Prudential

AGENT'S REPORT

PART 1

PROPOSED INSURED: _____

A. PURPOSE OF INSURANCE

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

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

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

1. Is the proposed insured a prior client? ☐ Yes ☐ No
2. Knowledge of the proposed insured: ☐ Self ☐ Known well for _____ years at: ☐ Home ☐ Business ☐ Other _____
   ☐ Know slightly ☐ Met very recently ☐ Other _____

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. 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

D. 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)	☐	☐
Other	☐ _____	☐ _____

(CONTINUED)

D. SOURCE OF FUNDS (CONTINUED)

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

E. UNDERWRITING CATEGORY QUOTED

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

☐ Special Class:_____ ☐ Aviation/Occupation (Flat) Extra Premium: $_____

☐ Temporary Extra Premium: $_____

F. ADDITIONAL COVERAGE

Complete only if the proposed insured is already covered by a Prudential/Pruco policy with an application date within three months of the date of this request for coverage.

What is the policy number that you would like to use the requirements/declaration from?_____

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

G. REMARKS

H. 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 H1 or H2, complete the appropriate disclosure form(s) and return to the Home Office.

I. PRODUCER'S STATEMENT

1. **Did you see the proposed insured at point-of-sale?** ☐ Yes ☐ No
   If NO - Refer to the Non Face to Face guidelines at PruXpress.com. The guidelines provide the acceptable criteria for a non face to face transaction.
2. If replacement, are all policies to be replaced Term policies? ☐ 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 the client with a current copy of the Privacy Notice;
- **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

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 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
   - ☐ ROP Term: ☐ 15 ☐ 20 ☐ 30
   - ☐ PruLife® Custom Premier II (VUL II) **Complete the *Variable Supplement.***
   - ☐ PruLife® Universal Life Plus (UL Plus)
   - ☐ PruLife® Universal Life Protector (UL Protector)
   - ☐ VUL Protector℠ (VULP) **Complete the *Variable Supplement.***
   - ☐ Other: _____
3. For **UL Plus, UL Protector, VULP** and **VUL II**: Death Benefit type:
   ☐ Type A (Level) ☐ Type B (Variable) ☐ Type C (Return of Premium) – **Not available for UL or VUL Protector.** – Interest rate: _____%
4. For **UL Plus, 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 $_____
   - ☐ Other Riders/Benefits (indicate amount where applicable): _____
   - ☐ Overloan Protection Rider
   - ☐ Child Rider **Complete *Child Rider Supplement.***
   - ☐ Automatic Premium Loan
   - ☐ Enhanced Cash Value Rider

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:

- **AR, 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.
- **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

Check applicable boxes:

IRS Certification: Under penalties of perjury, the policyowner certifies that:

- ☐ The number shown on the application is my correct Social Security/Tax ID number.
- ☐ I am not subject to backup withholding under Section 3406(a)(1)(C) of the Internal Revenue Code.
- ☐ I am a U.S. person (including a U.S. resident alien). *If not a U.S. person (including U.S. resident alien), submit the applicable Form W-8(BEN, 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

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. If you request one, 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

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

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

Policy number: _____

To evaluate your insurability, the Insurer named above has requested that you provide a sample of your bodily fluid(s) for testing and analysis to determine the presence of Human Immunodeficiency Virus (HIV) antibodies. By signing and dating this form you agree that this test may be done and that underwriting decisions will be based on the test result. A series of tests will be performed by a certified laboratory through a medically accepted procedure.

Many public health organizations have recommended that before taking an AIDS-related test, a person seek counseling to become informed concerning the implications of such a test. Because of the serious nature of HIV related illnesses, you may wish to consider counseling, at your expense, prior to being tested. The Commonwealth Department of Health (1-717-783-0479) or your local Health Department is available for HIV counseling.

Confidentiality of Test Results. All test results will be treated confidentially. They will be reported by the laboratory to the Insurer. When necessary for business reasons in connection with insurance you have or have applied for with the Insurer, the Insurer may disclose test results to others such as its affiliates, reinsurers, and its employees to whom disclosure is reasonably necessary in the ordinary course of business to carry out the purposes for which that disclosure is authorized or required. If the Insurer is a member of the Medical Information Bureau (MIB, Inc.), and if the test results for HIV antibodies/antigens are other than normal, the Insurer will report to the MIB, Inc., a generic code which signifies only a non-specific test abnormality. The test results may also be disclosed to any member company that receives an application for health or life insurance on your life. If your HIV test is normal, no report will be made about it to the MIB, Inc. The organizations described in this paragraph may maintain the test results in a file or data bank. Except as noted below, the Insurer will make no other disclosure of test results or even that the tests have been done except as may be required or permitted by law or as authorized by you. Positive test results of other significant abnormalities will adversely affect your application for insurance. This means your application may be declined, that an increased premium may be charged or that other policy changes may be necessary.

Notification of Test Results. If your HIV test is positive, we will not disclose the results to you. You are to designate a physician, the Commonwealth Department of Health, your local Health Department or a local community based organization to whom we can disclose the positive findings. If the test is negative, we will disclose it to you only if you indicate below that you wish to be so notified. Otherwise we will not disclose the negative results. ☐ Check here if you wish to receive a report of negative findings. Because a trained person should deliver that information so that you can understand clearly what the test result means, please list your private physician so that the insurer can have him or her tell you the test result and explain its meaning.

Name of physician or person for reporting the test result: _____

Address: _____

If you do not designate a physician or health care provider personal face-to-face counseling is available through the Pennsylvania Department of Health or your local health department. Additional information concerning AIDS or HIV infection can be obtained by calling the Pennsylvania Health Department at 1-717-783-0479.

Consent and Testing and Disclosure of Test Results. I have read and I understand this Notice and Consent for AIDS virus (HIV) Antibody/Antigen Testing. 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.

_____
Name of Proposed Insured *(please print)*

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

Prudential

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

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

Policy number: _____

To evaluate your insurability, the Insurer named above has requested that you provide a sample of your bodily fluid(s) for testing and analysis to determine the presence of Human Immunodeficiency Virus (HIV) antibodies. By signing and dating this form you agree that this test may be done and that underwriting decisions will be based on the test result. A series of tests will be performed by a certified laboratory through a medically accepted procedure.

Many public health organizations have recommended that before taking an AIDS-related test, a person seek counseling to become informed concerning the implications of such a test. Because of the serious nature of HIV related illnesses, you may wish to consider counseling, at your expense, prior to being tested. The Commonwealth Department of Health (1-717-783-0479) or your local Health Department is available for HIV counseling.

Confidentiality of Test Results. All test results will be treated confidentially. They will be reported by the laboratory to the Insurer. When necessary for business reasons in connection with insurance you have or have applied for with the Insurer, the Insurer may disclose test results to others such as its affiliates, reinsurers, and its employees to whom disclosure is reasonably necessary in the ordinary course of business to carry out the purposes for which that disclosure is authorized or required. If the Insurer is a member of the Medical Information Bureau (MIB, Inc.), and if the test results for HIV antibodies/antigens are other than normal, the Insurer will report to the MIB, Inc., a generic code which signifies only a non-specific test abnormality. The test results may also be disclosed to any member company that receives an application for health or life insurance on your life. If your HIV test is normal, no report will be made about it to the MIB, Inc. The organizations described in this paragraph may maintain the test results in a file or data bank. Except as noted below, the Insurer will make no other disclosure of test results or even that the tests have been done except as may be required or permitted by law or as authorized by you. Positive test results of other significant abnormalities will adversely affect your application for insurance. This means your application may be declined, that an increased premium may be charged or that other policy changes may be necessary.

Notification of Test Results. If your HIV test is positive, we will not disclose the results to you. You are to designate a physician, the Commonwealth Department of Health, your local Health Department or a local community based organization to whom we can disclose the positive findings. If the test is negative, we will disclose it to you only if you indicate below that you wish to be so notified. Otherwise we will not disclose the negative results. ☐ Check here if you wish to receive a report of negative findings. Because a trained person should deliver that information so that you can understand clearly what the test result means, please list your private physician so that the insurer can have him or her tell you the test result and explain its meaning.

Name of physician or person for reporting the test result: _____

Address: _____

If you do not designate a physician or health care provider personal face-to-face counseling is available through the Pennsylvania Department of Health or your local health department. Additional information concerning AIDS or HIV infection can be obtained by calling the Pennsylvania Health Department at 1-717-783-0479.

Consent and Testing and Disclosure of Test Results. I have read and I understand this Notice and Consent for AIDS virus (HIV) Antibody/Antigen Testing. 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.

_____
Name of Proposed Insured *(please print)*

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

Prudential

PENNSYLVANIA DISCLOSURE STATEMENT

The Prudential Insurance Company of America
Pruco Life Insurance Company
both are Prudential companies

This Disclosure Statement with all applicable blanks filled in is for your protection. It gives you basic information about the Cost and Coverage of the insurance being solicited. Read it carefully before signing any agreement to buy Life Insurance.

This Disclosure Statement shall not be considered as an offer to contract or as altering or modifying any Policy or rider that may be issued.

Name of Proposed Insured	Age	Sex
Name of Agent preparing Disclosure		
Agent home or agency address		
Telephone number of Agent		
Name of Insurer		
Home Office Address of Insurer (City and State)		

Direct all correspondence to Insurer:

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

	Descriptive Title of Coverage	Face Amount (1) If not applicable, Description of Coverage	Annual Premium If not known, Premium for Mode Quoted (2)
Base Policy - Check One ☐ Includes ☐ Excludes Waiver of Premium			
Rider(s)			
Supplemental Benefit(s)			

(1) The face amount of coverage of the base policy changes as follows:

_____

The amount of coverage of the rider (s) changes as follows:

_____

(2) The premium for the base policy changes; the ultimate _____ premium will be _____ at policy year _____.

If more than one premium change, representative _____ premium will be _____ and _____ at policy years _____ and _____.

The premium for the base policy changes; the ultimate _____ premium will be _____ at policy year _____.

If more than one premium change, representative _____ premium will be _____ and _____ at policy years _____ and _____ .

Total Initial _____ (mode) premium for the policy and rider(s) will be _____ .

Guaranteed Cash Value. If you continuously pay your premiums on this policy as they come due, you will have the following guaranteed cash value per face amount (or for each $1,000). You may borrow against this cash value at an annual % loan interest charge.

Number of Years Policy Has been in Force	5	10	20	Age 65
Total Accumulated Cash Value Per Total Face Amount (or per $1000)				

Dividends. The following is a dividend illustration for your policy based on the current interest, mortality and expense experience of the company as reflected in the dividends currently paid. However, the illustrations are not a guarantee of what future dividends will be.

Number of Years Policy Has been in Force	10	20
Illustrated Dividend for that Individual Year Per Face Amount (or per $1000)		

A Surrender Comparison Index will be provided upon delivery of the policy or earlier if requested. This Index provides one means of comparing the relative costs of two or more similar policies.

The prospective insured ☐ has ☐ has not requested an earlier delivery of the index.

Upon request either the company or agent will furnish you with additional information about the insurance described.

If inapplicable to insurance being offered, section may be deleted entirely or clearly marked "Not Applicable".

LIFE INSURANCE BUYER'S GUIDE

This guide can help you shop for life insurance.
It discusses how to:

- Find a policy that meets your needs and fits your budget
- Decide how much insurance policy you need
- Make informed decisions when you buy a policy

The Prudential Insurance Company of America
751 Broad Street, Newark, NJ 07102-3777.

ORD 113897 Ed. 12/2011

Prepared by the National Association of Insurance Commissioners

The National Association of Insurance Commissioners is an association of state insurance regulatory officials. This association helps the various insurance departments to coordinate insurance laws for the benefit of all consumers.

This guide does not endorse any company or policy.

Important Things to Consider

1. Review your own insurance needs and circumstances. Choose the kind of policy that has benefits that most closely fit your needs. Ask an agent or company to help you.
2. Be sure that you can handle premium payments. Can you afford the initial premium? If the premium increases later and you still need insurance, can you still afford it?
3. Don't sign an insurance application until you review it carefully to be sure all the answers are complete and accurate.
4. Don't buy life insurance unless you intend to stick with your plan. It may be very costly if you quit during the early years of the policy.
5. Don't drop one policy and buy another without a thorough study of the new policy and the one you have now. Replacing your insurance may be costly.
6. Read your policy carefully. Ask your agent or company about anything that is not clear to you.
7. Review your life insurance program with your agent or company every few years to keep up with changes in your income and your needs.

Buying Life Insurance

When you buy life insurance, you want coverage that fits your needs.

First, decide how much you need-and for how long-and what you can afford to pay. Keep in mind the major reason you buy life insurance is to cover the financial effects of unexpected or untimely death. Life insurance can also be one of many ways you plan for the future.

Next, learn what kinds of policies will meet your needs and pick the one that best suits you.

Then, choose the combination of policy premium and benefits that emphasizes protection in case of early death, or benefits in case of long life, or a combination of both.

It makes good sense to ask a life insurance agent or company to help you. An agent can help you review your insurance needs and give you information about the available policies. If one kind of policy doesn't seem to fit your needs, ask about others.

This guide provides only basic information. You can get more facts from a life insurance agent or company or from your public library.

What About the Policy You Have Now?

If you are thinking about dropping a life insurance policy, here are some things you should consider:

- If you decide to replace your policy, don't cancel your old policy until you have received the new one. You then have a minimum period to review your new policy and decide if it is what you wanted.
- It may be costly to replace a policy. Much of what you paid in the early years of the policy you have now, paid for the company's cost of selling and issuing the policy. You may pay this type of cost again if you buy a new policy.
- Ask your tax advisor if dropping your policy could affect your income taxes.
- If you are older or your health has changed, premiums for the new policy will often be higher. You will not be able to buy a new policy if you are not insurable.
- You may have valuable rights and benefits in the policy you now have that are not in the new one.
- If the policy you have now no longer meets your needs, you may not have to replace it. You might be able to change your policy or add to it to get the coverage or benefits you now want.
- At least in the beginning, a policy may pay no benefits for some causes of death covered in the policy you have now.

In all cases, if you are thinking of buying a new policy, check with the agent or company that issued you the one you have now. When you bought your old policy, you may have seen an illustration of the benefits of your policy. Before replacing your policy, ask your agent or company for an updated illustration. Check to see how the policy has performed and what you might expect in the future, based on the amounts the company is paying now.

How Much Do You Need?

Here are some questions to ask yourself:

- How much of the family income do I provide? If I were to die early, how would my survivors, especially my children, get by? Does anyone else depend on me financially, such as a parent, grandparent, brother or sister?
- Do I have children for whom I'd like to set aside money to finish their education in the event of my death?
- How will my family pay final expenses and repay debts after my death?
- Do I have family members or organizations to whom I would like to leave money?
- Will there be estate taxes to pay after my death?

- How will inflation affect future needs?

As you figure out what you have to meet these needs, count the life insurance you have now, including any group insurance where you work or veteran's insurance. Don't forget Social Security and pension plan survivor's benefits. Add other assets you have: savings, investments, real estate and personal property. Which assets would your family sell or cash in to pay expenses after your death?

What Is the Right Kind of Life Insurance?

All policies are not the same. Some give coverage for your lifetime and others cover you for a specific number of years. Some build up cash values and others do not. Some policies combine different kinds of insurance, and others let you change from one kind of insurance to another. Some policies may offer other benefits while you are still living. Your choice should be based on your needs and what you can afford.

There are two basic types of life insurance: term insurance and cash value insurance. Term insurance generally has lower premiums in the early years, but does not build up cash values that you can use in the future. You may combine cash value life insurance with term insurance for the period of your greatest need for life insurance to replace income.

Term Insurance covers you for a term of one or more years. It pays a death benefit only if you die in that term. Term insurance generally offers the largest insurance protection for your premium dollar. It generally does not build up cash value.

You can renew most term insurance policies for one or more terms even if your health has changed. Each time you renew the policy for a new term, premiums may be higher. Ask what the premiums will be if you continue to renew the policy. Also ask if you will lose the right to renew the policy at some age.

For a higher premium, some companies will give you the right to keep the policy in force for a guaranteed period at the same price each year. At the end of that time you may need to pass a physical examination to continue coverage, and premiums may increase.

You may be able to trade many term insurance policies for a cash value policy during a conversion period-even if you are not in good health. Premiums for the new policy will be higher than you have been paying for the term insurance.

Cash Value Life Insurance is a type of insurance where the premiums charged are higher at the beginning than they would be for the same amount of term insurance. The part of the premium that is not used for the cost of insurance is invested by the company and builds up a cash value that may be used in a variety of ways. You may borrow against a policy's cash value by taking a policy loan. If you don't pay back the loan and the interest on it. The amount you owe will be subtracted from the benefits when you die, or from the cash value if you stop paying premiums and take out the remaining cash value. You can also use your cash value to keep insurance

protection for a limited time or to buy a reduced amount without having to pay more premiums. You also can use the cash value to increase your income in retirement or to help pay for needs such as a child's tuition without cancelling the policy. However, to build up this cash value, you must pay higher premiums in the earlier years of the policy.

Cash value life insurance may be one of several types; whole life, universal life and variable life are all types of cash value insurance.

Whole Life Insurance covers you for as long as you live if your premiums are paid. You generally pay the same amount in premiums for as long as you live. When you first take out the policy, premiums can be several times higher than you would pay initially for the same amount of term insurance. But they are smaller than the premiums you would eventually pay if you were to keep renewing a term policy until your later years.

Some whole life policies let you pay premiums for a shorter period such as 20 years, or until age 65. Premiums for these policies are higher since the premium payments are made during a shorter period.

Universal Life Insurance is a kind of flexible policy that lets you vary your premium payments. You can also adjust the face amount of your coverage. Increases may require proof that you qualify for the new death benefit. The premiums you pay (less expense charges) go into a policy account that earns interest. Charges are deducted from the account. If your yearly premium payment plus the interest your account earns is less than the charges, your account value will become lower. If it keeps dropping, eventually your coverage will end. To prevent that, you may need to start making premium payments, or increase your premium payments, or lower your death benefits. Even if there is enough in your account to pay the premiums, continuing to pay premiums yourself means that you build up more cash value.

Variable Life Insurance is a kind of insurance where the death benefits and cash values depend on the investment performance of one or more separate accounts, which may be invested in mutual funds or other investments allowed under the policy. Be sure to get the prospectus from the company when buying this kind of policy and STUDY IT CAREFULLY. You will have higher death benefits and cash value if the underlying investments do well. Your benefits and cash value will be lower or may disappear if the investments you chose didn't do as well as you expected. You may pay an extra premium for a guaranteed death benefit.

Life Insurance Illustrations

You may be thinking of buying a policy where cash values, death benefits, dividends or premiums may vary based on events or situations the company does not guarantee (such as interest rates). If so, you may get an illustration from the agent or company that helps explain how the policy works. The illustration will show how the benefits that are not guaranteed will change as interest rates and other factors change. The illustration will show you what the company guarantees. It will also show you what could happen in the future. Remember that nobody knows what will happen in the future. You should be ready to adjust your financial

plans if the cash value doesn't increase as quickly as shown in the illustration. You will be asked to sign a statement that says you understand that some of the numbers in the illustration are not guaranteed.

Finding a Good Value in Life Insurance

After you have decided which kind of life insurance is best for you, compare similar policies from different companies to find which one is likely to give you the best value for your money. A simple comparison of the premiums is not enough. There are other things to consider. For example:

- Do premiums or benefits vary from year to year?
- How much do the benefits build up in the policy?
- What part of the premiums or benefits is not guaranteed?
- What is the effect of interest on money paid and received at different times on the policy?

Remember that no one company offers the lowest cost at **all** ages for **all** kinds and amounts of insurance. You should also consider other factors:

- How quickly does the cash value grow? Some policies have low cash values in the early years that build quickly later on. Other policies have amore level cash value build-up. A year-by-year display of values and benefits can be very helpful. (The agent or company will give you a policy summary or an illustration that will show benefits and premiums for selected years.)
- Are there special policy features that particularly suit your needs?
- How are nonguaranteed values calculated? For example, interest rates are important in determining policy returns. In some companies, increases reflect the average interest earnings on all of that company's policies regardless of when issued. In others, the return for policies issued in a recent year, or a group of years, reflects the interest earnings on that group of policies; in this case, amounts paid are likely to change more rapidly when interest rates change.

ISBN: 1-4277-5798-4
Reorder No.: 5607-7001

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)* _____

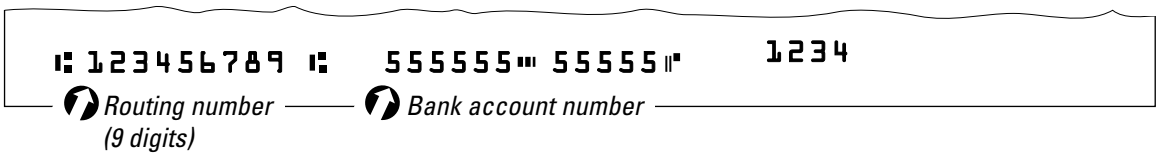
Policy number _____

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

Instructions for Completion of Application for Life Insurance

Before submitting this Application for Life Insurance, DO remember to:

- ❑ Confirm that you are appropriately licensed and appointed in the applicable states(s).
- ❑ Verify you have the correct version for the state you are writing in.
- ❑ Print in BLACK or BLUE ink only.
- ❑ Complete ALL applicable sections fully in order for the application to be reviewed and underwritten. **NOTE: Applications should be completed with the assistance of the producer and not solely by the client.**
- ❑ Fill out ALL applicable supplements and agreements, as required. Provide clear and legible handwriting.
- ❑ Provide the *Important Notice About Your Application for Insurance* (ORD 96200B) to the proposed insured.
- ❑ Provide the *Privacy Notice* to the proposed insured on ALL variable cases.
- ❑ Complete the IRS tax certification on page 6.
- ❑ Provide the state in which the owner is signing the application on page 6.
- ❑ If a prepayment is permitted under the terms of the Limited Insurance Agreement (LIA), make the prepayment check payable to Prudential Insurance Company, OR complete the *Request for Initial Premium (E-Pay) and/or to Establish Monthly Electronic Funds Transfer* (ORD 114416).
- ❑ Obtain ALL necessary signatures (proposed insured and policyowner(s), if different than proposed insured), titles, and dates, where applicable.
- ❑ Complete all information requested on the Authorization to Release Information.
- ❑ Have all changes initialed in BLACK or BLUE ink only.
- ❑ Always sign the application.

It is the responsibility of the producer to complete and sign the Agent's Report for ALL cases. Under no circumstances should the form be provided directly to the client.

When submitting for Index Advantage UL (IAUL) or PruLife® Founders Plus UL (PFP), DO:

- ❑ Use the Special Requests section (Section H) to list:
  - Death Benefit type: Type A (Level) or Type B (Variable) for IAUL; Type A (Level), Type B (Variable) or Type C (Return of Premium) for PFP.
  - Definition of life insurance: Cash Value Accumulation Test (CVAT) or Guideline Premium Test (GPT).

When submitting for the BenefitAccess Rider, DO:

- ❑ Only select PruLife® Universal Life Protector (UL Protector).
- ❑ Only select Death Benefit Type A (Level).

When using for a post-issue transaction, DO:

- ❑ Use the Special Requests section (Section H) for all Policy Change and Term Conversion requests, and remember to use the required special wording, where appropriate.
- ❑ Use the *Request for Policy Change* Supplement (ORD 96200 CHG) ONLY when:
  a. The existing policyowner of the policy being converted or changed is not the owner on the new or changed policy; or
  b. The rights restriction requires the beneficiary to sign all requests; or
  c. There is a collateral assignee.
- ❑ Submit the initial premium amount for all contractual conversions, regardless of coverage amount.

DO NOT:

- ✕ Waive any of our requirements or information we request as you do not have that authority.
- ✕ Guarantee or imply that we will provide insurance.
- ✕ Use correction fluid or tape for any alterations.
- ✕ Accept prepayment if:
  - Submitted in the form of cash.
  - Check is made payable to you or with the payee field left blank.
  - The proposed insured is unable to certify the health attestations.
  - The proposed insured's age is greater than 75 years.
  - The total amount of insurance requested in all applications on the proposed insured is greater than $5,000,000.

NOTE: The total death benefit payable under all LIAs combined is the amount applied for, up to a maximum of $1,000,000.