IS AGE 70 OR ABOVE & FACE AMOUNT OF $1,000,000 AND ABOVE FOR UL AND TERM.

Prudential will not knowingly participate in a life insurance sale where the sale of the policy in a secondary market or the participation of investors in the policy death benefits is being considered.

1. Has the policyowner or the proposed insured been offered "free insurance" or any inducement such as a cash payment, gifts, loan proceeds in excess of the amount necessary to fund the policy, or anything else of value as an encouragement to apply for this life insurance policy? ☐ Yes ☐ No
2. **Not applicable in LA**: Has the policyowner or the proposed insured been solicited to sell or transfer, or had any discussions about selling any of the following to a life settlement company or group of investors in the next five years: the proposed life insurance policy; any other life insurance policy on the life of the proposed insured; or, a trust, limited liability company or other entity that has been or will be established to own the policy? ☐ Yes ☐ No
3. Has the policyowner or the proposed insured entered into or been offered a financing arrangement where a lender or other third party, other than your employer or family member, will receive any portion of the death benefit of the policy applied for in excess of repayment of the principal and interest ☐ Yes ☐ No

If Yes to questions 1, 2, or 3, please provide details:

K. OWNER (COMPLETE IF OWNER IS OTHER THAN THE PROPOSED INSURED)

For multiple owners, list details in Remarks.

1. Name of owner: _____
2. Social Security/Tax identification number (SSN/TIN): _____
3. Residence address (No PO boxes): Street _____ Apt _____
   City _____ State _____ ZIP _____
4. If the mailing address is different than the residential address: _____ Apt _____
   City _____ State _____ ZIP _____
5. Owner's email address: _____

6a. For trust owner: **Complete the *Trustee Statement and Agreement* (COMB 86044).**

Trust date: _____

Trustee(s)_____

Type: ☐ Revocable ☐ Irrevocable ☐ Qualified Retirement Plan Trust ☐ Welfare Benefit Trust

6b. For business owner:

Form: ☐ Corporation ☐ Partnership ☐ Sole proprietorship ☐ Other: _____
☐ S Corporation ☐ LLC ☐ Tax exempt

6c. For personal owner:

Total insurance program: Currently in-force: $ _____ Pending applications: $_____

Relationship to Proposed Insured: _____ Date of birth: _____

Earned annual income: $_____ Unearned annual income: $_____ Net worth: $_____

Why will this person own the contract?

☐ Business Insurance ☐ Estate Tax ☐ Support for Insured
☐ Final Expenses ☐ Other _____

(CONTINUED)

L. BUSINESS INFORMATION (COMPLETE THIS SECTION WHEN THE APPLICATION IS FOR BUSINESS INSURANCE.)

Submit copies of material that supplements the information requested, such as loan commitments, written buy-sell arrangements, audited financial statements or letters.

1. Source of Financial Information. (Check all that apply.):
   ☐ Proposed Insured ☐ Accountant/CPA ☐ Banker ☐ Attorney ☐ Producer ☐ Other: _____
2. Who determined the amount of insurance applied for? (Check all that apply.)
   ☐ Proposed Insured ☐ Accountant/CPA ☐ Banker ☐ Attorney ☐ Producer ☐ Other: _____
3. Name of company: _____
4. When was the business established? (mm/yyyy) _____
5. The Proposed Insured is an: ☐ Employee ☐ Owner If owner, percentage of ownership: _____%
6. List amount of business insurance in force & applied for in all companies on each officer/member of the business.

Name	Age	Ownership %	In force Amount	Amount Applied For
_____	_____	_____%	$_____	$_____
_____	_____	_____%	$_____	$_____
_____	_____	_____%	$_____	$_____
_____	_____	_____%	$_____	$_____

7. Purpose: (Check all that apply and answer all supplemental questions.)
   a. ☐ Buy-Sell Arrangement
      1. Is there a written buy-sell agreement? ☐ Yes ☐ No
      2. Are all other parties to agreement already covered by or applying for comparable amounts of insurance? ☐ Yes ☐ No
         If No, explain : _____
   b. ☐ Key Person
      1. Are all other key persons covered by or applying for comparable amounts of insurance? ☐ Yes ☐ No
         If No, explain : _____
      2. Why is the Proposed Insured considered "key"? (Detail special skills/knowledge/ability.)
         _____
   c. ☐ Business Loan Collateral
      1. Is the insurance required by the creditor? ☐ Yes ☐ No
      2. Is the Proposed Insured personally responsible for the loan? ☐ Yes ☐ No
      3. Name of creditor/lending institution: _____
      4. What is the purpose of the loan? _____
      5. What is the amount of the loan? $_____
      6. What is the repayment schedule? _____
      7. Date loan was committed: _____
         If not yet committed, please explain : _____
         _____
8. What is the total fair market value of the business? $_____
9. Business values:
   Assets: $ _____ Gross annual sales and/or revenue: $_____
   Liabilities: $_____ Net profit after taxes: $_____
10. Additional comments: _____

M. ACCOUNT SELECTION FOR PRULIFE® FOUNDERS PLUS UL OR PRULIFE® INDEX ADVANTAGE UL

1A. COMPLETE THIS SECTION FOR PRULIFE FOUNDERS PLUS UL (2017 OR LATER)

The policy you are applying for provides for automatic transfers of premiums and other amounts paid into the policy from the Fixed Account to the Plus 100 Account. Amounts eligible for transfer are described in the policy.

Important conditions and requirements:

- Percentages selected must be whole numbers (for example 33⅓ is invalid).
- The sum of all percentages must equal 100 percent.

Until you provide revised instructions, as funds become eligible for transfer, we will transfer those amounts as you indicate below:

Retain in: Fixed Account: _____%

Transfer to: Plus 100 Account (offers opportunity for index interest based on performance of the *S&P 500® Index): _____ %

Total: 100 %

Optional Election of Designated Transfer Amount. If selected, only the amount designated will be transferred monthly on the Transfer Date, from the Fixed Account to the Plus 100 Account.
Transfers will continue until the sooner of:

- You discontinue designated transfers, or
- The number of months you specify has elapsed since the first designated transfer.

Use of this feature requires that at least a portion of your payment allocations in Section B be directed to the Fixed Account.

Important conditions and requirements:

Until you provide revised instructions, as funds become eligible for transfer, we will transfer amounts monthly as you indicate below:

Dollar amount of designated transfer: $ _____

Number of months for designated transfer: $ _____ or ☐ unlimited

1B. COMPLETE THIS SECTION FOR PRULIFE® FOUNDERS PLUS UL (2016)

The policy you are applying for offers a choice between either the Fixed Account or one of two Plus Accounts, Plus 50 or Plus 100. The Account option you select determines the methodology used to determine the amount of interest, if any, applied to the Policy's Account Value, which is also known as the Contract Fund.

Choose one of the three boxes below:

☐ **Fixed Account** (offers fixed account interest only)

Plus Accounts (offer opportunity for basic interest and index interest based on performance of the *S&P 500® Index)

☐ **Plus 50** (with a 50% participation rate, 0% floor, and current cap)

or

☐ **Plus 100** (with a 100% participation rate, 0% floor, and current cap)

Optional Election of Designated Transfer Amount. If selected, only the amount designated (plus the value of any plus segments that mature on that date) will be transferred from the Fixed Account to the Plus Account selected above on a monthly basis. If the Fixed Account balance is less than the designated amount, the full balance will be transferred. If you discontinue using the designated transfer amount feature, all amounts in the Fixed Account will transfer to a Plus Account, if you have selected one.

Designated Transfer Amount $ _____

** The S&P 500® Index is a product of S&P Dow Jones Indices LLC ("SPDJI"), and has been licensed for use by The Prudential Insurance Company of America for itself and affiliates including Pruco Life Insurance Company and Pruco Life Insurance Company of New Jersey (collectively "Pruco Life"). Standard & Poor's®, S&P®, and S&P 500® are registered trademarks of Standard & Poor's Financial Services LLC ("S&P"); Dow Jones® is a registered trademark of Dow Jones Trademark Holdings LLC ("Dow Jones"); and these trademarks have been licensed for use by SPDJI and sublicensed for certain purposes by Pruco Life. Pruco Life's products are not sponsored, endorsed, sold or promoted by SPDJI, Dow Jones, S&P, or their respective affiliates and none of such parties make any representation regarding the advisability of purchasing such product(s) nor do they have any liability for any errors, omissions, or interruptions of the S&P 500® Index. S&P 500® index values are exclusive of dividends.*

M. ACCOUNT SELECTION FOR PRULIFE® FOUNDERS PLUS UL OR PRULIFE® INDEX ADVANTAGE UL (CONTINUED)

2A. COMPLETE THIS SECTION FOR PRULIFE® INDEX ADVANTAGE UL (2016 OR LATER)

The Index Advantage Universal Life Policy you are applying for provides for automatic transfers of premiums and other amounts paid into the policy from the Fixed Account to Indexed Accounts. Amounts eligible for transfer are described in the policy.

Important conditions and requirements:

- **Percentages selected must be whole numbers (for example 33⅓ is invalid).**
- **The sum of all percentages must equal 100 percent.**

Until you provide revised instructions, as funds become eligible for transfer, we will transfer those amounts as you indicate below:

Retain in: Fixed Account: _____%

Transfer to: *S&P 500® Indexed Account: _____%

Transfer to: *S&P 500® Indexed Account with Multiplier: _____%

Transfer to: *S&P 500® Uncapped Indexed Account: _____%

Total **100** %

Designated Transfers *(Optional)*

Your policy allows you to specify a dollar amount to be transferred monthly on the Transfer Date, from the Fixed Account to Indexed Accounts. Transfers will continue until the sooner of:

- You discontinue designated transfers, or
- The number of months you specify has elapsed since the first designated transfer

Use of this feature requires that at least a portion of your payment allocations in Section B be directed to the Fixed Account.

Important conditions and requirements:

- **Percentages selected must be whole numbers (for example 33⅓ is invalid).**
- **The sum of all percentages must equal 100 percent.**

Until you provide revised instructions, as funds become eligible for transfer, we will transfer amounts monthly as you indicate below:

Dollar amount of designated transfer: $_____

Transfer to:

*S&P 500® Indexed Account: _____%

*S&P 500® Indexed Account with Multiplier: _____%

*S&P 500® Uncapped Indexed Account: _____%

Total **100** %

Number of months for designated transfer: _____ **or** ☐ **unlimited**

If the Fixed Account is only sufficient for us to transfer part of your designated transfer amount, then the entire available amount will be transferred. Months where no or only a partial transfer takes place because the Fixed Account is insufficient will count against the number of months elapsed in your instructions.

Maturing Index Segment Allocation Instructions *(Optional)*

Proceeds from maturing Index segments will be moved into the Fixed Account, then transferred from the Fixed Account to Indexed Accounts, after deductions from the Fixed Account.

Until you provide revised instructions, as index segments mature, proceeds from each maturing index segment will be allocated to a new segment in the same indexed account.

Other options for allocating proceeds from maturing index segments are available, including allocating these proceeds to the Fixed Account and / or other Indexed Accounts. In order to change your maturing index segment allocation instructions, please use the Request for Transfer / Allocation Change form (form # ORD 115267).

M. ACCOUNT SELECTION FOR PRULIFE® FOUNDERS PLUS UL OR PRULIFE® INDEX ADVANTAGE UL (CONTINUED)

2B. COMPLETE THIS SECTION FOR PRULIFE® INDEX ADVANTAGE UL (2015)

Account Selection: Percentages selected must be whole numbers (for example, 33⅓ is invalid), and the sum of all percentages must equal to 100. Until you provide revised instructions, as funds become eligible for transfer, we will transfer those amounts as you indicate below:

Retain in:	Basic Interest Account	_____%
Transfer to:	*S&P 500® Indexed Account	_____%
	Total	**100**%

The client acknowledges and believes this contract meets their insurance needs and financial objectives:

- He/She is applying for an indexed universal life insurance policy. Even though the values of the policy may be affected by an external Index, the policy does not directly participate in any stock, bond or equity investments and the value of any external Index does not reflect the payment of dividends.
- Any values shown, other than guaranteed minimum values, are not guarantees, promises or warranties.
- Pruco Life Insurance Company or Pruco Life Insurance Company of New Jersey has the right to change interest rates, Index Growth Caps, Index Growth Floors and Participation Rates as long as they do not go below the minimums shown in the policy.
- For a PruLife® Index Advantage UL policy (2016), Index interest is computed based on an Indexed Account segment's average daily balance over the course of the segment's one year period. Amounts deducted from the segment before its maturity will still be included in the average daily segment value calculation, but index interest will only be credited if the policy is still in force on the segment's maturity date (e.g. no Index interest if lapse, surrender, or death prior to a segment's maturity date).
- For a PruLife® Index Advantage UL policy (2015), Index interest is only computed on amounts in Index Account(s) on their maturity dates. Amounts deducted from the Indexed Accounts before their maturity dates (because of loans, withdrawals, charges, default, and lapse, surrender, or death) will not receive Index Interest.
- The policy applied for is not a registered security.

** The S&P 500® Index is a product of S&P Dow Jones Indices LLC ("SPDJI"), and has been licensed for use by The Prudential Insurance Company of America for itself and affiliates including Pruco Life Insurance Company and Pruco Life Insurance Company of New Jersey (collectively "Pruco Life"). Standard & Poor's®, S&P®, and S&P 500® are registered trademarks of Standard & Poor's Financial Services LLC ("S&P"); Dow Jones® is a registered trademark of Dow Jones Trademark Holdings LLC ("Dow Jones"); and these trademarks have been licensed for use by SPDJI and sublicensed for certain purposes by Pruco Life. Pruco Life's products are not sponsored, endorsed, sold or promoted by SPDJI, Dow Jones, S&P, or their respective affiliates and none of such parties make any representation regarding the advisability of purchasing such product(s) nor do they have any liability for any errors, omissions, or interruptions of the S&P 500® Index. S&P 500® index values are exclusive of dividends.*

N. VARIABLE CONTRACTS (COMPLETE THIS SECTION WHEN THE APPLICATION IS FOR A VARIABLE CONTRACT.)

1. **Telephone Reallocations/Transfer Privileges** (If more than one owner, telephone reallocations/transfer privileges are NOT allowed.)
   Did the policyowner authorize telephone reallocation and fund transfer? ☐ Yes ☐ No
   He/She understands that by not taking this option any future request for this option must be submitted in writing.

2. **Investment Options and Allocations** (Indicate investment option, code & allocation Percentage for each fund chosen. Total allocation must equal 100%.)

Investment Option	Code	Allocation %
_____	_____	_____%
_____	_____	_____%
_____	_____	_____%
_____	_____	_____%
_____	_____	_____%

3. **Allocated Charges** (Must be in whole percentages, Fixed Rate Option may not be chosen, maximum 2):
   Investment Option: _____ Percentage: _____%
   Investment Option: _____ Percentage: _____%

4. **CT ONLY**: Does the policyowner believe this contract meets his/her insurance needs and financial objectives? ☐ Yes ☐ No
   Does the policyowner understand that the contract's values and death benefit may vary depending on the contract's investment experience? ☐ Yes ☐ No
   MA ONLY: Does the policyowner believe this contract meets his/her insurance needs and financial objectives? ☐ Yes ☐ No
   All other states: The policyowner believes this contract meets his/her insurance needs and financial objectives, understands that the contract's values and death benefit may vary depending on the contract's investment experience. ☐ Yes ☐ No

O. REMARKS

Prudential

AGENT'S REPORT

PART 1

PROPOSED INSURED: _____

A. PURPOSE OF INSURANCE

Primary Purpose of Insurance (must choose one): (Supplemental riders/benefits such as BAR, do not qualify as a Primary Purpose of life insurance.)

Personal:
- ☐ Survivor income
- ☐ Supplemental retirement income
- ☐ Debt/Mortgage protection
- ☐ Estate liquidity
- ☐ Final expenses
- ☐ Asset Repositioning/Wealth Transfer
- ☐ Charitable giving
- ☐ Other _____

Executive Benefits:
- ☐ SERP/Deferred compensation
- ☐ Split dollar
- ☐ Restrictive bonus
- ☐ Executive 162 bonus
- ☐ Other _____

Business:
- ☐ Buy-Sell/Business continuation
- ☐ Loan indemnification
- ☐ Key person
- ☐ Other _____

Secondary Purpose of Insurance (must choose a Primary Purpose of Insurance above): ☐ BAR for Chronic/Terminal Illness

B. PRODUCER INFORMATION

Please identify all producers and firms involved in this sale. For split cases, please use whole percentage amounts. Include an additional page with all details if more than two producers. The producer will be paid directly for non-variable sales if no firm information is provided.

PRODUCER #1 Split commission %: _____

Producer name: _____ GA name: _____

Producer contract number: _____ GA contract number: _____

Producer Social Security number: _____ GA Employer Identification Number: _____

Complete only if producer #1 is acting on behalf of a firm *(Both must be properly licensed and appointed for the sale.)*

Firm name: _____ Firm contract number: _____

Firm Employer Identification Number: _____

PRODUCER #2 Split commission %: _____

Producer name: _____ GA name: _____

Producer contract number: _____ GA contract number: _____

Producer Social Security number: _____ GA Employer Identification Number: _____

Complete only if producer #2 is acting on behalf of a firm *(Both must be properly licensed and appointed for the sale.)*

Firm name: _____ Firm contract number: _____

Firm Employer Identification Number: _____ Case manager e-mail: _____

C. CASE DETAILS

Who is responsible for the requirement ordering?

Age and amount requirements: ☐ Prudential ☐ Producer/GA

Preferred Exam Vendor: ☐ APPS ☐ EMSI ☐ SMM

Attending Physician Statement (APS): ☐ Prudential ☐ Producer/GA

D. KNOWLEDGE OF PROPOSED INSURED

1. Did you see the proposed insured during the sales process? ☐ Yes ☐ No
2. Is the proposed insured a prior client? ☐ Yes ☐ No
3. Knowledge of Proposed Insured: ☐ Self ☐ Relative ☐ Know Slightly ☐ Known well for _____ Years at: ☐ Home ☐ Business ☐ Have never met ☐ Other (provide details on how you know the proposed insured) _____
4. If you have never met, provide how solicitation took place: ☐ Internet or Phone Sale ☐ Direct Mail ☐ Ticket Process ☐ Referral ☐ Financial Planner/CPA/Attorney Recommendation ☐ Walk in ☐ Other _____

E. SUITABILITY DECLARATIONS (VARIABLE PRODUCTS ONLY)

1. This application is submitted in the belief that the purchase of this policy is suitable for the policyowner based on the information furnished. ☐ Yes ☐ No
2. Reasonable inquiry has been made of the policyowner concerning the policyowner's insurance and investment objectives, financial situation and needs. ☐ Yes ☐ No
3. The policyowner is considering the purchase of this variable life insurance product primarily as a vehicle to provide for long term insurance needs and not primarily as an investment. ☐ Yes ☐ No

F. SOURCE OF FUNDS (CASH WILL NOT BE PERMITTED FOR PAYMENT.)

1. Is this policy being funded via a premium financing loan or with funds borrowed, advanced or paid from another person or entity? ☐ Yes ☐ No
   If "yes", additional disclosure form may be required.
2. What is the source of funds used to pay premiums on this policy? (Check all that apply.):

	Initial	**Future**
Current income	☐	☐
CDs or savings	☐	☐
Mutual funds or brokerage account	☐	☐
Existing life insurance policy(ies) or annuity contract(s)	☐	☐
1035 Exchange	☐	☐
Other	☐ _____	☐ _____

If using an existing Prudential or third party policy(ies) or annuity contract(s) to pay either initial or future premiums, complete questions 3 and 4: (If more than one policy or contract provide full details in the **Remarks** section.)

3. What is the policy number(s) for the source of the premiums? _____
   Will any of the above policies cease to exist? ☐ Yes ☐ No
4. What is the form of the proceeds for the above policy(ies)? (Check all that apply.):
   ☐ Accumulated dividends ☐ Loans ☐ Partial surrender or withdrawal

G. UNDERWRITING CATEGORY QUOTED

☐ Preferred Best ☐ Preferred Non-Tobacco ☐ Non-Smoker Plus ☐ Non-Smoker ☐ Preferred Smoker ☐ Smoker

☐ Special Class:_____ ☐ Temporary Extra Premium (per thousand): $_____

☐ Avocation/Occupation Flat Extra Premium (per thousand): $_____ ☐ Aviation Flat Extra Premium (per thousand): $_____

H. PRUDENTIAL/PRUCO POLICIES ISSUED WITHIN 3 MONTHS

1. Has the client been issued a Prudential/Pruco policy within the past 3 months? ☐ Yes ☐ No
   If YES, provide Prudential/Pruco policy number:_____
2. Has the health, mental or physical condition of the proposed insured changed since the answers and statements were given in the above application? ☐ Yes ☐ No

I. REMARKS

J. MILITARY

1. Is the proposed insured an active duty service member of the United States Armed Forces (including National Guard and Reserve)? ☐ Yes ☐ No
2. Is the policyowner, or the person to whom this policy was sold, an active duty service member of the United States Armed Forces (including National Guard and Reserve)? ☐ Yes ☐ No

For a YES answer to J1 or J2, complete the appropriate disclosure form(s) and return to the Home Office.

K. PRODUCER'S STATEMENT

1. If replacement, are all policies to be replaced Term policies? ☐ Yes ☐ No
2. Do you intend to deliver the policy face to face? ☐ Yes ☐ No

I certify that:

- The solicitation or sale did NOT take place on a military base or other Department of Defense (DOD) installation;
- I have no knowledge of any factors which may have a negative effect on the proposed insured's insurability;
- I have given the Important Notice About Your Application for Insurance to the proposed insured;
- I provided the policyowner with the brochure "What every consumer should know about life insurance" and answered any questions they had about the purchase;
- If required by state regulation, I have read the Important Notice Regarding Replacement aloud to the applicant or the applicant did not wish the notice to be read aloud;
- **If this is for the sale of a variable product:** I have provided current copies of the Privacy Notice and the ID Verification Notice to all owner(s) and legal representative(s) and I have offered the client a choice of a paper prospectus or CD and provided the client with their choice;
- **If this is for the sale of an equity-indexed product:** I have provided the owner(s) with the appropriate disclosures;
- **If this is a replacement**: I have discussed the advantages and disadvantages of the replacement with the client and determined that the transaction is appropriate and I have completed the state-required replacement form(s);
- I have no other information, other than as previously reported, that the proposed insured has existing life insurance or annuities or that indicates this coverage may replace or change any current insurance or annuity in any company
- If I become aware of a change in the health or habits of the proposed insured occurring after the date of the application but before policy delivery, I promise to inform the Company of the change and agree to withhold policy delivery until instructed by the company;
- **CA**: The CA Disclosure Statement was provided to the policyowner in accordance with CA Insurance Code section 789.8;
- **PA**: The Disclosure Statement as required by the Commonwealth of Pennsylvania Insurance Department was delivered to the policyowner;
- **VT**: If the policy applied for is a charitable gift, I have provided the Charitable Life Gifts Disclosure form to the proposed insured;
- All of the above statements are true and accurate.

➔ *Signature of producer* **X** _____ Date _____

Prudential

AUTHORIZATION TO RELEASE INFORMATION

Corporate Offices, Newark, New Jersey

Pruco Life Insurance Company
The Prudential Insurance Company of America
Both are Prudential Financial companies.

POLICY NUMBER (IF KNOWN): _____

PROPOSED INSURED NAME (PRINT): _____

This Authorization was intended to comply with the HIPAA Privacy Rule

- I authorize any licensed physician, medical practitioner, hospital, clinic, other health care provider, pharmacy benefit manager, insurance company or producer, financial or legal advisor, government agency, MIB Inc, consumer reporting agency, or other organization or person to give any information about me, or my mental or physical health to the Company and/or its agents authorized by the Company and/or MIB Inc to determine my eligibility for insurance and/or benefit payment, and/or to contest coverage and/or to conduct legally permissible actuarial, audit and research activities. It also includes motor vehicle records.
- The information authorized for release includes (but not limited to paper and/or electronic format):

  My entire medical record, including any information regarding medications used, drug and alcohol treatment, the results of any genetic testing previously performed, and communicable or venereal diseases, such as hepatitis, syphilis, gonorrhea, the human immunodeficiency virus (HIV), and Acquired Immune Deficiency Syndrome (AIDS), and the diagnosis and treatment of mental health conditions, excluding psychotherapy notes.
- **For purposes of this Authorization, I hereby revoke any prior restriction on disclosure of my medical records, and authorize the release of my entire medical record to the Company, excluding psychotherapy notes.**
- **I understand that the aforementioned parties requesting access to my (electronic or paper) medical records are acting as a patient authorized representative and will attempt to access my medical records in the most efficient manner possible, including electronic interchange through a Health Information Exchange or directly through My Providers' electronic health record system.**
- This Authorization may be revoked at any time by writing us at the Customer Service Office address provided in the Important Notice. The revocation will not be valid to the extent we relied on the authorization prior to the notice of revocation. In addition, the revocation does not effect our legal rights under the policy to contest a claim or the policy itself. Revocation or alteration of this Authorization may mean that we will not be able to complete the application process and may deny a claim for insurance.
- Once disclosed to the Company, the information will no longer be protected by the Health Insurance Portability and Accountability Act, but will be protected by other applicable federal and state laws relating to the protection of personal information.
- This Authorization also applies to any member of my family proposed for coverage in the application & is valid for 2 years after the date below for the purposes stated above.
- A copy of this Authorization will be provided to me or my authorized representative by my insurance representative or the Company, either at the time of execution or shortly thereafter. I understand my representative can tell me how and when I will receive a copy. A photocopy of this Authorization is as valid as the original.
- Treatment, payment, enrollment in a health plan, or eligibility for health benefits may not be conditioned on signing this authorization.

SIGNATURES

- I acknowledge that I have received the **Important Notice About Your Application for Insurance**.
- I authorize the Company to retain and disclose information to reinsurers, or for insurance underwriting, policyholder service or claim handling, to others who perform services for us, to financial professionals or their agents involved in the sale or placement of a policy, or as otherwise allowed by law. I also authorize the Company, its reinsurers or authorized third-party administrators to make a brief report to MIB Inc. Any revocation of this authorization will not impact these rights of disclosure.

➔ Signature of proposed insured **X** _____ Date: _____
(Parent/Guardian when proposed insured age is less than 18)

Prudential

Pruco Life Insurance Company
The Prudential Insurance Company of America
Corporate Offices, Newark, New Jersey

Notice and Consent for AIDS virus (HIV) Antibody/Antigen Testing

Policy Number: _____

To determine your insurability, we request that you provide a sample of your bodily fluid(s) for testing and analysis. All tests will be performed by a licensed laboratory.

The consent you give by signing this form authorizes us to collect your bodily fluid(s) and order laboratory tests only in regard to your present application for insurance.

Tests may be performed to determine the presence of antibodies to the Human Immunodeficiency Virus (HIV); the tests do not detect the presence of the AIDS virus. These tests include an enzyme-linked immunosorbent assay (ELISA) serologic test and the Western Blot Assay. Both of these tests have been approved by the Federal Food and Drug Administration, are extremely reliable and false positive reports are rare. If a person's initial ELISA test is positive, that test will be repeated. If the repeat ELISA also results in a positive report, the Western Blot Assay will be performed. A person will be considered to have the HIV antibodies present in his/her bodily fluids(s) only after positive results on two ELISA tests and a Western Blot.

All test results will be treated confidentially. They will be reported by the laboratory to us. When necessary for business reasons in connection with insurance you have or have applied for with us, we may disclose test results to others involved solely in the underwriting process such as its affiliates, reinsurers, employees or contractors. As a member of the Medical Information Bureau (MIB, Inc) and if the test results for HIV antibodies is other than normal, we will report to the MIB, Inc., a generic code which signifies only a non-specific test abnormality. If your HIV test is normal, no report will be made about it to the MIB, Inc. The organizations mentioned in this paragraph may maintain the test results in a file or data bank. The Insurer will make no other disclosure of the test results or even that tests have been done except as may be required or permitted by law or as authorized by you.

If your test results are negative, no routine notification will be sent to you. If your test results are reported by the laboratory to us as being other than normal, you are entitled to that information if you so desire. Because a trained person should deliver that information so that you can understand clearly what the test results mean, you are asked to list your private physician so that we can have him or her tell you the test results and explain its meaning.

Name of physician for reporting a possible positive test result: _____

Address: _____

If you have not given written consent authorizing a physician to receive positive test results, you will be urged, at the time you are informed of the positive test results, to contact a private physician, the County Department of Health, the State Department of Health, local medical societies or alternative test sites for appropriate counseling (list on reverse of Proposed Insured's Copy).

Positive HIV antibody test results do not mean that you have AIDS, but that you are at significantly increased risk of developing AIDS or AIDS-related conditions. Federal authorities say that persons who are HIV antibody positive should be considered infected with the AIDS virus and capable of infecting others.

Positive HIV antibody or antigen results or other significant abnormalities will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged or that other policy changes may be necessary.

Consent for Testing and Disclosure of Test Results
I have read and understand the Notice and Consent for AIDS virus (HIV) Antibody/Antigen Testing set forth above. I verify that the specimen(s) supplied by me are my blood, urine and/or oral fluid. I voluntarily consent to the withdrawal of my bodily fluid(s), the testing of the specimen(s) provided and the disclosure of the test results as described above. I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

Signature of Proposed Insured or Parent/Guardian _____ Date signed _____

Proposed Insured name _____

Address/City/State/ZIP _____

California AIDS Counseling Facilities

AIDS Project – East Bay
1755 Broadway
2nd Floor
Oakland, CA 94612
(510) 457-4022

AIDS Project – Los Angeles
3550 Wilshire Boulevard
Suite 300
Los Angeles, CA 90010
(213) 201-1388

AIDS Service Foundation of Orange County
17982 Sky Park Circle
Suite J
Irvine, CA 92614
(949) 809-5700

ARIS Project
380 N. First Street
San Jose, CA 95112-4050
(408) 293-2747

San Diego AIDS Project
2440 Third Avenue
San Diego, CA 92101
(619) 235-6151

San Francisco AIDS Foundation
995 Market Street
Suite 200
San Francisco, CA 94103
(415) 487-3000

Central Valley AIDS Team
P. O. Box 4640
Fresno, CA 93744
(209) 264-2437

Sacramento AIDS Foundation
P. O. Box 161418
Sacramento, CA 95816
(916) 448-2437

Prudential

Pruco Life Insurance Company
The Prudential Insurance Company of America
Corporate Offices, Newark, New Jersey

Notice and Consent for AIDS virus (HIV) Antibody/Antigen Testing

To determine your insurability, we request that you provide a sample of your bodily fluid(s) for testing and analysis. All tests will be performed by a licensed laboratory.

The consent you give by signing this form authorizes us to collect your bodily fluid(s) and order laboratory tests only in regard to your present application for insurance.

Tests may be performed to determine the presence of antibodies to the Human Immunodeficiency Virus (HIV); the tests do not detect the presence of the AIDS virus. These tests include an enzyme-linked immunosorbent assay (ELISA) serologic test and the Western Blot Assay. Both of these tests have been approved by the Federal Food and Drug Administration, are extremely reliable and false positive reports are rare. If a person's initial ELISA test is positive, that test will be repeated. If the repeat ELISA also results in a positive report, the Western Blot Assay will be performed. A person will be considered to have the HIV antibodies present in his/her bodily fluids(s) only after positive results on two ELISA tests and a Western Blot.

All test results will be treated confidentially. They will be reported by the laboratory to us. When necessary for business reasons in connection with insurance you have or have applied for with us, we may disclose test results to others involved solely in the underwriting process such as its affiliates, reinsurers, employees or contractors. As a member of the Medical Information Bureau (MIB, Inc) and if the test results for HIV antibodies is other than normal, we will report to the MIB, Inc., a generic code which signifies only a non-specific test abnormality. If your HIV test is normal, no report will be made about it to the MIB, Inc. The organizations mentioned in this paragraph may maintain the test results in a file or data bank. The Insurer will make no other disclosure of the test results or even that tests have been done except as may be required or permitted by law or as authorized by you.

If your test results are negative, no routine notification will be sent to you. If your test results are reported by the laboratory to us as being other than normal, you are entitled to that information if you so desire. Because a trained person should deliver that information so that you can understand clearly what the test results mean, you are asked to list your private physician so that we can have him or her tell you the test results and explain its meaning.

Name of physician for reporting a possible positive test result: _____

Address: _____

If you have not given written consent authorizing a physician to receive positive test results, you will be urged, at the time you are informed of the positive test results, to contact a private physician, the County Department of Health, the State Department of Health, local medical societies or alternative test sites for appropriate counseling (list on reverse of Proposed Insured's Copy)

Positive HIV antibody test results do not mean that you have AIDS, but that you are at significantly increased risk of developing AIDS or AIDS-related conditions. Federal authorities say that persons who are HIV antibody positive should be considered infected with the AIDS virus and capable of infecting others.

Positive HIV antibody or antigen results or other significant abnormalities will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged or that other policy changes may be necessary.

Consent for Testing and Disclosure of Test Results
I have read and understand the Notice and Consent for AIDS virus (HIV) Antibody/Antigen Testing set forth above. I verify that the specimen(s) supplied by me are my blood, urine and/or oral fluid. I voluntarily consent to the withdrawal of my bodily fluid(s), the testing of the specimen(s) provided and the disclosure of the test results as described above. I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

Signature of Proposed Insured or Parent/Guardian _____ Date signed _____

Proposed Insured name _____

Address/City/State/ZIP _____

California AIDS Counseling Facilities

AIDS Project – East Bay
1755 Broadway
2nd Floor
Oakland, CA 94612
(510) 457-4022

AIDS Project – Los Angeles
3550 Wilshire Boulevard
Suite 300
Los Angeles, CA 90010
(213) 201-1388

AIDS Service Foundation of Orange County
17982 Sky Park Circle
Suite J
Irvine, CA 92614
(949) 809-5700

ARIS Project
380 N. First Street
San Jose, CA 95112-4050
(408) 293-2747

San Diego AIDS Project
2440 Third Avenue
San Diego, CA 92101
(619) 235-6151

San Francisco AIDS Foundation
995 Market Street
Suite 200
San Francisco, CA 94103
(415) 487-3000

Central Valley AIDS Team
P. O. Box 4640
Fresno, CA 93744
(209) 264-2437

Sacramento AIDS Foundation
P. O. Box 161418
Sacramento, CA 95816
(916) 448-2437