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. e-mail address: _____
9. 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: _____
10. Earned annual income: $_____ Unearned annual income: $_____ Net worth: $_____
11. 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 UL
   - ☐ Other: _____
   - ☐ PruLife® Custom Premier II (VUL II)
   - ☐ VUL Protector℠ (VULP)
   - ☐ PruLife® Universal Life Plus (UL Plus)
   - ☐ PruLife® Universal Life Protector (UL Protector)
   - ☐ PruLife® Index Advantage UL (IAUL)
3. For **IAUL, 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 IAUL, UL Protector & VULP**–Interest rate: _____%
4. For **IAUL, UL Plus, PruLife® Founders Plus UL, VULP** and **VUL II:** 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
   - ☐ 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. The number provided above is the policyowner's correct Social Security/Tax ID number. ☐ Yes ☐ No

2. 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.

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. Owner's email address: _____

5a. 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

5b. For business owner:

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

5c. 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. INDEXED UNIVERSAL LIFE PRODUCTS (APPLIES TO BOTH PRULIFE® INDEX ADVANTAGE UL AND PRULIFE® FOUNDERS PLUS UL)

1. **ONLY FOR PRULIFE® INDEX ADVANTAGE UL**

   Fund 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 %

2. **ONLY FOR PRULIFE® FOUNDERS PLUS UL**

   The policy you are applying for provides a choice between the Fixed Account and Plus Account options below. 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:

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

   ☐ **Plus Account (offers basic interest plus the opportunity for index interest based on the performance of the *S&P 500® Index subject to a participation rate, cap and floor)**

3. **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, 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.
   - For a PruLife® Founders Plus UL policy, Index interest is computed based on the Plus Account segment's average daily balance over the course of the segment's one year period. Amounts deducted from the Plus Account segments before their 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).
   - 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

_____

_____

_____

_____

_____

WHAT TO EXPECT NEXT: (CLIENT COPY)

Prudential

CALLBACK APPOINTMENT TIME: _____

Informational and Underwriting Callback

You will be telephoned so that we may obtain important information necessary to issue a policy and to evaluate your eligibility. Depending on your product purchase and medical history, the call should take about 30 minutes. In order to help reduce any inconvenience during the call, please be prepared to have the following information available:

- Your physician's name, address and phone number
- Date of your most recent visit to your Personal Physician, plus:
  - Reason for that visit
  - Your height and weight
  - Current prescriptions
  - Your driver's license
  - Diagnosis and treatment
  - Any hospitalization/surgeries/medical tests
  - Occupation, hobbies and background

To ensure that you have a full understanding of what you are buying, an underwriter will also verify:

- If out-of-pocket funds will pay policy premiums or if policy dividends, cash value, loans or withdrawals from other policies will pay future premiums on this policy
- If this policy replaces any existing life insurance and/or annuity policies

Prior to the scheduled call, consult with your licensed financial professional if you do not understand any of the above items, or if you are unsure if they apply to you

Medical Exam

Based upon your age and the amount of life insurance you are applying for, an exam and/or some medical tests may be required. These additional tests will provide us with the information that we need to fairly assess your eligibility for life insurance. The medical exam will include a few or all of the following:

- Blood Pressure and Pulse Readings
- A Blood Test and Urinalysis
- Height and Weight Measurements
- An Electrocardiogram (ECG)

Policy Issue

Upon completion of the underwriting process, Prudential will either approve you for coverage (with or without changes and/or exclusions) or decline coverage. If approved, your policy will be issued and delivered to you by your licensed financial professional.

Prudential

AGENT'S REPORT

PART 1

PROPOSED INSURED: _____

A. PURPOSE OF 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 _____

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
4. I provided the policyowner with the brochure "What every consumer should know about life insurance" and answered any questions they had about the purchase. ☐ Yes ☐ No

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

1. 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 the following: (If more than one policy or contract provide full details in the **Remarks** section.)

2. What is the policy number(s) for the source of the premiums? _____
   Will any of the above policies cease to exist? ☐ Yes ☐ No
3. 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;
- 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

LIMITED INSURANCE AGREEMENT

Corporate Offices, Newark, New Jersey

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

THANK YOU FOR CHOOSING PRUDENTIAL FOR YOUR INSURANCE NEEDS

POLICY NUMBER: _____

PART 1 – HEALTH CERTIFICATE

A premium can be collected and insurance can take effect under this Limited Insurance Agreement (the "Agreement") only if the following statement is true: I certify and affirm that the proposed insured has not:

(1) Within the past 90 days been hospitalized or been advised by a member of the medical profession that he or she needs hospitalization for any reason (other than for normal pregnancy or well-baby care).
(2) Within the past 12 months received treatment or advice from a member of the medical profession for heart disease, chest pain, stroke or cancer (except skin).

Person proposed for coverage: _____

Amount of insurance requested: $_____ Amount of prepayment: $_____

All premium checks must be made payable to the Company – do not make check payable to the producer or leave the payee blank. This agreement is valid only if the form of payment submitted is honored. If payment is made by credit card or automatic bank draft, no premium is considered to be honored until the Company actually receives the funds unless otherwise provided by applicable law.

PART 2 – TERMS AND CONDITIONS

The Company agrees to provide limited life insurance coverage under the following terms and conditions:

A. EFFECTIVE DATE OF COVERAGE

Limited insurance starts on the date all of the following requirements have been met:

1. A payment equal to the full first required premium is received at our Administrative Office within the lifetime of the person proposed for coverage under this Agreement. A payment will be considered to be received only if one of the following valid items is received at our Administrative Office: (i) A check in the amount of the full first required premium; (ii) A completed and signed payment form for the first full premium; or (iii) Any other form of payment acceptable to the Company.
2. The form of payment submitted is honored. If payment is made by credit card or automatic bank draft, no premium is considered to be honored until the Company actually receives the funds unless otherwise provided by applicable law.
3. All application information (including, but not limited to, all information necessary to complete parts 1 & 2 of the application and any questionnaires and supplements to the application) is provided and received at our Administrative Office and any medical examinations and tests required by the Company are completed and received at our Administrative Office.
4. This Agreement has been fully completed, signed and dated by the policyowner, proposed insured (if different than the policyowner) and producer.

However, if the proposed insured dies as a direct result of, independent from all other causes, accidental bodily injury within 30 days of the date payment is honored but before any exam and tests are completed, a death benefit will be paid under the terms of this Agreement. We will not pay a benefit under the preceding sentence for death caused or contributed to by: (1) infirmity or disease of mind or body or treatment for it or (2) any infection other than one caused by an accidental cut or wound.

B. END DATE OF COVERAGE

Limited insurance ends when the first of the following occurs:

1. We issue a policy as applied for and the application has been signed.
2. We deliver a policy other than as applied for. The limited insurance will end on delivery of the policy regardless of whether the policy is accepted.
3. We mail you a letter notifying you that we have declined to issue you a policy or that we will not provide limited insurance coverage on a prepaid basis.
4. Sixty days have passed since the Effective Date of Coverage under this Agreement, and the limited insurance provided under this Agreement has not ended for any of the reasons listed above.

If the limited insurance ends and is not replaced by a policy, we will refund the amount you paid.

C. AMOUNT OF COVERAGE

If the proposed insured dies, the total death benefit under this Agreement is the amount requested, up to a maximum aggregate amount of death benefit payable under this Agreement and any other Limited Insurance Agreement issued by the Company on the proposed insured of $1,000,000. The total maximum aggregate amount of death benefit payable under this Agreement and any other Limited Insurance Agreement issued by the Company on any proposed insured cannot exceed $1,000,000.

E. SIGNATURES

I have read this Limited Insurance Agreement including the Special Limitations in section D on page 2. The terms, conditions and limitations of this Agreement have been fully explained to me by the producer, and I understand and agree to them.

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

➔ Signature of policyowner(s): **X** _____ Date: ____/____/____
(If different from proposed insured Parent/Guardian when proposed insured age is less than 18)

I have no personal knowledge of any factors which may have a negative effect on the proposed insured's insurability:

➔ Signature of producer: **X** _____ Date: ____/____/____

D. SPECIAL LIMITATIONS (CONTINUED FROM PAGE 1)

- This Agreement does not provide coverage for any riders or additional supplemental benefits which you have requested from the Company.
- The limited insurance is subject to the terms, limitations and exclusions of the policy you have requested from the Company. We will pay the death benefit under this Agreement to the beneficiary you designated to the Company.
- If benefits are payable under this Agreement, then no benefit relating to that death will be payable under any policy that is subsequently issued.
- No producer, medical examiner, or any other Company representative is authorized to accept risks or determine insurability, or to alter or waive any of the terms or conditions of this Agreement, or to waive any of the Company's rights or requirements.
- The total amount of insurance requested in all applications on the proposed insured (or if survivorship coverage is requested, both proposed insureds combined) cannot exceed $5,000,000.
- **There is no coverage under this Limited Insurance Agreement if the Health Certification is materially misrepresented or fraudulent. If death is due to suicide or intentionally self-inflicted injury, while sane or insane, payment will be limited to the return of the amount paid.**

Definitions: The term "Company" refers to the company named at the beginning of the Application for Life Insurance.

My original signature has been affixed to this Agreement. The original will be retained by the Company and I will receive a copy identical in form and substance.

Prudential

Important Notice About Your Application for Insurance

The Prudential Insurance Company of America
Pruco Life Insurance Company

The words "you" and "your" refer to the primary proposed insured and policyowner or applicant, if other than the primary proposed insured.

This notice tells you about the information practices we will employ in evaluating your application for insurance. Information about Prudential's information policies and practices relating to its customers and former customers is provided in our publication "Your Financial Security, Your Satisfaction and Your Privacy."

COLLECTING INFORMATION FOR UNDERWRITING

We review information about you to decide if you're eligible for coverage. In addition to the application, we may get information about you from the following sources: any required medical examination; the MIB, Inc., formerly known as Medical Information Bureau; and doctors, hospitals, health care providers, pharmacy benefit managers, publicly accessible sources, or any other organizations or persons who have information about you or your mental or physical health. We may obtain information, either directly or through an investigative consumer report, by means of interviews with your neighbors, friends, or others with whom you are acquainted. This inquiry includes information about your character, general reputation, personal characteristics, and mode of living. You may ask to be interviewed as well.

DISCLOSING INFORMATION

We will treat any information we obtain or have obtained about you as confidential. We may disclose information we have collected as follows: to affiliates or third parties that perform services for us, or on our behalf, or that are providing service to you; to your doctor; to insurance regulators; to law enforcement or other governmental authorities under limited circumstances; for actuarial or research studies; or as otherwise permitted or required, with or without your authorization, by applicable law. Prudential or its reinsurers may make a brief report to the MIB, a not for profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the MIB, upon request, will supply such company with the information in its file. Information about MIB may be obtained on its website at www.mib.com. Prudential, or its reinsurers, may also release information in its file to other life insurance companies to which you may apply for life or health insurance or to which a claim for benefits may be submitted. A consumer reporting agency that prepares a consumer report may keep the information it has gathered and disclose it to others.

We will not disclose information we have collected to affiliates for insurance marketing purposes or to companies in our corporate family or to non-Prudential companies to allow them to tell you about other products and services.

YOUR RIGHT TO INFORMATION

If we do not issue the contract you requested, we will tell you and explain the reasons for our decision in writing. You have the right to make a written request within a reasonable period of time to receive additional, detailed information about the nature and scope of any investigative consumer report we request. You also have the right to request a written summary of your rights as a consumer from the consumer reporting agency that prepared the report. Upon your request to the address below, we will provide you with our notice of information practices. If you write to us at the address shown below, we will describe the information we have relating to this insurance transaction, describe how you may get access to it, tell you about certain disclosures that may have been made, and tell you how you may request correction, amendment or deletion of information that you dispute. A copy of any consumer report we obtained about you will be provided to you.

Upon receipt of a request from you, the MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of the information in the MIB's file, you may contact the MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734, toll-free telephone number (866-692-6901).

Customer Service Office
2101 Welsh Road
Dresher, PA 19025-1406

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 authorized agents 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:

  My entire medical record, including any information regarding medications used, drug and alcohol treatment, 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.**
- 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 the MIB, reinsurers, or for insurance underwriting, policyholder service or claim handling, to others who perform services for us, or as otherwise allowed by law. 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

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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.

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

Proposed Insured name _____

Address/City/State/ZIP _____

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1755 Broadway
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(415) 487-3000

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P. O. Box 4640
Fresno, CA 93744
(209) 264-2437

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

Prudential

The Prudential Insurance Company of America
Pruco Life Insurance Company
Pruco Life Insurance Company of New Jersey,
all are Prudential Financial companies
Corporate Offices, Newark, New Jersey 07102 – 973-802-6000

Authorization to Disclose Medical Information to General Agent or Broker

I, _____,
(Print name of proposed Insured)

hereby authorize Prudential Insurance Company of America, Pruco Life Insurance Company and/or Pruco Life Insurance Company of New Jersey, their employees, officers, affiliates, (collectively, "Prudential") to disclose any and all medical information ("Information"), which has been collected by Prudential in connection with my current request for life insurance to the General Agent and Broker submitting that life insurance request. Information includes but is not limited to the results of any physical examination or tests, electrocardiogram, chest X-ray and Attending Physician Statements.

It is my understanding that the purpose of this authorization is to facilitate submission of this Information by the General Agent or Broker or their authorized representatives to other insurers to evaluate an application for insurance on my life. I understand that Prudential assumes no liability with respect to any application for insurance to other companies and makes no representation as to the completeness or accuracy of the Information. I also understand that Prudential will only provide disclosures as permitted by law, and, in its sole discretion, may not provide all Information in its possession. It is my responsibility to disclose any and all requested medical information to any insurance carrier to which I apply for insurance coverage.

I further understand that Prudential's privacy policy does not extend to the copy of the Information provided to the General Agent and/or Broker.

This authorization is effective as of the date it is signed and shall continue for six (6) months unless otherwise provided by law. I also understand that I may revoke this authorization by providing written notification to Prudential at Prudential Brokerage, PO Box 7426, Philadelphia, Pennsylvania 19176, which revocation shall be subject to the rights of Prudential to the extent Prudential has acted in reliance on the authorization prior to notice of revocation.

A copy of this authorization shall be as valid as the original.

I acknowledge that I have received a copy of this authorization from the General Agent or Broker.

_____ _____
Signature of Proposed Insured Date

Prudential

Request for Initial Premium (E-PAY) and/or to Establish Monthly Electronic Funds Transfer (EFT)

For Life New Business only

The Prudential Insurance Company of America
Pruco Life Insurance Company of New Jersey
Pruco Life Insurance Company
All are Prudential Financial companies.

Check all that apply: ☐ Initial premium E-Pay
☐ Establish monthly EFT

CLIENT INFORMATION

Name of insured *(first, middle initial, last name)* _____

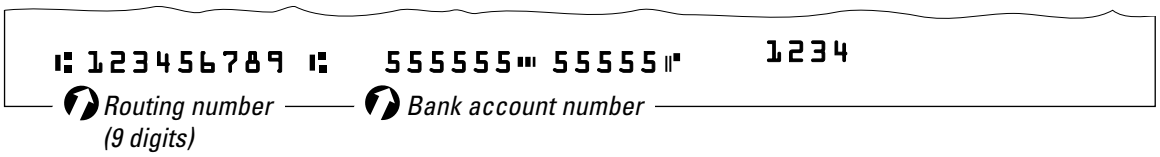
Policy number _____

INSTRUCTIONS

Use this form for Life New Business only to pay initial premium, COD, or additional monies due at policy placement using E-Pay and/or to establish monthly electronic funds transfers (EFT).

Please follow these steps:

- Complete sections 1 and 3 to request that your initial premium at point of sale or any premium or a balance due at placement be paid through E-Pay. Complete sections 2 and 3 to request monthly premium payments by EFT. Complete all sections to request both E-Pay and EFT.
- **If you are requesting initial premium or monthly EFT on more than one new policy, you must submit a separate form for each policy.**
- Print in black ink.
- Initial any corrections or changes that you make.
- Retain a copy of this form for your records.
- Refer to the check diagram below to help determine your bank routing number and bank account number.



On these pages, *I*, *me*, *my*, *you*, and *your* refer to the bank account owner. *Prudential*, *we*, and *us* refer to the Prudential company that issued the policy.

1 INITIAL PREMIUM (E-PAY) INFORMATION

Account owner type: ☐ Individual ☐ Corporate ☐ Trust ☐ Other _____

Name of account owner *(first, middle initial, last name)* _____

_____

Address _____

City/State/ZIP code _____

Bank Information

Account type: ☐ Savings ☐ Checking Withdrawal amount $ _____

Name of financial institution _____ Telephone number _____

Bank routing number *(9 digits)* _____ Bank account number _____

Copies provided to **Home Office**, **Representative**, and **Applicant**

2 MONTHLY ELECTRONIC FUNDS TRANSFER (EFT) INFORMATION

Monthly withdrawal **date**: _____ *(between the 1st and 28th of the month) **

**The monthly withdrawal date must be on or before the premium due date. If any premium withdrawal date falls on a weekend or bank holiday, the withdrawal will occur on the next business day.*

Monthly withdrawal **amount** $ _____ *(cannot exceed monthly premium unless the policy has flexible payment arrangements)*

☐ Use same bank account information in section 1. **If so, skip to Section 3**. Otherwise complete bank information below.

Account owner type: ☐ Individual ☐ Corporate ☐ Trust ☐ Other _____

Name of account owner *(first, middle initial, last name)*_____

_____

Address_____

City/State/ZIP code_____

Bank Information

Account type: ☐ Savings ☐ Checking

Name of financial institution_____ Telephone number _____

Bank routing number *(9 digits)* _____ Bank account number _____

3 AGREEMENT AND SIGNATURE *(Complete this section for all transactions.)*

As a convenience to me, I authorize Prudential to make the fund transfer(s) from my account listed above. By signing below, I understand and agree that:

For Initial Premium E-Pay

- If a withdrawal request is not honored by the financial institution, Prudential will not consider the payment to be made.
- For initial premium E-Pay, Prudential will process this withdrawal request immediately and it cannot be revoked.

For Monthly EFT

- I may cancel the authorization at any time by giving Prudential prior written notification up to three business days preceding the scheduled date of the transfer.
- I have the right to receive notice of all varying transfers. Varying transfers might occur on a date and in a different amount than the one selected, but notification will occur.
- Prudential, in its sole discretion, reserves the right to remove any policy from the electronic funds transfer payment program at any time. The payment frequency on a non-EFT basis may be changed to quarterly or another less frequent mode.
- Prudential cannot establish an electronic funds transfer program if the dividend option is to reduce premiums. In that event, Prudential will withdraw the full amount of the premiums from my account. Unless otherwise elected, any future dividends will be used to provide paid-up additional insurance, if available, or will otherwise accumulate at interest.
- If a withdrawal request is not honored by the financial institution, Prudential will not consider the payment to be made. Prudential may, in its sole discretion, resubmit the withdrawal request for collection.
- I may modify this Agreement by authorizing Prudential to make preauthorized electronic funds transfer or other forms of check withdrawals from any other bank account or financial institution that I so designate verbally, in writing, or through an automated voice response system. Any such verbal request will be confirmed by Prudential in writing.
- If I am changing the bank account that funds are withdrawn from and past premiums are due at the time Prudential receives the completed form, Prudential will draft my bank account for any past premiums due no sooner than two days and no later than eight days after receiving this form. This does not apply to variable universal or universal life policies.

For Initial Premium E-Pay or Monthly EFT

- I have 60 days from the date of the withdrawal to notify Prudential of any errors related to a transfer under this agreement.
- Except as required by the Electronic Funds Transfer Act and Regulation E, Prudential will not be liable for any exemplary, special, consequential, punitive, indirect or incidental damages, regardless of whether any claim is based on a contract or whether any such damages were foreseeable.

X_____ _____

Account owner's signature *Date (month/day/year)*

Copies provided to **Home Office**, **Representative**, and **Applicant**

Prudential

Important Notice Regarding Replacement

Prudential Insurance Company of America
Corporate Offices
Newark, New Jersey 07102
973-802-6000

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

REPLACING YOUR LIFE INSURANCE POLICY OR ANNUITY?

Are you thinking about buying a new life insurance policy or annuity and discontinuing or changing an existing one? If you are, your decision could be a good one -- or a mistake. You will not know for sure unless you make a careful comparison of your existing benefits and the proposed benefits.

Make sure you understand the facts. You should ask the company or agent that sold you your existing policy to give you information about it.

Hear both sides before you decide. This way you can be sure you are making a decision that is in your best interest.

We are required by law to notify your existing company that you may be replacing their policy.

Applicant's Signature	Agent's Signature	Date

Prudential

Important Notice Regarding Replacement

Prudential Insurance Company of America
Corporate Offices
Newark, New Jersey 07102
973-802-6000

The Prudential Insurance Company of America
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