# Prudential Term Life Instructions

1. **Copy of Laser Visa**

2. **Copy of Passport**

3. **Personal History Interview is possible on all foreign national cases.**

# 1-800-VIP-LIFE

## NEW BUSINESS TRANSMITTAL FORM

**Agent/Broker Name:**_____

**Agent/Broker Email:**_____

**Agent/Broker Phone:**_____

**Agent/Broker Fax:**_____

**Client (s) Name:**_____

_____

**Date:**_____

**Carrier:**_____

**Product:**_____ **(Term/UL/SUL/VUL/MoneyGuard/Annuity)**

**Attached, I have enclosed the following (please check):**

**Application:**_____

**Exam:**_____

**APS:**_____

**Check:**_____ **in the amount of:**_____

**** IF NO EXAM IS ATTACHED I WOULD LIKE (please check):**

_____ **VIP TO ORDER THE EXAM**

_____**I WILL ORDER THE EXAM**

# Underwriting

Choose from the following to retrieve guidelines, requirements and height & weight charts for the corresponding carrier:

## Underwriting Search Engine

| | |
|---|---|
| Company | Prudential Financial |
| Product | Term Essential 10, 15, 20, 30 |
| Show | Underwriting Requirements |

Submit Reset

## Prudential Financial - Term Essential 10, 15, 20, 30 Underwriting Requirements

| Male Amount / Ages | 0 - 14 | 15 - 17 | 18 - 39 | 40 - 40 | 41 - 45 | 46 - 50 | 51 - 64 | 65 - 70 | 71 - 75 | 75 - 99 |
|---|---|---|---|---|---|---|---|---|---|---|
| 25,000 - 25,000 | - | - | - | - | - | - | A | A | A | B |
| 25,001 - 49,999 | - | - | - | - | - | A | A | A | A | B |
| 50,000 - 50,000 | - | - | - | - | - | C | C | C | C | D |
| 50,001 - 59,999 | - | - | G | G | E | E | E | E | E | S |
| 60,000 - 99,999 | - | - | G | G | E | E | E | E | E | U |
| 100,000 - 249,999 | - | - | F | F | H | H | H | T | T | I |
| 250,000 - 499,999 | - | - | F | F | H | H | T | T | T | I |
| 500,000 - 999,999 | V | V | F | J | T | T | T | T | T | I |
| 1,000,000 - 2,499,999 | K | W | F | J | T | T | T | T | T | I |
| 2,500,000 - 9,999,999 | K | W | F | R[1] | P[1] | P[1] | P[1] | P[1] | O[1] | N[1] |
| 10,000,000 - 50,000,000 | L | M | X | Q[1] | O[1] | O[1] | O[1] | O[1] | O[1] | N[1] |

| Female Amount / Ages | 0 - 14 | 15 - 17 | 18 - 39 | 40 - 40 | 41 - 45 | 46 - 50 | 51 - 64 | 65 - 70 | 71 - 75 | 75 - 99 |
|---|---|---|---|---|---|---|---|---|---|---|
| 25,000 - 25,000 | - | - | - | - | - | - | A | A | A | B |
| 25,001 - 49,999 | - | - | - | - | - | A | A | A | A | B |
| 50,000 - 50,000 | - | - | - | - | - | C | C | C | C | D |
| 50,001 - 59,999 | - | - | G | G | E | E | E | E | E | S |
| | | | | | | | | | | |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| 50,000 - 99,999 | - | - | G | G | E | E | E | E | E | U |
| 100,000 - 249,999 | - | - | F | F | H | H | H | T | T | I |
| 250,000 - 499,999 | - | - | F | F | H | H | T | T | T | I |
| 500,000 - 999,999 | V | V | F | J | T | T | T | T | T | I |
| 1,000,000 - 2,499,999 | K | W | F | J | T | T | T | T | T | I |
| 2,500,000 - 9,999,999 | K | W | F | $R^1$ | $P^1$ | $P^1$ | $P^1$ | $P^1$ | $O^1$ | $N^1$ |
| 10,000,000 - 50,000,000 | L | M | X | $Q^1$ | $O^1$ | $O^1$ | $O^1$ | $O^1$ | $O^1$ | $N^1$ |

| Requirements Combination Key | |
|---|---|
| A | Paramed[4] Exam |
| B | Paramed[4] Exam, EKG, APS |
| C | Paramed[4] Exam, Urinalysis |
| D | Paramed[4] Exam, Urinalysis, EKG, APS |
| E | Paramed[4] Exam, Urinalysis, Urinalysis HIV |
| F | Paramed[4] Exam, MVR, Insurance Risk Profile |
| G | Urinalysis HIV |
| H | Paramed[4] Exam, Insurance Risk Profile |
| I | Paramed[4] Exam, MVR, EKG, Insurance Risk Profile, APS |
| J | Paramed[4] Exam, MVR, EKG, Insurance Risk Profile |
| K | Paramed[4] Exam, APS |
| L | APS, MD Exam |
| M | Insurance Risk Profile, APS, MD Exam |
| N | MVR, EKG, Insurance Risk Profile, X-Ray, APS, MD Exam |
| O | EKG, Insurance Risk Profile, X-Ray, MD Exam |
| P | Paramed[4] Exam, EKG, Insurance Risk Profile, X-Ray |
| Q | MVR, EKG, Insurance Risk Profile, X-Ray, MD Exam |
| R | Paramed[4] Exam, MVR, EKG, Insurance Risk Profile, X-Ray |
| S | Paramed[4] Exam, Urinalysis, EKG, APS, Urinalysis HIV |
| | |

| | |
|---|---|
| T | Paramed[4] Exam, EKG, Insurance Risk Profile |
| U | Paramed[4] Exam, Urinalysis, EKG, APS, Urinalysis HIV |
| V | APS |
| W | Paramed[4] Exam, Insurance Risk Profile, APS |
| X | MVR, Insurance Risk Profile, MD Exam |

| Footnote Key | |
|---|---|
| 1 | Chest X-Ray needed if smoker in the past 5 years. |
| 2 | Amounts over these require an MD exam:<br><br>Ages 18-39: $9,999,999<br>Ages 40-59: $4,999,999<br>Ages 60+: $2,499,999 |
| 3 | Amounts over these require an MD exam:<br><br>Ages 18-39: $9,999,999<br>Ages 40-59: $4,999,999<br>Ages 60+: $2,499,999<br><br>Chest X-Ray needed if smoker in the past 5 years. |
| 4 | When the application is submitted via the traditional paper process, the Paramed requirement is satisfied via a full exam (physical measurements as well as completion of medical declarations) is required. A modified exam is required when the application is submitted via Express Worksheet. |

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# Prudential Financial

## Application for Life Insurance or Policy Change

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

**Part 1** **Policy number** _____ ☐ **Check here if policy change.**

**A About the Primary Proposed Insured**

1. Name of primary proposed insured *(or current insured person, if policy change)*
   _____
   *(First name, middle initial, last name)*
2. Social Security number _____
3. Sex ☐ female ☐ male
4. Marital status ☐ single ☐ married ☐ widowed ☐ separated ☐ divorced
5. Date of birth ____/____/____
   *month day year*
6. Age _____
7. State of birth *(country if not U.S.)* _____
8. Billing address _____
   *(street, city, state, ZIP)*
   _____
9. Home address *(if different)* _____
   *(street, city, state, ZIP)*
   _____
10. Home telephone number (____)_____
11. Business telephone number (____)_____
12. Current employer _____
13. List all existing life insurance coverage. ☐ Check here if none.

| Company | Amount | Year issued | Type of insurance | To be replaced? |
|---|---|---|---|---|
| | $ | | ☐ Individual ☐ Group | ☐ Yes ☐ No |
| | $ | | ☐ Individual ☐ Group | ☐ Yes ☐ No |
| | $ | | ☐ Individual ☐ Group | ☐ Yes ☐ No |
| | $ | | ☐ Individual ☐ Group | ☐ Yes ☐ No |
| | $ | | ☐ Individual ☐ Group | ☐ Yes ☐ No |

**B All Other Proposed Insureds** *(Include applicant if requesting Applicant's Waiver of Premium [AWP] Benefit)*

| Name *(first, initial, last)* | relationship to primary proposed insured | sex *(F/M)* | date of birth *(M/D/Y)* | age | state of birth *(country if not U.S.)* | total life insurance in all companies |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

## C Coverage Information

1. Plan of insurance _____
   If applicable to the plan, check one. ☐ Level Death Benefit ☐ Variable Death Benefit
2. Initial amount of insurance $_____
3. Supplementary benefits and riders
   - ☐ Waiver of Premium
   - ☐ Applicant's Waiver of Premium
   - ☐ Automatic Premium Loan
   - ☐ Acceleration of Death Benefits (Living Needs Benefit)
   - ☐ Accidental Death Benefit $_____
   - ☐ Option to Purchase Additional Insurance (OPAI) $_____
   - ☐ Option to Purchase Paid-up Life Insurance Additions *(include details in section G, **Special Requests**)*

Other riders and benefits *(indicate amount where applicable)* _____

## D Beneficiaries and Ownership

*(If trust, provide name of trust, trustee and date of trust)*

1. **Beneficiary information**

| | Name | Relationship to primary proposed insured | Age |
|---|---|---|---|
| Primary *(Class 1)* | | | |
| | | | |
| Contingent *(Class 2)* | | | |
| | | | |

2. Is the policyowner someone other than the primary proposed insured? ☐ Yes ☐ No
   ***(If Yes, provide information requested below.)***
   Name _____ Date of birth ____/____/____
   *(First name, middle initial, last name)* *month day year*
   Address _____
   *(street, city, state, ZIP)*

## E Payment Information

1a. Within the past 90 days, has any proposed insured 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? ☐ Yes ☐ No

b. Within the past 12 months, has any proposed insured received treatment or advice from a member of the medical profession for heart disease, chest pain, stroke or cancer (except skin)? ☐ Yes ☐ No

2. Is a medical examination required on the primary proposed insured? ☐ Yes ☐ No
   second proposed insured? ☐ Yes ☐ No

3. Premium payment mode *(collect full modal premium if prepaid)*
   - ☐ Annual ☐ Semiannual ☐ Quarterly ☐ Monthly
   - ☐ Electronic Funds Transfer (EFT) ☐ Payroll Budget ☐ Government Allotment

4. Amount of prepayment submitted with this application $_____ *(include any unscheduled premium payments)*
   ☐ None *(must be **None** if **1a** or **1b** is **Yes**, except for Gibraltar [GIB] products)*

5. Date prepayment collected, ____/____/____
   *month day year*

## F Replacement

For any proposed insured, would this insurance replace or cause a change in any existing insurance or annuity in any company? ***(If Yes, enclose all required replacement forms.)*** ☐ Yes ☐ No

## G Special Requests

## H Background on Proposed Insureds

1. Has either the primary proposed insured or second proposed insured (if any) ever used tobacco or other nicotine products such as cigarettes, cigars, pipe, chewing tobacco, snuff, nicotine gum or nicotine patch? ***(If Yes, provide date when last used and indicate all types of products.)*** ☐ Yes ☐ No

| | *Date (mo., yr.)* | *Product(s)* |
|---|---|---|
| Primary proposed insured | | |
| | | |
| Second proposed insured | | |
| | | |

2. What are the occupation and duties of the primary proposed insured? _____

3. Within the last two years, has any proposed insured done or does he or she plan to do the following:
   - **a.** operate or have any duties aboard an aircraft, glider, balloon or similar device? ☐ Yes ☐ No
     ***(If Yes, complete* Aviation Questionnaire.)**
   - **b.** participate in hazardous sports, such as auto, motorcycle, snowmobile or powerboat competitions/exhibitions, scuba diving, mountain climbing, parachuting, skydiving or any other such sport or hobby? ***(If Yes, complete* Avocation Questionnaire.)** ☐ Yes ☐ No

4. Is any proposed insured applying for or requesting reinstatement or policy change(s) of any other life or health insurance policy? ***(If Yes, provide insurance company, policy plan and amount.)*** ☐ Yes ☐ No

5. Has any proposed insured been convicted of, or currently charged with, the commission of any criminal offense – other than the violation of a motor vehicle law – within the last 10 years? ☐ Yes ☐ No
   ***(If Yes, provide details.)*** _____

6. **a.** Driver's license number and state of issue of primary proposed insured _____
   - **b.** In the last three years, has any proposed insured
     - **(1)** had a driver's license denied, suspended or revoked? ☐ Yes ☐ No
     - **(2)** been convicted of or cited for
       - **(a)** three or more moving violations? ☐ Yes ☐ No
       - **(b)** driving under the influence of alcohol or drugs? ☐ Yes ☐ No
     - **(3)** been involved as a driver in two or more auto accidents? ☐ Yes ☐ No

     ***(If Yes to any of the above, provide details, including type of violation, accident, or reason for denial, suspension or revocation.)*** _____

7. Does any proposed insured plan to live or travel outside the United States or Canada within the next 12 months? ***(If Yes, list countries and purpose and duration of each trip.)*** ☐ Yes ☐ No

## I Additional Coverage

*Complete only if this is an application for additional coverage on a person already covered by a Prudential or Pruco policy with an application date within three months of the date of this application.*

To the best of your knowledge, has the health or the mental or physical condition of any person proposed for insurance changed since the answers and statements were given in the application included in policy number _____? ☐ Yes ☐ No

***(If Yes, complete the appropriate Part 2 Medical Information section.)***

## J Changes

Changes made by the Company **(not applicable in New Mexico or West Virginia)**

## K Physician Information

**Primary proposed insured**

*Physician last consulted*

Name _____

Address _____
*(street, city, state, ZIP)*

_____

Telephone number (___) _____ Date last seen ___/___/___
*month day year*

Reason last seen _____

*Primary physician*

Name _____

Address _____
*(street, city, state, ZIP)*

_____

Telephone number (___) _____ Date last seen ___/___/___
*month day year*

Reason last seen _____

**Second proposed insured or applicant for Applicant's Waiver of Premium (AWP)**

*Physician last consulted*

Name _____

Address _____
*(street, city, state, ZIP)*

_____

Telephone number (___) _____ Date last seen ___/___/___
*month day year*

Reason last seen _____

*Primary physician*

Name _____

Address _____
*(street, city, state, ZIP)*

_____

Telephone number (___) _____ Date last seen ___/___/___
*month day year*

Reason last seen _____

## L Physical Measurements

| | Height | Weight |
|---|---|---|
| Primary proposed insured | | |
| Second proposed insured | | |
| AWP applicant | | |

**M Category II Changes and Plans other than Gibraltar (GIB)**

**1.** Family record

| | Current age or age at death | Year and cause of death | | Current age or age at death | Year and cause of death |
|---|---|---|---|---|---|
| Father | | | Mother | | |
| Brother | | | Sister | | |
| Brother | | | Sister | | |
| Brother | | | Sister | | |

**2.** Has anyone proposed for coverage been diagnosed with or treated by a member of the medical profession for

- **a.** chest pain or any disorder of the heart or blood vessels? ☐ Yes ☐ No
- **b.** high blood pressure? ☐ Yes ☐ No
- **c.** cancer, tumor, leukemia, melanoma or lymphoma? ☐ Yes ☐ No
- **d.** diabetes or high blood sugar? ☐ Yes ☐ No
- **e.** mental or psychiatric illness? ☐ Yes ☐ No
- **f.** Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC)? ☐ Yes ☐ No
- **g.** infection caused by the Human Immunodeficiency Virus (HIV)? **(Not applicable in California. Wisconsin:** 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.) ☐ Yes ☐ No
- **h.** any sexually transmitted diseases? ☐ Yes ☐ No
- **i.** asthma or any disorder of the lungs? ☐ Yes ☐ No
- **j.** any disorder of the brain or nervous system? ☐ Yes ☐ No
- **k.** hepatitis or any disorder of the liver, stomach or intestines? ☐ Yes ☐ No
- **l.** any disorder of the kidney or urinary tract? ☐ Yes ☐ No

**3.** Is anyone proposed for coverage currently taking prescription medication? ☐ Yes ☐ No

**4.** Other than above, has anyone proposed for coverage

- **a.** been a patient in a hospital or other medical facility? ☐ Yes ☐ No
- **b.** in the last five years, had or been advised to have surgery, medical tests (other than HIV) or diagnostic procedures such as ECGs, stress tests, X-rays, blood tests, urine tests, etc.? ☐ Yes ☐ No

**5.** Has anyone proposed for coverage

- **a.** used, or is he or she now using, cocaine, amphetamines, marijuana, heroin or other drugs, except as prescribed by a member of the medical profession? ☐ Yes ☐ No
- **b.** had or been advised to have treatment or counseling for alcohol or drug use? ☐ Yes ☐ No

**6.** Does anyone proposed for coverage have any disease, disorder or condition not previously mentioned? ☐ Yes ☐ No

**7.** Has anyone proposed for coverage had life or health insurance declined, postponed or issued with an increased premium? **(Missouri:** this question may be answered No if an individual has been declined for coverage.) ☐ Yes ☐ No

**8.** Is anyone proposed for coverage currently unable to perform his or her normal daily activities or all normal occupational duties on a full-time basis at the customary place of employment? ☐ Yes ☐ No

**9.** Has anyone proposed for coverage requested or received disability or compensation benefits? ☐ Yes ☐ No

*(continued on next page)*

**M Category II Changes and Plans other than Gibraltar (GIB)** *(continued)*

**10.** Details of "**Yes**" answers for questions 2-9

| Question number and name of proposed insured | Indicate illness, hospitalization, reason for checkup, medication and any advice or treatment given by a medical professional | Dates and duration of illness | Name, address and telephone number of medical professionals and hospitals |
|---|---|---|---|

For additional medical details, use another application.

**Signatures (continued)**

- **Not applicable in Arizona:**

  **Any person who knowingly 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:**

  - **Arkansas, Hawaii, Louisiana, New Mexico, Tennessee, Virginia** and **Washington:** may be subject to fines, denial of insurance benefits, or confinement in prison.
  - **Colorado:** 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.
  - **District of Columbia:** or any other person has committed a crime. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.
  - **All other states:** may have committed fraud, or may have violated state law.

Signed at _____ on ____/____/____
*(city, state)* *month day year*

*Signature of primary proposed insured, if age 8 or over, or of currently insured person, if policy change* **X** _____

*Signature of spouse (applicable in South Carolina, if proposed for coverage.)* **X** _____

*Signature of policyowner (if different from the primary proposed insured) or of existing policyowner if a policy change. If the policyowner is a firm or corporation, give that company's name and have an officer sign below.* **X** _____

*Signature and title of officer of firm or corporation* **X** _____

*Signature of applicant, if different from primary proposed insured or policyowner* **X** _____

*Signature of beneficiary, if policy change and rights are limited* **X** _____

*Signature of witness (Licensed Writing Representative must witness.)* **X** _____

**Licensed Writing Representative's Certification**

Do you have any information, other than that stated in this application, which indicates that any proposed insured may replace or change any current insurance or annuity in any company? ☐ Yes ☐ No

*Signature of Writing Representative* **X** _____

# Prudential Financial

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

## Authorizations, Acknowledgment and Limited Insurance Agreement

**Name** _____

**Policy number** _____

## Limited Insurance Agreement *(Please see the Limited Insurance Agreement on the reverse side.)*

Thank you for choosing Prudential for your insurance needs.

**Health Certification** — A premium can be collected and insurance can take effect under this agreement only if the following statement is true:

I certify and affirm that no person proposed for coverage has:

(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).

Amount of insurance requested $ _____ Amount of prepayment $ _____

Person(s) proposed for coverage _____

## Tax Certification *(Please see Important Taxpayer Information on the reverse side.)*

To be completed by the policyowner. *(If joint policyowners, to be completed by policyowner who assumes tax reporting liability.)*

**Policyowner's name** _____

**Under penalties of perjury I (as policyowner) certify that**

My correct taxpayer identification number (TIN) is ☐☐☐-☐☐-☐☐☐☐

*(A TIN could be either a Social Security number or an Employer Identification Number. For individuals, a TIN is the Social Security number.)*

I am not subject to backup withholding for the following reasons:
(a) I have not been notified that I am subject to backup withholding as a result of a failure to report all interest or dividends, or
(b) the IRS has notified me that I am no longer subject to backup withholding, or (c) I am exempt from backup withholding.

**Complete the following if applicable:**

☐ I have been notified by the IRS that I am subject to backup withholding due to the underreporting of interest or dividends.

☐ I am not a U.S. person (including resident alien), I am a citizen of _____
*(Attach the applicable IRS Form W-8 [BEN,ECI, EXP, IMY].*

## Authorization to Release Information

**Acknowledgment.** I have received the **Important Notice About Your Application for Insurance.**

I authorize any licensed physician, medical practitioner, hospital, clinic, other health care provider, pharmacy benefit manager, insurance company, government agency, or the Medical Information Bureau 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. The information authorized for release includes my entire medical record, excluding psychotherapy notes, but includes 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 record 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 prior to the notice of revocation. In addition, we may continue to use 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.

## Signatures

I have read and agreed to all the applicable terms of this form, including all relevant information pertaining on the reverse side. I also understand this form in its entirety will be provided to any of the individuals listed in the Authorization above in order to request medical information to determine eligibility for coverage.

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

**CALIFORNIA ONLY:** 1) A copy of any consumer investigative report conducted will be provided to you; 2)the writing representative certifies that the CA Disclosure Statement was provided to the policyowner in accordance with CA Insurance Code section 789.8.

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

Signature of spouse, *if proposed for coverage* **X** _____

Signature of policyowner, *if different from primary proposed insured or applicant* **X** _____

Name of company, if owner is a business or corporation _____

Officer of company **X** _____
*Must sign here and give his or her title.*

Writing representative **X** Contract number Field office

**The Company checked on reverse side is referenced hereafter as "Company, we, us, our."**

## Limited Insurance Agreement

**All premium checks must be made payable to the Insurance Company - do not make check payable to the agent or leave the payee blank. This agreement is valid only if the check or other form of payment is good and can be collected, and if the Company received this payment, Limited Insurance Agreement and the request for coverage on the same date.**

Upon payment of the full initial premium, the Company agrees to provide limited life insurance coverage under the following terms and conditions:

- Limited insurance starts on the latest of the following dates: the date of this agreement or the date all required initial medical exams and tests are completed on all proposed insureds. However, if any proposed insured dies from accidental bodily injury within 30 days of the date of this agreement and before any exam and tests are completed, a death benefit will be paid under the terms of this agreement.
- If any proposed insured dies, (or if survivorship coverage is requested and both proposed insureds die), the total death benefit under this Limited Insurance Agreement is the amount requested, up to a maximum of $1,000,000.
- This agreement does not include any supplemental benefits including Waiver of Premium, Applicant's Waiver of Premium and Accidental Death (and Dismemberment) benefits you have requested from the Company.
- The 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.

Limited insurance ends when any 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. If you do not accept the policy, the prepayment will be refunded.
3. We mail you a letter notifying you that we have declined to issue you a policy or that we will not provide life insurance coverage on a prepaid basis.
4. Sixty days have passed since the date of this agreement, and the limited insurance provided under this agreement has not ended for any of the reasons listed above.

If this is a request for a policy change or conversion, the amount of insurance provided by this limited insurance agreement is the amount requested minus the amount of insurance being discontinued as part of this request, up to a maximum of $1,000,000.

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

No Company representative has any right to accept risks, waive or change policies, give up any of our rights or requirements, or change the provisions of this agreement.

**There is no coverage under this Limited Insurance Agreement if the Health Certification is materially mis- represented or fraudulent. If death is due to suicide or intentionally self-inflicted injury, payment will be limited to the return of the amount paid.**

If you have not received a policy or your money back after 60 days have passed, please tell the Company the amount and date paid, and the name of the writing representative who accepted the payment.

ORD 96200A 1/2005

Customer Service Office
2101 Welsh Road
Dresher, PA 19025

## Important Taxpayer Information

The Company and its representatives and associates may not give tax or legal advice. We encourage you to consult your attorney or tax professional regarding tax questions or tax advice.

**Taxpayer Identification Number**

You must give us your Taxpayer Identification Number (TIN) in the **Tax Certification** section of this form. A TIN could be either a social security number or an Employer Identification Number. If the policyowner is an individual, the TIN is the Social Security number.

**Backup Withholding**

You must tell us if the Internal Revenue Service has notified you that you are subject to backup withholding because you didn't report all your taxable interest and dividends on your tax return. You are not subject to backup withholding if: (a) you did not receive such a notice from the IRS, or (b) if the IRS recently told you that you are no longer subject to a backup withholding order, or (c) you are exempt from such withholding. If you have been notified that you are subject to backup withholding, please check the appropriate box in the Tax Certification section on the reverse of this form.

**Citizenship**

You must state whether you are or are not a U.S. person (including resident alien) in the Tax Certification section on the reverse of this form. If you are not a U.S. person (including resident alien), you must provide the country of which you are a citizen and submit the applicable Form W-8 (BEN, ECI, EXP, IMY). In most situations, the IRS Form W-8BEN will be the appropriate IRS Form W-8.

**Penalties**

You may be subject to IRS penalties, including fines and imprisonment, if you fail to provide your correct Taxpayer Identification Number, fail to report taxable interest or dividends on your tax return, or give false tax information.

## Agent's Report Name of Proposed Insured *(F/M/L)* _____

How were purpose and amount of the policy determined? Check all that apply.

☐ Needs analysis ☐ Insured request _____ ☐ Business needs analysis
☐ Income times rule_____ x income ☐ Single needs presentation
☐ Estate analysis: ☐ capital preservation ☐ capital liquidation ☐ Other _____

**Purpose?** Check all that apply.

*Personal:* ☐ Death benefit ☐ Basic last expenses ☐ Income replacement
☐ Mortgage protection ☐ Estate conservation ☐ Charitable giving
☐ Potential cash accumulation (*permanent insurance only*) ☐ Retirement income needs
☐ Other _____

*Business* ☐ Deferred compensation ☐ Buy/Sell ☐ Key person
☐ Loan indemnification ☐ Executive bonus (section 162) ☐ Business continuation
☐ Split dollar ☐ Other _____

**What is the source of initial and future premiums?**

Check all that apply:

**Initial Premium**
☐ Current income or savings account[1]
☐ Other:_____

**Future Premium**
☐ Current income or savings account[1]
☐ Other:_____

Will any premiums come from dividends, policy loans, withdrawals or cash surrenders[2]? ☐ Yes ☐ No
**(If yes, provide details.)** Specify Prudential policy number or other insurance company and all proceeds that apply:

Pru Policy number _____ ☐ Non-Pru _____
Dividends $ _____ Loan $_____
PUA $ _____ Withdrawal $_____
Surrender: ☐ Yes ☐ No

Will any additional monies, other than scheduled/target premium payments, be paid over the next 12 months? ☐ Yes ☐ No
**(If yes, provide amount and source of additional funding) $**_____

☐ current income ☐ mutual fund(s) ☐ CD's/liquid assets/savings
☐ annuity(s) ☐ life insurance policy(s) ☐ other_____

[1] Cash will not be permitted for payment

[2] While financed insurance is not appropriate in most situations, it may be in some, depending on the customer's individual circumstances. If the customer finances premium payments, it must be explained that sustained borrowing for premium payments may result in the lapse of the policy and loss of valuable policy benefits. When appropriate, the representative must complete the Think Twice form and any state forms which are required for replacement and financing.

## Additional Information - Completion of Sections A, E and G is required.

### A About the Primary Proposed Insured

**1.** Previous home address: City _____ State _____ Address since (mo/yr) ____/____

**2.** Business address: Street _____
City _____ State _____ ZIP _____
Phone number (_____)_____ Address since (mo/yr) ____/____

**3.** Previous employer name: _____
Street _____
City _____ State _____ ZIP _____
Employed from (mo/yr) ____/____ to ____/____

**4.** If a consumer report is required, does the primary proposed insured (PPI) want to be interviewed? ☐ Yes ☐ No

**5.** Premium will be paid by ☐ insured ☐ employer ☐ spouse ☐ parent ☐ other

**6.** Earned annual income $_____ Unearned annual income $_____
Spouse/Domestic Partner's annual income: $ _____
*If PPI is a juvenile (In PA: ages 0-17; in all other states: ages 0-14), income figures are for the contract owner.*

**7a.Complete if face amount is $1,000,000 or greater:** Net worth: $ _____

**7b.Complete if face amount is $5,000,000 or greater** (*submission of a cover letter is recommended*)**:**
Assets: Cash:$_____ Investments (Stocks, Bonds, Mutual Funds, etc): $_____
Savings: $_____ Home: $_____ Other Real Estate (Include Details):$_____
Business: $_____ Personal Property: $_____ Other (Include Source): $_____
Liabilities: Home Mortgage: $_____ Loans: $_____ Other (Include Source): $_____

**8.** Premium Payor Information:
Name: _____
Relationship to primary proposed insured _____
Amount of life insurance coverage in force (existing & applied for) $ _____ Income $ _____

**9.** If any proposed insured has changed his or her last name in the last five years, give
Current name _____ Previous name _____

## Agent's Report *(Continued)* **Name of Proposed Insured** *(F/M/L)* _____

### A. About the Primary Proposed Insured *(continued)*

**10.** How well do you know the primary proposed Insured?
☐ Self ☐ Relative ☐ Know slightly ☐ Met very recently ☐ Known well for ____ years at: ☐ Home ☐ Business ☐ Other:_____

**11.** Is the primary proposed Insured a prior client of yours? ☐ Yes ☐ No

**12.** Did someone other than you suggest this insurance? ☐ Yes ☐ No
**If yes,** state who and what prompted this request._____

**13.** Was a third-party adviser involved in this sale? ☐ Yes ☐ No **If yes,** name and title: _____

### B. About Dependent Children *(Complete if any dependent children are proposed for coverage)*

**If Yes, give details in Remarks.**

**1.** Are the dependent children
**a.** foster children or children whose legal adoption is not final? ☐ Yes ☐ No
**b.** living elsewhere than in the household of primary proposed insured? ☐ Yes ☐ No
**c.** dependent on someone other than the primary proposed insured? ☐ Yes ☐ No

**2.** Does the primary proposed insured have other children under age 18 who are not proposed for coverage? ☐ Yes ☐ No

**3. Complete if the primary proposed insured is 14 years old or younger.**

| Name | Date of birth (M/D/Y) | Amount of existing life insurance | Pending Pru/Pruco app? |
|---|---|---|---|
| Father _____ | ___/___/___ | _____ | ☐ Yes ☐ No |
| Mother _____ | ___/___/___ | _____ | ☐ Yes ☐ No |
| Brother _____ | ___/___/___ | _____ | ☐ Yes ☐ No |
| Sister _____ | ___/___/___ | _____ | ☐ Yes ☐ No |

### C. About Business Insurance *(Complete if the application is for business insurance)*

**1.** Type of firm: ☐ corporation ☐ partnership ☐ sole proprietorship
**2.** Type of business _____ Number of employees _____
**3.** Is the primary proposed Insured: ☐ employee ☐ owner ? If owner. % of ownership? _____%
**4.** Company name: _____
**5.** Has the business been established for less than two (2) years? ☐ Yes ☐ No ☐ Unknown
**6.** What is the net worth of the business? $_____
**7. Complete if face amount of contract is $5,000,000 or greater** (*submission of a cover letter is recommended*):
Assets: $_____ Liabilities: $_____ Fair Market Value: $_____
Gross Annual Sales: $_____ Net Profit After Taxes: $_____
**8.** The purpose of this business insurance is
☐ Business continuation ☐ Key person indemnification ☐ Retirement
☐ Executive compensation/Section 162 ☐ Loan security ☐ Other _____
**9.** Is this a Split Dollar sale? ☐ Yes ☐ No
**10.** List amount of existing business insurance & insurance applied for in all companies on each officer or member of the business.

| Name | Age | % Ownership | In force | Amount applied for |
|---|---|---|---|---|
| _____ | _____ | _____ | $_____ | $_____ |
| _____ | _____ | _____ | $_____ | $_____ |

### D. Remarks

### E. Producer Information - For splits greater than two, use an additional page with all details.

**PRODUCER #1** Split Commission %: _____ Non-variable commissions to be paid? .....☐ Directly to me ☐ To my Firm or Broker Dealer
Producer Name: _____ National Account: _____

GA Contract No. | GA Name | GA EIN | Producer Contract No. | Producer SSN

**COMPLETE ONLY IF PAYING FIRM:**

Firm Paying Contract No. | Firm Name | Firm EIN | GA Contact Name/Email Address

**PRODUCER #2** Split Commission %: _____ Non-variable commissions to be paid? .....☐ Directly to me ☐ To my Firm or Broker Dealer
Producer Name: _____

GA Contract No. | GA Name | GA EIN | Producer Contract No. | Producer SSN

**COMPLETE ONLY IF PAYING FIRM:**

Firm Paying Contract No. | Firm Name | Firm EIN | GA Contact Name/Email Address

### F. Replacement Certification

- Have you discussed the advantages and any disadvantages of the replacement with the applicant? ☐ Yes ☐ No
- Have you determined that the replacement transaction is appropriate for the applicant? ☐ Yes ☐ No

### G. Certification

- I certify that I saw the primary proposed insured on the date below; and
- I am not aware of any information, other than that stated in this application, that would adversely affect the insurability of all proposed insureds. I recommend that the Company accept the proposed insured(s) for coverage.

*Signature of Writing Representative* **X** _____ Date ___/___/___

*Field Manager, if present when application is signed* **X** _____ *Title of Field Manager* _____

Prudential Financial

The Prudential Insurance Company of America
Pruco Life Insurance Company

# Important Notice About Your Application for Insurance

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 Medical Information Bureau (MIB); 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 non-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) [TTY # 866-346-3642 for the hearing impaired].

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

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 evaluate your insurability, the Insurer named above has requested that you provide a sample of your blood, oral fluid extracted from cheek and gum tissue, or urine 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 three tests will be performed by a licensed laboratory through a medically accepted procedure.

**Pre-Testing Considerations**
Many public health organizations have recommended that before taking an HIV-related test a person seek counseling to become informed concerning the implications of such a test. You may wish to consider counseling, at your expense, prior to being tested.

**Meaning of Positive Test Result**
The test is not a test for AIDS. It is a test for antibodies to the HIV virus, the causative agent for AIDS, and shows whether you have been exposed to the virus. A positive test result does not mean that you have AIDS but that you are at significantly increased risk of developing problems with your immune system. The test for HIV antibodies is very sensitive. Errors are rare, but they do occur. Your private physician, a public health clinic, or an AIDS information organization in your city might provide you with further information on the medical implications of a positive test.

Positive HIV antibody test results 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.

**Confidentiality of Test Results**
All test results are required to be treated confidentially. They will be reported by the laboratory to the Insurer. The test results may be disclosed as required by law or may be disclosed to employees of the Insurer who have the responsibility to make underwriting decisions on behalf of the Insurer or to outside legal counsel who needs such information to effectively represent the Insurer in regard to your application. The results may be disclosed to a reinsurer, if the reinsurer is involved in the underwriting process. The test may be released to an insurance medical information exchange under procedures that are designed to assure confidentiality, including the use of general codes that also cover results of tests for other diseases or conditions not related to AIDS, or for the preparation of statistical reports that do not disclose the identify of any particular person.

**Notification of Test Result**
If your test results are negative, no routine notification will be sent to you. If your test results are reported by the laboratory to the Insurer as being positive, you will receive written notification of such results from a physician you have designated or, in the absence of such designation, from the Texas Department of Health. 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 for reporting a possible positive test result: _____

Address: _____

In the event the test is positive and you are denied coverage because of that fact and you request the reason for the denial, the insurer may require you to name a physician at that time in order to receive the information.

If the test indicates a positive result, but you do not designate a private physician, the test results will be provided to you by a representative of the Texas Department of Health.

**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 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 | Signature of Proposed Insured or Parent/Guardian | Date signed |
|---|---|---|

Address

Prudential Financial

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

# Important Notice Regarding Replacement

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

## IMPORTANT NOTICE: REPLACEMENT OF LIFE INSURANCE OR ANNUITIES

This document must be signed by the applicant and the producer, if there is one, and a copy left with the applicant.

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A *replacement* occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A *financed purchase* occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy, to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interest. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on the back of this form.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? ☐ Yes ☐ No
2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? ☐ Yes ☐ No

**If you answered "Yes" to either of the above questions, list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured or annuitant, and the policy or contract number if available) and whether each policy or contract will be replaced or used as a source of financing:**

| | Insurer Name | Contract or Policy # | Insured or Annuitant | Replaced (R) or Financing (F) |
|---|---|---|---|---|
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. ***(If you request one, an in-force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer.)*** Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

The existing policy or contract is being replaced because _____

_____.

I certify that the responses herein are, to the best of my knowledge, accurate.

_____ _____
*Applicant's Signature and Printed Name* *Date*

_____ _____
*Producer's Signature and Printed Name* *Date*

**I do not want this notice read aloud to me. _____ (Applicants must initial only if they do not want the notice read aloud.)**

*If you are replacing an existing policy or contract, no later than 30 days after the new policy or annuity contract is delivered to you, you may return it to us or your agent and receive an unconditional full refund of all premiums paid on it, including any policy fees or charges, less the amount of any payment(s) we may have already made.*

*If you are returning a variable policy or annuity contract, you will receive the cash surrender value provided under the policy or contract plus the fees and other charges deducted from the gross premiums or considerations, less the amount of any payment(s) we may have already made.*

***Copies provided to Insurance Company, Agent, and Applicant***

Prudential Financial

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

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| Insurer Name | Contract or Policy # | Insured or Annuitant | Replaced (R) or Financing (F) |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. ***(If you request one, an in-force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer.)*** Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

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I certify that the responses herein are, to the best of my knowledge, accurate.

_____ _____
*Applicant's Signature and Printed Name* *Date*

_____ _____
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*If you are returning a variable policy or annuity contract, you will receive the cash surrender value provided under the policy or contract plus the fees and other charges deducted from the gross premiums or considerations, less the amount of any payment(s) we may have already made.*

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Prudential Financial

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

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**Pruco Life Insurance Company**
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| | Insurer Name | Contract or Policy # | Insured or Annuitant | Replaced (R) or Financing (F) |
|---|---|---|---|---|
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. ***(If you request one, an in-force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer.)*** Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

The existing policy or contract is being replaced because _____

_____.

I certify that the responses herein are, to the best of my knowledge, accurate.

_____ _____
*Applicant's Signature and Printed Name* *Date*

_____ _____
*Producer's Signature and Printed Name* *Date*

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*If you are returning a variable policy or annuity contract, you will receive the cash surrender value provided under the policy or contract plus the fees and other charges deducted from the gross premiums or considerations, less the amount of any payment(s) we may have already made.*

***Copies provided to Insurance Company, Agent, and Applicant***

Prudential Financial

# Premium Provisions of Indeterminate Premium Contracts

**Pruco Life Insurance Company**
*A subsidiary of The Prudential Insurance Company of America*

---

**Proposed Insured** _____

**Date of Birth** _____ **Contract Number** _____

I understand that the premium provisions of the Indeterminate Premium contract that I have applied for are essentially as follows:

1. After a period of level premiums, the amount of the premiums will increase on each contract anniversary; in addition to that increase, premiums may change on or after the Guaranteed Premium End Date shown in the contract if Pruco Life is then increasing or decreasing its rate basis for all contracts in the same class as my contract. Scheduled premiums and maximum premiums as of each anniversary will be shown in the contract's Schedule of Premiums.

2. The non-guaranteed premium used in any solicitation or advertising for this contract is subject to change up to the full maximum shown in the contract.

3. Pruco Life reserves the right to charge the maximum premium beginning with any premium due on a contract anniversary.

4. The changed premium, if less than the maximum premium stated in the contract, is not guaranteed beyond the contract year to which it applies.

5. Pruco Life will not exercise its right to change the premium more often than once a year.

**X** _____ _____
*Signature of Applicant* *Date*

Prudential Financial

# Premium Provisions of Indeterminate Premium Contracts

**Pruco Life Insurance Company**
*A subsidiary of The Prudential Insurance Company of America*

---

**Proposed Insured** _____

**Date of Birth** _____ **Contract Number** _____

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3. Pruco Life reserves the right to charge the maximum premium beginning with any premium due on a contract anniversary.

4. The changed premium, if less than the maximum premium stated in the contract, is not guaranteed beyond the contract year to which it applies.

5. Pruco Life will not exercise its right to change the premium more often than once a year.

X _____ _____

*Signature of Applicant* *Date*

Prudential Financial

**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

## Replacement Sales Material Checklist

**Policy/Contract Number** _____ **Name** _____ **Date of Birth** _____

This form is to be completed for states that have replacement regulations requiring that any sales material used during the sales presentation be submitted to the Home Office.

***Note: See the state replacement highlighter for applicable states.***

**Sales Material**:

Sales material includes product specific brochures, illustrations, or similar type materials used in the sales presentation (including electronic materials). Sales material does NOT include fact finders, Survivor Needs Analysis, Asset Allocation Questionnaire and Output, or similar type materials.

**Please check below the sales materials you used in your presentation. There is no need to submit a copy of these materials to the Home Office.**

These materials will be sent by the Home Office to the replaced insurer for their review when required by state regulations.

**For All Life Products:**

- ☐ What Every Consumer Should Know About Life Insurance IFS-A023847
- ☐ Living Needs Benefit Brochure IFS-A021275*

*Use state specific version where applicable

**For Variable Life Products:**

- ☐ PruLife Custom Premier Product Overview IFS-A060681
- ☐ PruLife Custom Premier Prospectus VUL-2

**For Universal Life Products:**

- ☐ PruLife UL Plus Overview - IFS-A108474
- ☐ PruLife Universal Plus (2003) Overview - IFS-A083134
- ☐ PruLife Universal Protector (2003) Overview - IFS-A101881

**For Whole Life Products:**

- ☐ Prudential Guaranteed Life Product Overview IFS-A066070

**For Term Products:**

- ☐ Term Essential/Term Elite Product Overview (IFS-A079716)
- ☐ Return of Premium Term Product Overview (IFS-A126936)

**For Survivorship Products:**

- ☐ Survivorship Variable Universal Life (SVUL) Product Overview IFS-A051935
- ☐ PruLife SUL Protector and PruLife SUL Plus Overview - IFS-A079695
- ☐ PruLife SUL Protector Product Overview - IFS-A078247

**For Annuity Products:**

- ☐ None (other than prospectus)
- ☐ Applicable Annuity Prospectus
- ☐ Annuity One Overview (ORD 000039)
- ☐ Annuity One-Client Kit (ORD 000044OR)
- ☐ Annuity One (Enhanced) Client Guide (ORD 01088)
- ☐ Annuity One (Enhanced) Client Kit (ORD 01087)
- ☐ Annuity One 3 Client Guide (ORD 01121)
- ☐ Annuity One 3 Client Kit (ORD 01143)
- ☐ Strategic Partners Advisor Client Guide (ORD 01013)
- ☐ Strategic Partners Advisor Kit
- ☐ Strategic Partners Select Client Guide (ORD 01015)
- ☐ Strategic Partners Select Client Kit
- ☐ Strategic Partners FlexElite Client Guide (ORD 01078)
- ☐ Strategic Partners Flex Elite CLient Kit
- ☐ Strategic Partners Horizon Client Guide (ORD 01127)
- ☐ Strategic Partners Horizon Client Kit
- ☐ Variable Investment Option Digest (PRU728)
- ☐ Discovery Classic Client Brochure (ORD 97688)
- ☐ PIA Client Brochure (ORD 97687)

**Please check below and list any other sales materials not shown above used in the presentation (A copy of these materials must be submitted to the Home Office).**

☐ **Illustration or Presentation** - must be submitted for LIFE if either a computer screen or paper illustration or presentation, matching the policy applied for, was presented at time of sale.

**Other:**

☐ _____ ☐ _____

**Representative's Replacement Certification**

1. Have you discussed the advantages and any disadvantages of the replacement with the applicant? ☐ Yes ☐ No
2. Have you determined that the replacement transaction is appropriate for the applicant? ☐ Yes ☐ No

| Name of Representative (Please Print) | Representative's Signature | Contract/FA# | Office Code | Date |
|---|---|---|---|---|
| | | | | |

Prudential Financial

# Request for Initial Premium Electronic Funds Transfer

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

## INSTRUCTIONS

Complete the entire form in blue or black ink. Initial any corrections or changes that you make and retain a copy for your records. Each new policy must have a separate electronic funds transfer request.

For assistance in completing this form, please contact your representative.

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. POLICY AND WITHDRAWAL INFORMATION

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

Policy number _____ Withdrawal amount $_____

## 2. BANK ACCOUNT INFORMATION

**Account owner type:** ☐ Individual/Joint ☐ Corporate ☐ Trust ☐ Other _____

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

Address _____

City/State/ZIP code _____

**Account type:** ☐ Savings ☐ Checking

Name of financial institution _____

Local branch telephone number (optional) _____

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

**See **Instructions For Completing Section 2** on next page.*

## 3. AGREEMENT AND SIGNATURE

As a convenience to me, I authorize Prudential to make a one-time electronic fund transfer from my account. By signing below, I understand and agree that:

- If a withdrawal request is not honored by the financial institution, Prudential will not consider the payment to be made.
- I have 60 days from the date of the withdrawal to notify Prudential of any errors related to a transfer under this agreement.
- Prudential will process this initial premium withdrawal request immediately upon receipt of this authorization.
- 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.

*Note: This authorization for a one-time electronic transfer will be processed immediately and therefore cannot be revoked once submitted.*

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

Prudential Financial

# Instructions For Completing Section 2

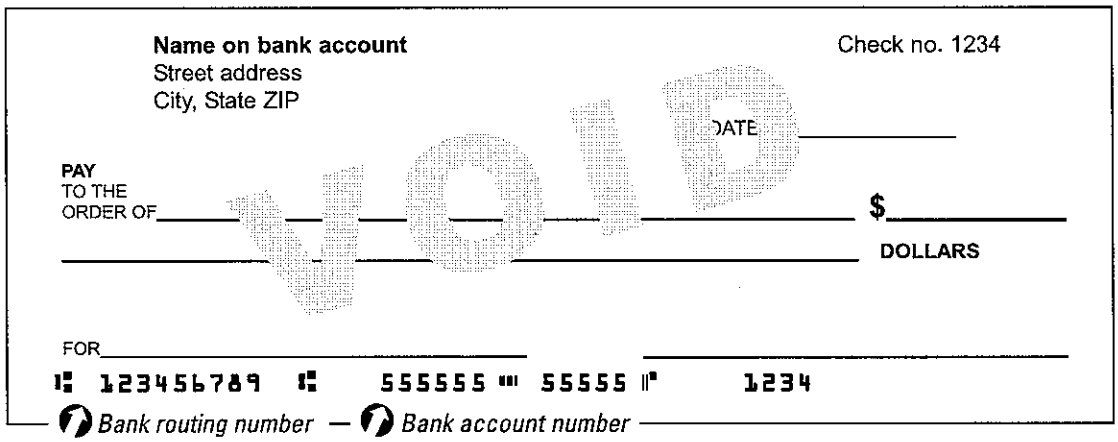
**The Prudential Insurance Company of America**
**Pruco Life Insurance Company of New Jersey**
**Pruco Life Insurance Company**
*All are Prudential Financial companies.*

## INSTRUCTIONS

**Record all banking information on the form in section 2, Bank Information.**

**Checking account.** If you wish us to withdraw the initial payment from a checking account, please refer to the diagram below to help you determine the bank transit routing number and the bank account number of that checking account.

**Savings account.** If a savings account is being used, you must first check with your bank to ensure that you do not exceed limits on how many electronic withdrawals can be made each month. Also ask them to provide you with the correct bank transit routing number and account number for electronic withdrawals.




- The bank account number varies in number of digits and may include dashes or spaces.
- The ⑈ symbol indicates the end of the account number.
- Include any dashes and spaces that are within the account number in section 2.
- Do not include the check sequence number on the form.

# Prudential

## Policyowner Statement

**The Prudential Insurance Company of America**
**Pruco Life Insurance Company of New Jersey**
**Pruco Life Insurance Company**
*All are Prudential companies.*
Corporate Offices, Newark, New Jersey 07102
Telephone: 973-802-6000

_____ _____

*Name of Proposed Insured(s)* *Name of Policyowner*

***Prudential will not knowingly participate in a life insurance sale where the sale of the policy in a secondary market or the participation of investors in the policy death benefits is being considered. Accordingly, the Policyowner is asked to answer the following questions:***

1. Have you or the proposed insured been offered "free insurance" or any inducement such as a cash payment, gifts, loan proceeds in excess of the amount necessary to fund the policy, or anything else of value as an encouragement to apply for this life insurance policy? ☐ Yes ☐ No
2. Have you or the proposed insured been solicited to sell or transfer, or had any discussions about selling any of the following to a life settlement company or group of investors in the next five years: the proposed life insurance policy; any other life insurance policy on the life of the proposed insured; or, a trust, limited liability company or other entity that has been or will be established to own the policy? ☐ Yes ☐ No
3. Have you or the proposed insured entered into or been offered a financing arrangement where a lender or other third party, other than your employer or family member, will receive any portion of the death benefit of the policy applied for in excess of repayment of the principal and interest? ☐ Yes ☐ No
4. Are you or the proposed insured considering the sale or transfer of the policy being applied for to a life settlement company or other third party investors within the next five years? ☐ Yes ☐ No
5. Will any entity other than a life insurance company, life reinsurance company or medical service provider engaged by either of these companies, be medically evaluating the proposed insured to determine life expectancy? ☐ Yes ☐ No

**I certify and affirm that all answers to the above questions are complete, true and correctly recorded.**

**X** _____ ____/____/____

*Signature of Policy Owner* *Date*

**Producer's Statement:**

1. I represent that all answers to the above questions are correct, true and complete, to the best of my knowledge and belief.
2. I have no knowledge of any plans for the policy being applied for to be sold to a life settlement or viatical company.

**X** _____ ____/____/____

*Signature of Producer* *Date*

**Prudential Financial**

**Financial Questionnaire to:**
- ☐ **The Prudential Insurance Company of America**
- ☐ **Pruco Life Insurance Company of New Jersey**
- ☐ **Pruco Life Insurance Company**

*All are Prudential companies.*

**Instructions:**

1. To be completed by Agents in the Select Underwriting Program on applications under $1,000,000 when an inspection report would normally be required.
2. Complete Section I and Section II (Personal Insurance) or Section III (Business Insurance).
3. Please submit copies of loan commitments, written buy-sell agreements, audited financial statements, letters or any other material which supplements the information requested.

| Proposed Insured's Name | Contract No. |
|---|---|
| | |

**Section I – General Information (Always complete)**

A. Basis of Amount Applied for:

1. Who determined amount of insurance applied for?
   ☐ Proposed Insured ☐ Accountant ☐ Attorney ☐ Agent ☐ Other: (specify) _____
2. How was the amount determined? _____

B. Financial Information:

1. Current Income:
   Gross Annual Compensation: (e.g. Salary, Commissions, Bonuses, etc.) $_____
   Gross Annual Investment and Other Income:
   (e.g. Dividends, Interest, Net Real Estate Income, etc.) $_____
   Total Annual Cash Income before taxes: $_____
2. Current Net Personal Worth:
   Assets: $_____
   Liabilities: (including mortgages) $_____
   Net Worth: $_____
3. Have either the Proposed Insured or Applicant filed for bankruptcy within the past five years? Yes ☐ No ☐
   (If "Yes", explain.)

_____

_____

_____

C. 1. Source of Financial Information for **Sections I, II** and **III**:
   ☐ Proposed Insured ☐ Accountant ☐ Banker ☐ Attorney ☐ Agent
   ☐ Other: (specify) _____
2. Have the financial sources contacted been authorized to release information? Yes ☐ No ☐

**Sections II – Personal Insurance – (**Complete Only When Applying for Personal Coverage)

Purpose: (Check appropriate box(es) and answer all supplemental questions.)

☐ Family Income ☐ Education fund ☐ Gift ☐ Mortgage Protection

☐ Personal Loan Collateral (other than mortgage protection): Answer supplemental questions under business Loan Collateral in **Section III**, B3.

☐ Estate Settlement:
   Taxable Estate: $_____
   Estimated Settlement Cost: (taxes and administration expenses) $_____
   Total Liquid Assets: $_____

☐ Other: (specify) _____

_____

**Section III – Business Insurance** – (Complete Only When Applying for Business Insurance)

A. Financial Information:

Year Business Established: _____

| | | |
|---|---|---|
| Estimated Fair Market Value of Business: | $_____ | |
| Total Business Assets: | $_____ | |
| Total Business Liabilities: | $_____ | |
| Total Business Net Worth: | $_____ | $_____ |
| | (Last full year) | (Previous full year) |

Gross Annual Sales: (Last full year) $ _____ (Previous full year) $ _____

Net profit after taxes (Past 2 years) _____ $ _____ _____ $ _____

Are financial statements available? ..... Yes ☐ No ☐

B. Purpose: (Check appropriate box(es) and answer all supplemental questions.)

| | Yes | No |
|---|---|---|
| 1. ☐ Buy-Sell/Stock redemption: | | |
| Is there a written buy-sell/stock redemption agreement? ..... | ☐ | ☐ |
| Is this a Section 303 Redemption? (If "Yes", complete Estate Settlement portion of **Section II**.) ..... | ☐ | ☐ |
| Are all other parties to agreement already covered by or applying for comparable amounts of insurance?..... | ☐ | ☐ |
| (If "No", explain.) _____ | | |
| 2. ☐ Key Person: | | |
| Are all other key persons covered by or applying for comparable amounts of insurance? ..... | ☐ | ☐ |
| (If "No", explain.) _____ | | |
| Why is the Proposed Insured considered "Key"? (Detail special skills/knowledge/ability.) _____ | | |
| 3. ☐ Business Loan Collateral: | | |
| Name of creditor/lending institution: _____ | | |
| What is the purpose and amount of the loan? _____ | | |
| What is the Repayment Schedule? _____ | | |
| Date loan was committed: _____ | | |
| If not yet committed, explain: _____ | | |
| Is insurance required by the creditor? ..... | ☐ | ☐ |
| 4. ☐ Deferred Compensation/Salary Continuation: | | |
| Is there a written plan? ..... | ☐ | ☐ |
| Are all other eligible individuals covered by or applying for comparable amounts of insurance? ..... | ☐ | ☐ |
| (If "No", explain.) _____ | | |
| 5. ☐ Other: (specify) | | |

C. Additional Comments:

The above statements and answers are true and complete to the best of my knowledge and belief. The Insurer may rely on them in acting on this application.

Signature of Proposed Insured (If age 8 or over)

Dated at _____ on _____

(City/State)

Signature of Applicant (If other than proposed Insured – If applicant is a firm or corporation, show that company's name)

Witness

By

Writing Representative

(Signature and title of officer signing for that company)

Form **W-8BEN**
(Rev. February 2006)
Department of the Treasury
Internal Revenue Service

# Certificate of Foreign Status of Beneficial Owner for United States Tax Withholding

▶ Section references are to the Internal Revenue Code. ▶ See separate instructions.
▶ Give this form to the withholding agent or payer. Do not send to the IRS.

OMB No. 1545-1621

**Do not use this form for:** **Instead, use Form:**

- A U.S. citizen or other U.S. person, including a resident alien individual . . . . . W-9
- A person claiming that income is effectively connected with the conduct of a trade or business in the United States . . . . . W-8ECI
- A foreign partnership, a foreign simple trust, or a foreign grantor trust (see instructions for exceptions) . . . . . W-8ECI or W-8IMY
- A foreign government, international organization, foreign central bank of issue, foreign tax-exempt organization, foreign private foundation, or government of a U.S. possession that received effectively connected income or that is claiming the applicability of section(s) 115(2), 501(c), 892, 895, or 1443(b) (see instructions) . . . . . W-8ECI or W-8EXP

**Note:** *These entities should use Form W-8BEN if they are claiming treaty benefits or are providing the form only to claim they are a foreign person exempt from backup withholding.*

- A person acting as an intermediary . . . . . W-8IMY

**Note:** *See instructions for additional exceptions.*

## Part I Identification of Beneficial Owner (See instructions.)

1 Name of individual or organization that is the beneficial owner

2 Country of incorporation or organization

3 Type of beneficial owner: ☐ Individual ☐ Corporation ☐ Disregarded entity ☐ Partnership ☐ Simple trust ☐ Grantor trust ☐ Complex trust ☐ Estate ☐ Government ☐ International organization ☐ Central bank of issue ☐ Tax-exempt organization ☐ Private foundation

4 Permanent residence address (street, apt. or suite no., or rural route). **Do not use a P.O. box or in-care-of address.**

City or town, state or province. Include postal code where appropriate.

Country (do not abbreviate)

5 Mailing address (if different from above)

City or town, state or province. Include postal code where appropriate.

Country (do not abbreviate)

6 U.S. taxpayer identification number, if required (see instructions) ☐ SSN or ITIN ☐ EIN

7 Foreign tax identifying number, if any (optional)

8 Reference number(s) (see instructions)

## Part II Claim of Tax Treaty Benefits (if applicable)

9 **I certify that (check all that apply):**

a ☐ The beneficial owner is a resident of ..... within the meaning of the income tax treaty between the United States and that country.

b ☐ If required, the U.S. taxpayer identification number is stated on line 6 (see instructions).

c ☐ The beneficial owner is not an individual, derives the item (or items) of income for which the treaty benefits are claimed, and, if applicable, meets the requirements of the treaty provision dealing with limitation on benefits (see instructions).

d ☐ The beneficial owner is not an individual, is claiming treaty benefits for dividends received from a foreign corporation or interest from a U.S. trade or business of a foreign corporation, and meets qualified resident status (see instructions).

e ☐ The beneficial owner is related to the person obligated to pay the income within the meaning of section 267(b) or 707(b), and will file Form 8833 if the amount subject to withholding received during a calendar year exceeds, in the aggregate, $500,000.

10 **Special rates and conditions** (if applicable—see instructions): The beneficial owner is claiming the provisions of Article ..... of the treaty identified on line 9a above to claim a .....% rate of withholding on (specify type of income): ..... .

Explain the reasons the beneficial owner meets the terms of the treaty article: .....

## Part III Notional Principal Contracts

11 ☐ I have provided or will provide a statement that identifies those notional principal contracts from which the income is **not** effectively connected with the conduct of a trade or business in the United States. I agree to update this statement as required.

## Part IV Certification

Under penalties of perjury, I declare that I have examined the information on this form and to the best of my knowledge and belief it is true, correct, and complete. I further certify under penalties of perjury that:

1 I am the beneficial owner (or am authorized to sign for the beneficial owner) of all the income to which this form relates,

2 The beneficial owner is not a U.S. person,

3 The income to which this form relates is (a) not effectively connected with the conduct of a trade or business in the United States, (b) effectively connected but is not subject to tax under an income tax treaty, or (c) the partner's share of a partnership's effectively connected income, and

4 For broker transactions or barter exchanges, the beneficial owner is an exempt foreign person as defined in the instructions.

Furthermore, I authorize this form to be provided to any withholding agent that has control, receipt, or custody of the income of which I am the beneficial owner or any withholding agent that can disburse or make payments of the income of which I am the beneficial owner.

**Sign Here** ▶ ..... Signature of beneficial owner (or individual authorized to sign for beneficial owner) ..... Date (MM-DD-YYYY) ..... Capacity in which acting

**BBVA** Investments

**Compañias**

21st Century
American General Life
Allianz
Allstate
American National
AXA Equitable
Banner
Coventry
EMSI
Genworth Financial
Hartford
Indianapolis Life
ING
Integrity Life Solutions
Jefferson Pilot
John Hancock
Lincoln Benefit
Lincoln Financial
Mass Mutual
Met Life
Midland National
Mutual of Omaha
New York Life
North American
Northwestern Mutual
Pacific Life
Phoenix Mutual
Principal Financial
Protective
Prudential
Strategic Medical Consulting, Inc.
Sun Life
Transamerica Occidental Life Ins. Co.
United of Omaha
United States Life
US Financial
West Coast Life

## Autorización para que la información de salud se pueda comunicar a la aseguradora VIP Insurance y sus compañias asociadas

La presente autorización se ajusta a la privacidad establecida por la ley de responsabilidad y portabilidad de los seguros médicos de Estados Unidos (HIPAA, por sus siglas en ingles)

_____ ___/___/_____ _____-____-_____

Nombre del asegurado / paciente (En letras de imprenta) | Fecha de nacimiento | Numero de Seguro Social

Yo autorizo que todo proveedor de un plan de salud, médico, profesional de la salud, hospital, clínica, laboratorio, farmacia, administrador de prestaciones farmacéuticas, centro médico, compañía de seguro, organización de apoyo para compañías de seguro u otro proveedor de servicios de salud (los "Proveedores") que, en forma directa o indirecta, haya hecho un pago en mi nombre, o me haya proporcionado un tratamiento o prestado servicios, comunique a Volente Insurance Partners, LLC (la "Compañía"), así como a sus empleados, agentes, representantes y filiales, la historia clínica completa, incluidos los informes de los exámenes personales y cualquier otra información de salud protegida. Esta autorización abarca la información sobre el diagnóstico o el tratamiento del virus de inmunodeficiencia humana (VIH) y de enfermedades de transmisión sexual. Asimismo, comprende la información sobre el diagnóstico o el tratamiento de las enfermedades mentales y del consumo de alcohol, estupefacientes y tabaco, con exclusión de las notas de las sesiones de psicoterapia.

Con su firma al pie de esta autorización, el que suscribe concluye todos los acuerdos que haya celebrado con los Proveedores para restringir la divulgación de la información de salud protegida, autorizándolos para comunicar su historia clínica completa sin limitación.

La información de salud protegida de quien suscribe se comunicará conforme a la presente Autorización, con la que la Compañía podrá: 1) transmitirla a otras compañías para que puedan proporcionarle al interesado un contrato de seguro mediante la evaluación de los requisitos, los riesgos, la emisión de la póliza y la solicitud de la cobertura; 2) procurar el reaseguro de otras compañías; 3) administrar los reclamos de seguro, así como evaluar o satisfacer la cobertura y la provisión de las prestaciones; 4) administrar la cobertura; y 5) llevar a cabo otras actividades permitidas por la legislación aplicable que se relacionen con la cobertura que el interesado tenga o haya solicitado en la Compañía.

Esta autorización será válida por veinticuatro meses desde su firma al pie. Por su parte, las copias de esta autorización tendrán la misma validez que el documento original. El interesado entiende que tiene el derecho de revocar la autorización en cualquier momento, por medio de una solicitud a tal fin dirigida al Ejecutivo de Privacidad HIPPA, o HIPPA Privacy Official en idioma inglés, de la Compañía, al domicilio 355 County Road 185, Suite 800, Cedar Park, TX 78613. La autorización también se podrá revocar enviando la solicitud mencionada a los Proveedores. La revocación no surtirá efecto cuando alguno de los Proveedores haya actuado en virtud de esta autorización ni cuando la Compañía tenga el derecho de impugnar un reclamo o la cobertura conforme a las pólizas de seguro. Por su parte, la información que se comunique conforme a esta autorización podrá quedar sujeta a retransmisión por parte de sus destinatarios, caso en el que ya no contará con la protección de la normativa federal que contempla la privacidad y la confidencialidad de la información de salud (p. ej., la privacidad establecida por la ley mencionada en el encabezado).

El que suscribe entiende que si decide no firmar esta autorización, la Compañía podrá no procesar su solicitud y, en caso de que ya se haya emitido una póliza de seguro, podrá no cubrir sus prestaciones; y declara que ha recibido una copia de esta autorización.

X _____ _____

Firma del asegurado / paciente o de su representante personal | Fecha

_____

Descripción de la relación o el poder del representante personal del asegurado / paciente

# REPORTE MEDICO

Nombre del asegurado / paciente

Nombre del Doctor

Ciudad, Estado

Fecha de Nacimiento

Estimado Doctor:

En orden para poder establecer elegibilidad para un seguro de vida de este paciente, favor de completar la forma adjunta. Estamos interesados en información relacionada a visitas de consultas de este paciente con Usted en los últimos 5 años. Si es posible, favor de incluir copias de los resultados de posibles estudios y procedimientos diagnósticos. Autorización para que Usted pueda remitir esta información acompaña esta forma.

Si requiere más espacio para completar esta información, favor de copiar la hoja adherida las veces que sea necesario. Si Usted prefiere no usar esta forma, regrésela con el reporte que usted desee mandar. Favor de enviar esta información vía fax al (512)-794-0126.

Gracias por su cooperación.

Atentamente,

## REPORTE MEDICO

Nombre del asegurado / paciente _____ Ciudad, Estado _____

| FECHA | QUEJAS Y DESCUBRIMIENTOS FISICOS Y ABNORMALES | DURACIÓN DE ENFERMEDAD | DIAGNOSIS | TRATAMIENTO |
|---|---|---|---|---|
| | | | | |

- Resultados de exámenes o laboratorios (Radiografías, Electrocardiogramas, Reportes Patológicos, Etc., incluyendo fechas.) _____

_____

- Condición presente. _____

_____

- Se a consultado algún otro o cirujano? Fecha y diagnosis. _____

_____

- Favor de anotar cualquier otra información pertinente a la salud de este paciente. _____

_____

- En su conocimiento, sabe Usted si este paciente a fumado en los últimos 12 meses? _____

_____

Nombre: _____

Firma: _____ Fecha: _____