Prudential

APPLICATION FOR LIFE INSURANCE

PART 1

☐ Pruco Life Insurance Company
☐ The Prudential Insurance Company of America
Both are Prudential Financial companies.
Corporate Offices, Newark, New Jersey

POLICY NUMBER (IF KNOWN):_____

A. PROPOSED INSURED (POLICY OWNER UNLESS SECTION D IS COMPLETED)

1. Name: _____
2. Previous name (if changed in the last 5 yrs.): _____
3. Social Security number: _____ 4. State of birth (Country if not U.S.): _____
5. Gender: ☐ Female ☐ Male 6. Date of birth: 7. Date policy to Save Age? ☐ Yes ☐ No
8. Are you a permanent, legal US resident? ☐ Yes ☐ No
***If No, provide country of legal residence, type and number of visa, expiration date and length of US residence*:**
_____
9. Driver's license issuing state: _____ Number: _____ Expiration date: _____
***If None, why not?*:** _____
10. Residence address (No PO boxes): Street _____ Apt _____
City _____ State _____ ZIP _____
11. e-mail address: _____
12. Home telephone number: _____ Business telephone number (ext.): _____
13. Current employer name: _____
Business address: Street _____ Suite _____
City _____ State _____ ZIP _____
14. Occupation: _____
Duties: _____
15. Earned annual income $_____ Unearned annual income $_____ Net worth $_____

B. PLAN OF INSURANCE

1. Amount of insurance applied for: $_____ **Complete *Financial Supplement* with total 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.**
2. Product applied for:
   - ☐ Term Essential®: ☐ 10 ☐ 15 ☐ 20 ☐ 30
   - ☐ Term Elite®: ☐ 10 ☐ 15 ☐ 20 ☐ 30
   - ☐ ROP Term: ☐ 15 ☐ 20 ☐ 30
   - ☐ PruLife® Custom Premier II (PCP II) **Complete the *Variable Supplement.***
   - ☐ PruLife® Founders Plus (PFP) **Complete the *PFP Supplement.***
   - ☐ PruLife® Index Advantage (IAUL) **Complete the *IAUL Supplement.***
   - ☐ PruLife® Essential Universal Life (EUL)
   - ☐ PruLife® Universal Protector (UL Protector)
   - ☐ VUL Protector℠ (VULP) **Complete the *Variable Supplement.***
   - ☐ Other: _____
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 **Complete *BenefitAccess Rider Supplement.***
     If applicable, **Select Max Monthly Benefit Percentage ☐ 2% or ☐ 4%**
   - ☐ Overloan Protection Rider
   - ☐ Child Rider **Complete *Child Rider Supplement.***
   - ☐ Automatic Premium Loan
   - ☐ Enhanced Cash Value Rider
   - ☐ Other Riders/Benefits (indicate amount where applicable): _____

C. 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: ☐ Annual ☐ Semiannual ☐ Quarterly ☐ Monthly – Electronic Funds Transfer
3. **For non-term plans**, billed premium: $_____

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

For multiple owners, details are to be listed in Special Requests, section H.

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: **Complete the *Business Supplement.***

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: $______

E. BENEFICIARY DETAILS

If insurance is for business purposes, also complete the Business Insurance Supplement. 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, please 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
					☐	☐
					☐	☐
					☐	☐
					☐	☐

F. 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?
______	$______	☐ Group ☐ Individual	☐ Annuity ☐ Life	☐ Yes ☐ No	☐ Yes ☐ No
______	$______	☐ Group ☐ Individual	☐ Annuity ☐ Life	☐ Yes ☐ No	☐ Yes ☐ No
______	$______	☐ Group ☐ Individual	☐ Annuity ☐ Life	☐ Yes ☐ No	☐ Yes ☐ No
______	$______	☐ Group ☐ Individual	☐ Annuity ☐ Life	☐ Yes ☐ No	☐ Yes ☐ No
______	$______	☐ Group ☐ Individual	☐ Annuity ☐ Life	☐ Yes ☐ No	☐ Yes ☐ No

*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.

4. Are you applying for or reinstating life insurance with any company? ☐ Yes ☐ No
   If Yes, give company name, amount applied for and total amount to be placed, including this application :
   ______
   ______
5. Have you had life or health insurance declined, postponed, rated or issued with an increased premium? ☐ Yes ☐ No
   If Yes, give company name, type of insurance, date, action taken and reason for action :
   ______
   ______

(CONTINUED)

F. INSURANCE HISTORY (CONTINUED)

6. 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? ☐ Yes ☐ No

If Yes, provide details : _____

_____

_____

G. GENERAL INFORMATION

1. In the past five years, have you flown as a pilot, student pilot or crew member or do you intend to become a pilot? ☐Yes ☐No
2. In the past five years, have you participated in any activities such as motorized vehicle racing, SCUBA diving, mountain climbing, skydiving, extreme sports such as BASE jumping, bungee jumping or cave exploration, or do you intend to? ☐Yes ☐No

   If Yes, to Question 1 or 2 above, complete the appropriate Supplement.
3. Have you ever used tobacco or any other nicotine products such as cigarettes, cigars, pipe, chewing tobacco, snuff, nicotine gum or nicotine patch? ***If Yes, provide details*** : ☐Yes ☐No

Product Type(s)	Date Last Used	Frequency of Use

4. In the past five years, have you:
   a. had your driver's license denied, suspended or revoked? ☐Yes ☐No
   b. been convicted of or pled guilty to driving under the influence of alcohol and/or drugs? ☐Yes ☐No
   c. been convicted of or pled guilty to any moving violations? ☐Yes ☐No
5. Within the past 10 years, have you been arrested, convicted, or imprisoned for any crime and/or are you currently awaiting trial for any crime? ☐Yes ☐No
6. Will you live or travel outside the United States within the next 12 months? ☐Yes ☐No

   Details required include location (city/country), frequency, duration and purpose of each trip.
7. Give complete details of any "Yes" answers for questions 4 – 6, including question number and appropriate details:

Question #	Details

H. SPECIAL REQUESTS

PART 2

A. PERSONAL PHYSICIAN INFORMATION

Name _____

Address: Street _____ Suite _____

City _____ State _____ ZIP _____

Telephone number: (____) _____ Date last seen: _____

Reason last seen: _____

If more than one personal physician, provide details in section D number 6.

B. PHYSICAL MEASUREMENTS

1. Height: _____ feet _____ inches Weight: _____ pounds
2. Within the last 12 months, have you had a change of weight (gain or loss) of more than 10 pounds? ☐ Yes ☐ No
   If Yes, provide details **:** _____

C. FAMILY HISTORY

1. Have any immediate family members (mother, father, brother, sister) been diagnosed with or died from coronary artery disease, cerebrovascular disease, diabetes or cancer before age 70? ☐ Yes ☐ No
   If Yes, provide details including which member and medical condition, age at diagnosis, and age at death (if applicable) **:**

2. **Father:** Current age _____ or Age at death: _____ **Mother:** Current age _____ or Age at death: _____

D. MEDICAL INFORMATION

1. Has a member of the medical profession ever treated you for or diagnosed you with:
   a. high blood pressure, chest pain, a heart attack, coronary artery disease, a heart valve disorder, a heart murmur, an irregular heart beat, cerebrovascular disease, a stroke, circulatory disease, an aneurysm or any disease of the heart or blood vessels? ☐ Yes ☐ No
   b. anemia or other abnormality of the blood (other than HIV)? ☐ Yes ☐ No
   c. a polyp, cyst, tumor, cancer, leukemia, melanoma, lymphoma or Hodgkin's disease? ☐ Yes ☐ No
   d. diabetes, high blood sugar, glucose intolerance or other endocrine disorder? ☐ Yes ☐ No
   e. anxiety, depression, or any other mental or psychiatric illness? ☐ Yes ☐ No
   f. an infection caused by the Human Immunodeficiency Virus (HIV) (**Not applicable in CA. In WI:** AIDS virus, HIV antibody testing is limited to FDA-licensed enzyme immunoassay and confirmatory HIV antibody tests. Any test performed at an anonymous counseling and testing site or home testing is confidential and need not be revealed on this application.), Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), or any other sexually transmitted disease? ☐ Yes ☐ No
   g. asthma, emphysema, cystic fibrosis, sleep apnea, sarcoidosis, tuberculosis or any other disorder of the lungs or respiratory system? ☐ Yes ☐ No
   h. a seizure, epilepsy, multiple sclerosis, Parkinson's disease, muscular dystrophy, cerebral palsy, paralysis, Alzheimer's disease or any other disorder of the brain or nervous system? ☐ Yes ☐ No
   i. an ulcer, hepatitis, cirrhosis, pancreatitis, ulcerative colitis, Crohn's disease or any other disorder of the esophagus, liver, stomach or intestines? ☐ Yes ☐ No
   j. nephritis, polycystic kidney disease or any other disorder of the bladder, kidney, urinary tract or prostate? ☐ Yes ☐ No
   k. arthritis, gout, back trouble, or any disease or disorder of the joints, muscles or bones? ☐ Yes ☐ No
   l. lupus, rheumatoid arthritis, chronic fatigue syndrome, fibromyalgia, or any other disease or disorder of the autoimmune system? ☐ Yes ☐ No
2. Have you ever used:
   a. cocaine, crack, marijuana, heroin, Ecstasy, PCP, LSD, methamphetamine, any other hallucinogenic drug or controlled substance? ☐ Yes ☐ No
   b. amphetamines, barbiturates, sedatives, opiates or methadone, or controlled substance except as prescribed by a physician? ☐ Yes ☐ No
3. Have you had or been advised to have treatment or counseling for alcohol or drug use or been asked to reduce or eliminate their usage? ☐ Yes ☐ No
4. Other than what has already been disclosed, within the past 5 years, have you:
   a. requested or received disability or compensation benefits? ☐ Yes ☐ No
   b. been a patient in a hospital or other medical facility, other than for normal childbirth? ☐ Yes ☐ No
   c. had any other disease, disorder or condition? ☐ Yes ☐ No
   d. been advised to have surgery, medical tests or diagnostic procedures (other than for HIV)? ☐ Yes ☐ No
5. Are you currently receiving medical treatment or taking any other medication or herbal supplement that has not already been disclosed? ☐ Yes ☐ No

(CONTINUED)

D. MEDICAL INFORMATION (CONTINUED)

6. Give complete details of any "Yes" answers for questions 1-5, including: **Question number, diagnosis, date of onset and recovery, medication/treatment prescribed and the name, address and telephone number of all attending physicians and hospitals.**

Question #	Diagnosis	Date of Onset	Date of Recovery	Medication/ Treatment Prescribed	Physician/Hospital Name, Address & Phone Number

AGREEMENTS

By signing this form, I have carefully reviewed the application including all supplements attached to the policy, and I agree to the following:

- To the best of my knowledge and belief, the statements in this application are complete, true and correctly recorded.
- Except for failure to pay premium, the validity of this policy will not be contested after it has been in force during the insured's lifetime for two years from the date it takes effect.
- If I have requested the Acceleration of Death Benefits (Living Needs Benefit), I have read the disclosures in the Living Needs Benefit brochure.
- My original signature has been affixed to this application, the original will be retained by the Company named at the beginning of this application ("Company"). The copies attached to the policy issued to me are identical in form and substance.
- Any policy issued on this application shall not take effect until after all of the following conditions are met:
  - A payment equal to the full first required premium is received by the Company within the lifetime of the proposed insured. A payment will only be considered to be received if one of the following valid items is received by the Company: (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.
  - The form of payment submitted is honored. If payment is made by credit/debit card, wire transfer or automatic bank draft, no premium is considered to be honored until the Company actually receives the funds unless otherwise provided by applicable law.
  - A signed copy of this Application is received by the Company.
  - The Owner has personally received the policy during the lifetime of and while the health of the Proposed Insured is as stated in this application.
- Only an officer of the Company with the rank or title of Vice President may make or alter any contract or agree not to enforce any of the rights of the Company, and then only in writing. **No producer or medical examiner is authorized to accept risks, pass on insurability, make or alter contracts, or waive any of the other rights or requirements of the Company.** Notice to or knowledge imputed to any producer or medical examiner will not be notice of or knowledge to the Company unless it is set out in writing in this application.

FRAUD WARNING

(Not applicable in **AZ**.) Any person who knowingly:

- **HI, LA, NM, TN, VA and WA**: and intentionally gives false or deceptive information when completing an application for insurance or filing a claim, for the purpose of defrauding an insurance company may be subject to fines, denial of insurance benefits, or confinement in prison.
- **AL:** presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.
- **CO:** and intentionally gives false or deceptive information when completing an application for insurance or filing a claim, for the purpose of defrauding an insurance company may have committed fraud, or may have violated state law. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.
- **AR, DC and RI:** presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
- **OH:** and with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.
- **PA:** and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.
- **All other states:** and intentionally gives false or deceptive information when completing an application for insurance or filing a claim, for the purpose of defrauding an insurance company may have committed fraud, or may have violated state law.

SIGNATURES

Owner's Tax Certification (check boxes **ONLY** if applicable**):**

Under penalties of perjury, I certify that the taxpayer identification number (TIN) I have listed on this form is my correct TIN. I further certify that I am a U.S. person (including resident alien), I am not subject to backup withholding under Section 3406(a)(1)(C) of the Internal Revenue Code, and I am not subject to FATCA reporting.

☐ I have been notified by the Internal Revenue Service that I am subject to backup withholding due to the underreporting of interest or dividends

☐ I am subject to FATCA reporting

☐ I am not a U.S. person (including resident alien). You must submit the applicable Form W-8 (BEN, BEN-E, ECI, EXP or IMY). In most cases, Form W-8BEN will be the appropriate form.

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

Signed at (**STATE**) _____ on (**DATE**) _____

➔ Signature of proposed insured **X** _____

If policyowner is different from the proposed insured:

➔ *For a personal policyowner(s)*: Signature(s) of policyowner(s) **X** _____

For an entity policyowner(s) (i.e., trust, business):

Name of entity _____

➔ Signature of officer/trustee(s) **X** _____

Title of officer/trustee(s) _____

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

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

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 Privacy Notice.

UNDERWRITING INFORMATION AND PRACTICES

We review information about you to decide if you're eligible for coverage. Your application is the primary source of this information. We may also obtain information about you from the following other sources: any required medical examination; the MIB, Inc.; and doctors, hospitals, health care providers, pharmacy benefit managers, consumer reporting agencies, publicly accessible sources, or any other organizations or persons who have information about you or your mental or physical health. In addition, we may request that an investigative consumer report be prepared in which information about your character, general reputation, personal characteristics, and mode of living is obtained through interviews with your neighbors, friends, associates, acquaintances, or others who may have knowledge concerning such items of information. You may ask to be interviewed in connection with the preparation of the investigative consumer report.

Your eligibility for coverage will depend on the information we collect, the application process we use to collect that information, and our underwriting risk assessment. Eligible proposed insureds who submit information through our telephone interview process may qualify for an accelerated underwriting program. This program is available for select products and could result in coverage being issued without a medical exam, which would otherwise be required. We strive for consistent results in our underwriting decisions regardless of the application process used. However, differences can occur, which could affect your premium. For example, if the insurance exam provides information not otherwise available, your policy costs could be higher than they would have been if underwritten through our accelerated underwriting program. It's important to review any questions you have about our underwriting process with your financial professional.

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.

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 and the toll-free telephone number is 866-692-6901.

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 may share your personal information with affiliates so that Prudential companies can market their products and services to you, unless you opt out of such sharing. Unless you agree otherwise, we do not disclose your information to other companies for them to market their products and services to you.

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. A copy of any consumer report we obtained about you will be provided to you. Upon your request to the address below, we will provide you with our notice of information practices, which is a more detailed description of our information practices and your rights. You have the right to make a written request to us at the address below for access to personal information we have about you or to request that we correct, amend, or delete any information we have on record about you.

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 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

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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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(510) 457-4022

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San Diego, CA 92101
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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

PRINT 2 COPIES FOR SUL CASES

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)* _____

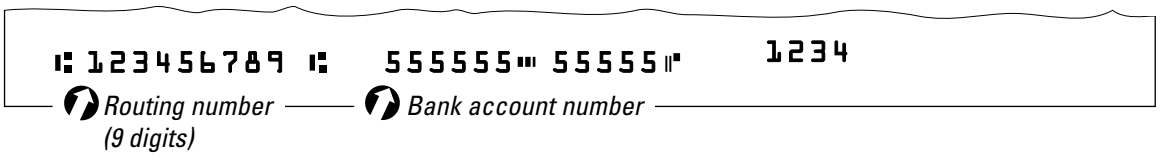
Policy number _____

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

Trustee Statement and Agreement

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

Please print using blue or black ink.

Instructions

Use this form where a trust is being designated as owner of a life insurance policy. For a foreign-sitused trust, also submit those portions of the trust document that authorize investments within the United States.

On these pages, *we*, *us*, and *the Company* refer to the Prudential company that issued the policy.

Policy Information

Note: If a policy number has not yet been assigned, we will provide the number after this Trustee Statement has been received by us.

Policy number(s) _____

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

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

Trust Owner Information

Name of trust _____

Date of trust _____ **Trust is** *(check one)* ☐ Irrevocable ☐ Revocable

State where sitused _____ Country where sitused *(if other than the United States)* _____

Name(s) of Grantor(s) (Trust may refer to as Settlor or Trustor) *(first, middle initial, last name)* **Relationship to Insured**

_____ _____

_____ _____

_____ _____

Type of trust *(check one)*

☐ Family trust ☐ Insurance trust ☐ Trusteed Buy/Sell ☐ Employer Sponsored Trust ☐ Charity trust

☐ Other *(explain)* _____

Are there any agreements, other than the Trust Agreement, related to the rights, benefits or duties under the Trust Agreement?
☐ Yes ☐ No

Is this Trust being used to initiate a life insurance policy for the benefit of investors who do not have an insurable interest in the insured? ☐ Yes ☐ No

Examples of such activities include:

1. *Ownership or beneficial interest in the Trust by a sub trust that is established to benefit investors;*
2. *A plan or practice at policy inception to change the beneficial owners or beneficiaries of the Trust to investors after the policy is purchased; or*
3. *Any other activity intended to hide the fact that the Trust is being used to benefit investors who do not have an insurable interest in the insured.*

Trustee Information

Name(s) of all current trustee(s) *(first, middle initial, last name)*

_____

_____

_____

If the insurance producer is a trustee, please provide the reason and relationship of that individual to the insured.

☐ Immediate family member ☐ Other _____

Reason _____

For Trusts with Multiple Trustees *(provide the following information)*

A. Signature Information

Please indicate below who is authorized to sign under the terms of the trust agreement or any applicable state law. If a box is not checked, we will require the signature of all trustees on this statement, as well as for the exercise of any rights under the policy.

☐ All trustees must sign ☐ Any trustee may sign alone ☐ The majority of trustees must sign

☐ _____ alone, is the only trustee authorized to act

☐ Other *(explain)*_____

B. Contact Information. Please provide the name, address, and telephone number of trustee who will receive communications from us.

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

Street_____ Apt/Suite_____

City_____ State_____ ZIP code_____

Telephone number_____

Trust Beneficiaries

List relationship to the insured of all trust beneficiaries (check all that apply). **If 'Other' is checked** – please provide the relationship(s) to the Insured as well as the percentage of interest that such beneficiary has in the trust.

☐ Spouse ☐ Child ☐ Parent ☐ Grandchild ☐ Sister ☐ Brother ☐ Business associate

☐ Employer ☐ Charity

☐ Other _____ _____%
relationship

_____ _____%
relationship

Signatures

Conditions

The undersigned Trustee(s) certify(ies) and agree to the following:

- The trust is in effect and has not been revoked, modified, or amended in any manner that would cause the representations in this Trustee Statement to be incorrect.
- The Trustee(s) may purchase life insurance in the state in which it is applied for and delivered in, apply for the policy, and invest trust funds in the policy(ies).
- The Trustee(s) may be named as policyowner and have the power to exercise all rights of ownership of a life insurance policy, including, but not limited to, the right to surrender the policy(ies), take a loan or withdrawal, or make changes in the allocation of any invested premium amounts.
- The Trustee(s) agree to notify the Company in writing of any amendment to the Trust, any change in the composition of the trustees or any other event that may alter the statements contained herein and that the Company may rely on the validity of this certification absent receipt of such notice.
- The Company is relying on the representations in this Trustee Statement and not upon a review of the trust document, even if the trust document has been or is later provided and can rely upon the representations in this Trustee Statement, unless or until the Company receives notice in writing of any change, amendment, or revocation of the trust.
- The undersigned Trustee(s), indemnify(ies) the Company, its agents, employees, and representatives and agrees to hold them harmless against all obligations, demands, losses, or liabilities, including attorney's fees, that may be incurred or paid because of reliance on this Trustee Statement or as a result of any transactions made by the Trustee(s).

X_____ _____/_____/_____
Trustee's signature and date signed *month day year*

X_____ _____/_____/_____
Trustee's signature and date signed *month day year*

X_____ _____/_____/_____
Trustee's signature and date signed *month day year*

Prudential

NON U.S. RESIDENT DISCLOSURE FORM

The Prudential Insurance Company of America
Pruco Life Insurance Company of New Jersey
Pruco Life Insurance Company
All are Prudential companies (herein after referred to as the "Company")

INSTRUCTIONS

This form must be completed at point of sale and submitted if a proposed insured's or policyowner's residence is outside the USA (non U.S. resident).

A. PERSONAL INFORMATION

1ST PROPOSED INSURED

Name of proposed insured: _____

Country(ies) of residence of proposed insured. *If more than one country listed, provide length of time in each:* _____

_____

2ND PROPOSED INSURED

Name of proposed insured: _____

Country(ies) of residence of proposed insured. *If more than one country listed, provide length of time in each:* _____

_____

Name of policyowner (if different than proposed insured): _____

Country(ies) of residence of policyowner (if different than proposed insured) *If more than one country listed, provide length of time in each:*

B. LOCATION INFORMATION

1. Where (specific geographic location, state or country) were the forms for life insurance completed and signed?
   ***If the application for life insurance was signed outside of the United States, provide complete details*:**

2. Did all solicitation and communication, including the distribution and discussion of all sales or marketing material, take place within the United States and in the specific state where the application was signed? ☐ Yes ☐ No
   ***If No, provide complete details below* :**

3. Where (specific geographic location, state or country) will the insurance policy be delivered and received by the policyowner?

C. ACKNOWLEDGEMENTS

I acknowledge that I have carefully reviewed this form in its entirety and understand and agree to the following:

- To the best of my knowledge and belief the statements made above are complete, true and correctly recorded.
- The solicitation and communication related to the purchase of life insurance products, as well as the completion and signing of the life insurance application must be completed in the United States.
- The delivery and placement of the insurance policy, including delivery by mail, must take place within the United States unless otherwise approved in writing by the Company.
- If any part of the life insurance transaction takes place outside the United States, it may result in the policy being rescinded or deemed invalid.
- If I become aware of any changes to the responses to the questions above, I will inform the Company.

➔ Signature of proposed insured(s) **X** _____ Date _____

➔ Signature of policyowner *(if different than proposed insured)* **X** _____ Date _____

➔ Signature of producer **X** _____ 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
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

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Applicant's Signature	Agent's Signature	Date

Copies provided to Insurance Company, Agent, and Applicant

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Applicant's Signature	Agent's Signature	Date

Copies provided to Insurance Company, Agent, and Applicant

Prudential Financial

Authorization to Release Information

☐ **The Prudential Insurance Company of America**
☐ **Pruco Life Insurance Company,** *a subsidiary of The Prudential Insurance Company of America*
Corporate Offices, Newark, New Jersey

Name _____

Policy number _____

I authorize _____ 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. The information authorized for release includes my entire medical record, excluding psychotherapy notes, but 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). It also includes motor vehicle records.

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 records to the Company, excluding psychotherapy notes.

This Authorization may be revoked at any time by writing us at any of the Service Offices in the Important Notice. The revocation will not be valid to the extent we relied on the Authorization to contest coverage. 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.

The Company may retain and disclose information to the Medical Information Bureau, 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.

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 and is valid for two years after the date below.

A copy of this Authorization will be provided to me 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.

I have read and agreed to all the applicable terms of this form. I also understand this form in its entirety will be provided to the individual listed in the Authorization above in order to request medical information to determine eligibility for coverage.

Signature of primary proposed insured **X** _____ ____/____/____
(If age 15 or over, otherwise applicant) month day year

Prudential Financial

Authorization to Release Information

☐ **The Prudential Insurance Company of America**
☐ **Pruco Life Insurance Company,** *a subsidiary of The Prudential Insurance Company of America*
Corporate Offices, Newark, New Jersey

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(If age 15 or over, otherwise applicant) month day year