Prudential

AGENT'S REPORT

PART 1

PROPOSED INSURED: _____

A. PURPOSE OF INSURANCE

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

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

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

B. PRODUCER INFORMATION

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

PRODUCER #1 Split commission %: _____

Producer name: _____ GA name: _____

Producer contract number: _____ GA contract number: _____

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

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

Firm name: _____ Firm contract number: _____

Firm Employer Identification Number: _____

PRODUCER #2 Split commission %: _____

Producer name: _____ GA name: _____

Producer contract number: _____ GA contract number: _____

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

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

Firm name: _____ Firm contract number: _____

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

C. CASE DETAILS

Who is responsible for the requirement ordering?

Age and amount requirements: ☐ Prudential ☐ Producer/GA

Preferred Exam Vendor: ☐ APPS ☐ EMSI ☐ SMM

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

D. KNOWLEDGE OF PROPOSED INSURED

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

E. SUITABILITY DECLARATIONS (VARIABLE PRODUCTS ONLY)

1. This application is submitted in the belief that the purchase of this policy is suitable for the policyowner based on the information furnished. ☐ Yes ☐ No
2. Reasonable inquiry has been made of the policyowner concerning the policyowner's insurance and investment objectives, financial situation and needs. ☐ Yes ☐ No
3. The policyowner is considering the purchase of this variable life insurance product primarily as a vehicle to provide for long term insurance needs and not primarily as an investment. ☐ Yes ☐ No
4. I provided the policyowner with the brochure "What every consumer should know about life insurance" and answered any questions they had about the purchase. ☐ Yes ☐ No

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

1. What is the source of funds used to pay premiums on this policy? (Check all that apply.):

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

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

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

G. UNDERWRITING CATEGORY QUOTED

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

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

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

H. PRUDENTIAL/PRUCO POLICIES ISSUED WITHIN 3 MONTHS

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

I. REMARKS

J. MILITARY

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

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

K. PRODUCER'S STATEMENT

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

I certify that:

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

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

Prudential

APPLICATION FOR LIFE INSURANCE

PART 1

☑ Pruco Life Insurance Company of New Jersey
☐ The Prudential Insurance Company of America
Both are Prudential 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
   - ☐ Other: _____
   - ☐ PruLife® Universal Life Plus (UL Plus)
   - ☐ PruLife® Universal Life Protector (UL Protector)
   - ☐ VUL Protector℠ (VULP) **Complete the *Variable Supplement.***
   - ☐ PruLife® Custom Premier II (VUL II) **Complete the *Variable Supplement.***
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

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 convicted for any crime and/or are you currently charged with 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. Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC)? ☐ Yes ☐ No
   g. any sexually transmitted disease? ☐ Yes ☐ No
   h. asthma, emphysema, cystic fibrosis, sleep apnea, sarcoidosis, tuberculosis or any other disorder of the lungs or respiratory system? ☐ Yes ☐ No
   i. 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
   j. an ulcer, hepatitis, cirrhosis, pancreatitis, ulcerative colitis, Crohn's disease or any other disorder of the esophagus, liver, stomach or intestines? ☐ Yes ☐ No
   k. nephritis, polycystic kidney disease or any other disorder of the bladder, kidney, urinary tract or prostate? ☐ Yes ☐ No
   l. arthritis, gout, back trouble, or any disease or disorder of the joints, muscles or bones? ☐ Yes ☐ No
   m. 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

For additional medical details, use Overflow Details Supplement (ORD 96200OD-2010 NEW YORK). This Part 2 will be attached to and made a part of the policy when issued.

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.
- I confirm that if I have requested the Acceleration of Death Benefits (Living Needs Benefit) rider, I have read the disclosures in the brochure **(ORD 87246 NY);** and am aware that **(1) receipt of accelerated death benefits may affect eligibility for public assistance programs and may be taxable; and (2) a discount is applied to determine any accelerated death benefit payable and a $150 administrative charge will be deducted at the time of payment.**
- My original signature has been affixed to this application. The original application will be retained by the Company and I will receive a copy identical in form and substance to the original, attached to and will become a part of my policy.
- 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.

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 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 of New Jersey
Both are Prudential companies.

THANK YOU FOR CHOOSING PRUDENTIAL FOR YOUR INSURANCE NEEDS

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: To the best of my knowledge and belief, 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).

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. If survivorship coverage is requested, and one proposed insured dies during the Limited Insurance Agreement coverage period and the insured who died had completed all initial medical exams and tests and was found to be insurable according to the Company's underwriting rules, a joint and last survivor policy will be offered to the surviving insured if that insured is also found to be insurable according to the Company's underwriting rules. If one proposed insured dies during the Limited Insurance Agreement coverage period and the one insured who died had not completed all initial medical exams and tests or was found to be uninsurable according to the Company's underwriting rules, the premium paid would then be refunded and no policy would be issued.
4. 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 examination and tests required by the Company are completed and received at our Administrative Office.
5. 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. Five days have passed after the date we mailed 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. SPECIAL LIMITATIONS

- 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. If death is due to suicide or intentionally self-inflicted injury, 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.

PART 2 – TERMS & CONDITIONS (CONTINUED)

D. 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.

SIGNATURES

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.

I have read this Limited Insurance Agreement including all information on Page 1. 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: ____/____/____

Prudential

AUTHORIZATION TO RELEASE INFORMATION

Pruco Life Insurance Company of New Jersey
The Prudential Insurance Company of America
Both are Prudential 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 as referenced in the Important Notice 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), 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. Information related to alcohol and drug abuse that has been disclosed to the Company may be protected by Federal Regulations 42 CFR part 2.
- 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. When used for claim purposes, it is valid for 2 years after the date below or for the duration of the claim.
- A copy of this Authorization will be provided to me or my authorized representative by my insurance representative or the Company, either at 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

CVAT or GPT Selection Form

Pruco Life Insurance Company of New Jersey,
A subsidiary of The Prudential Insurance Company of America

No. _____

A Supplement to the Application in which _____is named as the proposed Insured.

The policy applied for offers a choice of two different tests to determine whether the policy meets the definition of life insurance under Internal Revenue Code Section 7702: the Cash Value Accumulation Test (CVAT) and the Guideline Premium Test (GPT).

Cash Value Accumulation Test (CVAT) and Guideline Premium Test (GPT)

These two tests are used to determine whether an insurance policy meets the definition of life insurance under I.R.C. Section 7702. The CVAT test generally permits more premium to be paid into a policy during its initial years than the GPT test. The CVAT test requires that you maintain a higher level of death benefit in relation to cash value than the GPT test. You should consider the CVAT test if you wish to maximize premium payments over a short period. You should consider the GPT test if you wish to maintain a higher level of cash value in relation to death benefit protection. Once you elect one of the tests, you may never change it.

The definition of life insurance test that works best for you will depend on a number of factors, including the amount of death benefit you want, the amount of premium you plan to pay, and whether you intend to make withdrawals or loans. If a death benefit guarantee is offered on the policy, the definition of life insurance test and the type of death benefit that you choose may affect the duration of the death benefit guarantee.

You should consult your sales representative for more information about our policies so that you can select the test and death benefit type that best accomplish your goals. You may request an illustration on both tests from your sales representative to help in your decision.

I have read and understand the above disclosure regarding the availability of the different tests under I.R.C. Section 7702.

I am selecting the following test:

- ☐ Cash Value Accumulation Test (CVAT)
- ☐ Guideline Premium Test (GPT)

Signature of Applicant:_____ Date:_____

Prudential

Corporate Offices
Newark, New Jersey 07102

☐ **The Prudential Insurance Company of America, or**
☑ **Pruco Life Insurance Company of New Jersey,**
Both are Prudential companies.

DEPARTMENT OF FINANCIAL SERVICES OF THE STATE OF NEW YORK - DEFINITION OF REPLACEMENT

IN ORDER TO DETERMINE WHETHER YOU ARE REPLACING OR OTHERWISE CHANGING THE STATUS OF EXISTING LIFE INSURANCE POLICIES OR ANNUITY CONTRACTS, AND IN ORDER TO RECEIVE THE VALUABLE INFORMATION NECESSARY TO MAKE A CAREFUL COMPARISON IF YOU ARE CONTEMPLATING REPLACEMENT, THE AGENT OR BROKER IS REQUIRED TO ASK YOU THE FOLLOWING QUESTIONS AND EXPLAIN ANY ITEMS THAT YOU DO NOT UNDERSTAND.

AS PART OF YOUR PURCHASE OF A NEW LIFE INSURANCE POLICY OR A NEW ANNUITY CONTRACT, HAS EXISTING COVERAGE BEEN, OR IS IT LIKELY TO BE:

(1) LAPSED, SURRENDERED, PARTIALLY SURRENDERED, FORFEITED, ASSIGNED TO THE INSURER REPLACING THE LIFE INSURANCE POLICY OR ANNUITY CONTRACT , OR OTHERWISE TERMINATED? ☐ YES ☐ NO

(2) CHANGED OR MODIFIED INTO PAID-UP INSURANCE; CONTINUED AS EXTENDED TERM INSURANCE OR UNDER ANOTHER FORM OF NONFORFEITURE BENEFIT; OR OTHERWISE REDUCED IN VALUE BY THE USE OF NONFORFEITURE BENEFITS, DIVIDEND ACCUMULATIONS, DIVIDEND CASH VALUES OR OTHER CASH VALUES? ☐ YES ☐ NO

(3) CHANGED OR MODIFIED SO AS TO EFFECT A REDUCTION EITHER IN THE AMOUNT OF THE EXISTING LIFE INSURANCE OR ANNUITY BENEFIT OR IN THE PERIOD OF TIME THE EXISTING LIFE INSURANCE OR ANNUITY BENEFIT WILL CONTINUE IN FORCE? ☐ YES ☐ NO

(4) REISSUED WITH A REDUCTION IN AMOUNT SUCH THAT ANY CASH VALUES ARE RELEASED, INCLUDING ALL TRANSACTIONS WHEREIN AN AMOUNT OF DIVIDEND ACCUMULATIONS OR PAID-UP ADDITIONS IS TO BE RELEASED ON ONE OR MORE OF THE EXISTING POLICIES? ☐ YES ☐ NO

(5) ASSIGNED AS COLLATERAL FOR A LOAN OR MADE SUBJECT TO BORROWING OR WITHDRAWAL OF ANY PORTION OF THE LOAN VALUE, INCLUDING ALL TRANSACTIONS WHEREIN ANY AMOUNT OF DIVIDEND ACCUMULATIONS OR PAID-UP ADDITIONS IS TO BE BORROWED OR WITHDRAWN ON ONE OR MORE EXISTING POLICIES? ☐ YES ☐ NO

(6) CONTINUED WITH A STOPPAGE OF PREMIUM PAYMENTS OR REDUCTION IN THE AMOUNT OF PREMIUM PAID? ☐ YES ☐ NO

IF YOU HAVE ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, A REPLACEMENT AS DEFINED BY NEW YORK STATE INSURANCE REGULATION NO. 60 HAS OCCURRED OR IS LIKELY TO OCCUR AND YOUR AGENT OR BROKER IS REQUIRED TO PROVIDE YOU WITH A COMPLETED DISCLOSURE STATEMENT AND THE **IMPORTANT** NOTICE REGARDING REPLACEMENT OR CHANGE OF LIFE INSURANCE POLICIES OR ANNUITY CONTRACTS.

Date: _____ Signature of Applicant _____

Date: _____ Signature of Applicant _____

To the best of my knowledge, a replacement is involved in this transaction: ☐ YES ☐ NO

Date: _____ Signature of Agent or Broker: _____

Prudential

Corporate Offices
Newark, New Jersey 07102

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AS PART OF YOUR PURCHASE OF A NEW LIFE INSURANCE POLICY OR A NEW ANNUITY CONTRACT, HAS EXISTING COVERAGE BEEN, OR IS IT LIKELY TO BE:

(1) LAPSED, SURRENDERED, PARTIALLY SURRENDERED, FORFEITED, ASSIGNED TO THE INSURER REPLACING THE LIFE INSURANCE POLICY OR ANNUITY CONTRACT , OR OTHERWISE TERMINATED? ☐ YES ☐ NO

(2) CHANGED OR MODIFIED INTO PAID-UP INSURANCE; CONTINUED AS EXTENDED TERM INSURANCE OR UNDER ANOTHER FORM OF NONFORFEITURE BENEFIT; OR OTHERWISE REDUCED IN VALUE BY THE USE OF NONFORFEITURE BENEFITS, DIVIDEND ACCUMULATIONS, DIVIDEND CASH VALUES OR OTHER CASH VALUES? ☐ YES ☐ NO

(3) CHANGED OR MODIFIED SO AS TO EFFECT A REDUCTION EITHER IN THE AMOUNT OF THE EXISTING LIFE INSURANCE OR ANNUITY BENEFIT OR IN THE PERIOD OF TIME THE EXISTING LIFE INSURANCE OR ANNUITY BENEFIT WILL CONTINUE IN FORCE? ☐ YES ☐ NO

(4) REISSUED WITH A REDUCTION IN AMOUNT SUCH THAT ANY CASH VALUES ARE RELEASED, INCLUDING ALL TRANSACTIONS WHEREIN AN AMOUNT OF DIVIDEND ACCUMULATIONS OR PAID-UP ADDITIONS IS TO BE RELEASED ON ONE OR MORE OF THE EXISTING POLICIES? ☐ YES ☐ NO

(5) ASSIGNED AS COLLATERAL FOR A LOAN OR MADE SUBJECT TO BORROWING OR WITHDRAWAL OF ANY PORTION OF THE LOAN VALUE, INCLUDING ALL TRANSACTIONS WHEREIN ANY AMOUNT OF DIVIDEND ACCUMULATIONS OR PAID-UP ADDITIONS IS TO BE BORROWED OR WITHDRAWN ON ONE OR MORE EXISTING POLICIES? ☐ YES ☐ NO

(6) CONTINUED WITH A STOPPAGE OF PREMIUM PAYMENTS OR REDUCTION IN THE AMOUNT OF PREMIUM PAID? ☐ YES ☐ NO

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Date: _____ Signature of Applicant_____

Date: _____ Signature of Applicant_____

To the best of my knowledge, a replacement is involved in this transaction: ☐ YES ☐ NO

Date: _____ Signature of Agent or Broker: _____

Copies provided to Insurance Company, Agent, and Applicant

Prudential

Corporate Offices
Newark, New Jersey 07102

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(1) LAPSED, SURRENDERED, PARTIALLY SURRENDERED, FORFEITED, ASSIGNED TO THE INSURER REPLACING THE LIFE INSURANCE POLICY OR ANNUITY CONTRACT , OR OTHERWISE TERMINATED? ☐ YES ☐ NO

(2) CHANGED OR MODIFIED INTO PAID-UP INSURANCE; CONTINUED AS EXTENDED TERM INSURANCE OR UNDER ANOTHER FORM OF NONFORFEITURE BENEFIT; OR OTHERWISE REDUCED IN VALUE BY THE USE OF NONFORFEITURE BENEFITS, DIVIDEND ACCUMULATIONS, DIVIDEND CASH VALUES OR OTHER CASH VALUES? ☐ YES ☐ NO

(3) CHANGED OR MODIFIED SO AS TO EFFECT A REDUCTION EITHER IN THE AMOUNT OF THE EXISTING LIFE INSURANCE OR ANNUITY BENEFIT OR IN THE PERIOD OF TIME THE EXISTING LIFE INSURANCE OR ANNUITY BENEFIT WILL CONTINUE IN FORCE? ☐ YES ☐ NO

(4) REISSUED WITH A REDUCTION IN AMOUNT SUCH THAT ANY CASH VALUES ARE RELEASED, INCLUDING ALL TRANSACTIONS WHEREIN AN AMOUNT OF DIVIDEND ACCUMULATIONS OR PAID-UP ADDITIONS IS TO BE RELEASED ON ONE OR MORE OF THE EXISTING POLICIES? ☐ YES ☐ NO

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(6) CONTINUED WITH A STOPPAGE OF PREMIUM PAYMENTS OR REDUCTION IN THE AMOUNT OF PREMIUM PAID? ☐ YES ☐ NO

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Date: _____ Signature of Applicant_____

Date: _____ Signature of Applicant_____

To the best of my knowledge, a replacement is involved in this transaction: ☐ YES ☐ NO

Date: _____ Signature of Agent or Broker: _____

Copies provided to Insurance Company, Agent, and Applicant

Prudential

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

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

Policy number: _____

In order to evaluate your application for insurance, we request a sample of your bodily fluid(s) to test for the presence of antibodies to the Human Immunodeficiency Virus (HIV), also known as the AIDS virus. If the initial HIV test is positive for the presence of HIV antibodies, that test will be repeated. If the second test is also positive, a different test will be performed on the same bodily fluid(s) to make sure that the results of the preceding HIV tests were correct. These tests are very reliable and false positives are rare. All tests will be performed by a licensed laboratory.

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

Notification of Test Results

If your HIV test results are negative and/or your other test results fall within normal range, no routine notification will be sent to you. If, however, your HIV test results are positive or indeterminate, or the non-HIV test results fall outside of the normal range, you are entitled to that information if you so desire. Because a medically trained person should deliver that information so that you can understand clearly what the test results mean, you are asked to list your private physician, health care provider or another person to whom the Insurer will report the test results and who may explain their meaning.

Physician or other person to whom positive or indeterminate test results will be reported:

_____ _____

Name Address:

_____

City State Zip

Meaning of Positive HIV Test Result

The HIV 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. 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 or provide for further independent testing.

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.

For further information about AIDS, the meaning of HIV related test results and the availability and location of HIV counseling services call the New York State Department of Health toll-free Hotline number **1-800-541-AIDS**.

Consent for 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 of New Jersey
The Prudential Insurance Company of America
Corporate Offices, Newark, New Jersey

Policy number: _____

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Physician or other person to whom positive or indeterminate test results will be reported:

Name _____ Address: _____

City _____ State _____ Zip _____

Meaning of Positive HIV Test Result

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_____

Name of Proposed Insured *(please print)*

_____ _____

Signature of Proposed Insured or Parent/Guardian Date signed

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

NY Regulation 200 Information Request

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

POLICY NUMBER: ____________________

PROPOSED INSURED: ____________________

NY Regulation 200 requires the Company to request the following information prior to a policy's issuance to ensure that all benefits or other monies are distributed to the appropriate persons upon the death of the insured. This information is requested of every owner, additional insured and beneficiary listed on your application for life insurance.

Provide in the spaces below the following information, as applicable, for each proposed owner other than the primary proposed insured and beneficiary listed on your application for insurance: first, middle and last name; complete address with street, city, state and ZIP; date of birth; Social Security Number (SSN) or Tax Identification Number (TIN); home telephone number; cell telephone number; e-mail address. Also, if the application includes a Child Rider, the information is also requested for each proposed child.

Use additional copies of this form for additional beneficiaries, children proposed for coverage or proposed owners.

NOTE: THIS IS NOT A FORM TO REQUEST ANY CHANGES TO THE INFORMATION PROVIDED AS PART OF YOUR APPLICATION.

A. APPLICABLE TO ALL ENTITIES, INDIVIDUALS AND TRUSTS NAMED AS BENEFICIARIES ON THE APPLICATION

Beneficiary(ies):

Name: First: ____________ Middle: ____________ Last: ____________
Address: Street: ____________
City: ____________ State: ____________ ZIP: ____________
Home Phone: ____________ Cell Phone: ____________
e-mail address: ____________
Date of Birth: ____________ SSN/TIN: ____________ Relationship: ____________

Name: First: ____________ Middle: ____________ Last: ____________
Address: Street: ____________
City: ____________ State: ____________ ZIP: ____________
Home Phone: ____________ Cell Phone: ____________
e-mail address: ____________
Date of Birth: ____________ SSN/TIN: ____________ Relationship: ____________

Name: First: ____________ Middle: ____________ Last: ____________
Address: Street: ____________
City: ____________ State: ____________ ZIP: ____________
Home Phone: ____________ Cell Phone: ____________
e-mail address: ____________
Date of Birth: ____________ SSN/TIN: ____________ Relationship: ____________

Name: First: ____________ Middle: ____________ Last: ____________
Address: Street: ____________
City: ____________ State: ____________ ZIP: ____________
Home Phone: ____________ Cell Phone: ____________
e-mail address: ____________
Date of Birth: ____________ SSN/TIN: ____________ Relationship: ____________

B. ONLY PROVIDE THE FOLLOWING DETAILS FOR ANY CHILD(REN) UNDER A CHILD RIDER REQUESTED ON THE APPLICATION

Proposed Child(ren):

Name: First: _____ Middle: _____ Last: _____

Address: Street: _____

City: _____ State: _____ ZIP: _____

Home Phone: _____ Cell Phone: _____

e-mail address: _____

Date of Birth: _____ SSN: _____

Name: First: _____ Middle: _____ Last: _____

Address: Street: _____

City: _____ State: _____ ZIP: _____

Home Phone: _____ Cell Phone: _____

e-mail address: _____

Date of Birth: _____ SSN: _____

Name: First: _____ Middle: _____ Last: _____

Address: Street: _____

City: _____ State: _____ ZIP: _____

Home Phone: _____ Cell Phone: _____

e-mail address: _____

Date of Birth: _____ SSN: _____

C. COMPLETE ONLY IF THE OWNER IS TO BE OTHER THAN THE PRIMARY PROPOSED INSURED

Proposed Owner(s):

Name: First: _____ Middle: _____ Last: _____

Address: Street: _____

City: _____ State: _____ ZIP: _____

Home Phone: _____ Cell Phone: _____

e-mail address: _____

Date of Birth: _____ SSN/TIN: _____

Name: First: _____ Middle: _____ Last: _____

Address: Street: _____

City: _____ State: _____ ZIP: _____

Home Phone: _____ Cell Phone: _____

e-mail address: _____

Date of Birth: _____ SSN/TIN: _____

Name: First: _____ Middle: _____ Last: _____

Address: Street: _____

City: _____ State: _____ ZIP: _____

Home Phone: _____ Cell Phone: _____

e-mail address: _____

Date of Birth: _____ SSN/TIN: _____

Prudential

RIDER TO PROVIDE ACCELERATION OF DEATH BENEFIT DISCLOSURE

(BenefitAccess Rider)

Pruco Life Insurance Company
a Prudential Financial company

This Disclosure provides a summary of the important features of the BenefitAccess Rider ("Rider"). It does not alter any of the Rider's provisions. Eligibility and receipt of accelerated benefits provided by the Rider will be governed in full by the actual terms and provisions set forth in the Rider. Defined terms can be found at the end of this disclosure.

Notice to Buyer: The Rider may not cover all of the costs associated with the terminal or chronic illness of the Insured. The buyer is advised to review carefully the Rider benefits.

Exercise of an accelerated benefit option under the Rider will cause a reduction in, or elimination of, the contract's death benefit, cash value and loan value. Premiums or charges needed to keep the contract in force will also be reduced based on the reduced death benefit.

The benefits paid under the Rider are intended to be treated as accelerated death benefits under the Internal Revenue Code Section 101 (g)(1). Accelerated benefit payments due to chronic illness are subject to limits imposed by the federal government and any amounts received in excess of these limits are includable in gross income. The Rider is not intended to be a qualified long-term care insurance contract under section 7702B of the Internal Revenue Code nor is it intended to eliminate the need for insurance of these types. Any benefit received under the Rider may impact the recipient's eligibility for Medicaid or other government benefits. In some circumstances, accelerated benefits paid under the Rider may be taxable as income. We do not provide tax advice. We advise you to seek the help of a professional tax advisor for assistance with any questions you may have.

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1. What is an Accelerated Benefit?

The advance payment of some or all of the death proceeds payable under a life insurance policy when the Insured meets certain eligibility criteria.

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2. When am I eligible for Benefit Payments?

TERMINAL ILLNESS OPTION

You are eligible to receive an accelerated benefit under this option when you provide written certification by a licensed health care practitioner that the Insured is terminally ill, which means that the Insured has a medical condition that is reasonably expected to result in the Insured's death within six months or less. The following conditions must also have been met:

1. The contract must be in force and the Insured must be living;
2. You must submit a claim in a form that meets our needs;
3. We reserve the right to set a minimum of no more than $50,000 on the amount of the death benefit you may exercise under the option;
4. You must provide the consent, in writing, of any assignee and irrevocable beneficiary(ies) on the policy; and
5. You must send us the contract if we ask for it.

CHRONIC ILLNESS OPTION

You are eligible to receive an accelerated benefit under the Chronic Illness Option when we receive written certification by a licensed health care practitioner, prior to the start of every benefit year, that the Insured is chronically ill and not expected to recover during his or her lifetime. This means that the Insured is unable to perform (without substantial assistance from another individual) at least two activities of daily living for a period of at least ninety days due to a loss of functional capacity, or requires substantial supervision for protection from threats to health and safety due to severe cognitive impairment. The following conditions must also have been met:

1. The contract must be in force and the Insured must be living;
2. You must submit a claim in a form that meets our needs;
3. We have the right to complete, at our discretion and expense, a personal interview with and an assessment of the Insured, which may include examination or tests by a licensed health care practitioner of our choice;
4. We must receive authorization from the Insured to obtain copies of any relevant medical records that we require;
5. You must not have received a benefit payment under the Terminal Illness Option; and
6. You must provide the consent, in writing, of any assignee and irrevocable beneficiary(ies) on the policy.

We reserve the right to have the Insured examined, at our expense, by a licensed health care practitioner of our choice, while a claim is pending or during a benefit period, to ensure that the Insured is chronically ill as defined above. If there is a difference in opinion between the Insured's licensed health care practitioner and ours, eligibility will be determined by a third medical opinion provided by a licensed health care practitioner who is mutually agreed upon by the Insured and the Company.

We will send you a request for recertification (which you must complete and return to us prior to the start of the next benefit year) to satisfy us that the Insured continues to be eligible for benefit payment, otherwise, subsequent benefits under the Rider will be treated as a new claim.

NOTE: Accelerated benefits will be made available to you on a voluntary basis only and you are not eligible for benefits under either the Terminal Illness Option or the Chronic Illness Option if you are required by law or by a government agency to use the benefits for the following purposes: (a) To meet the claims of creditors, whether in bankruptcy or otherwise; and (b) To apply for, obtain, or keep a government benefit or entitlement.

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3. What amount can I accelerate and what are the benefit payment options?

TERMINAL ILLNESS OPTION

You have the option to accelerate all or a partial amount of the death benefit. If you accelerate a partial amount, the remaining death benefit must be no less than $25,000, and you may only make one additional acceleration, which must be for the full death benefit. The only payment option is a single lump sum benefit payment which will be determined based on the following factors: (1) The amount of the death benefit; (2) The Insured's reduced life expectancy; and (3) An interest rate no greater than the greater of: (a) the yield on 90-day Federal Treasury bills at the time the benefit is accelerated, and (b) the current maximum adjustable policy loan interest rate at the time the benefit is accelerated based on the greater of: (i) Moody's Corporate Bond Yield Average Corporates – published by Moody's investors Service, Inc, or any successor thereto, that is approved by the New York Superintendent of Insurance for the calendar month ending two months before the date of application for an accelerated payment, and (ii) the policy guaranteed cash value interest rate plus one percent per annum (1%). Payments will begin when we receive evidence, satisfactory to us, that the Insured is terminally ill and we have approved the claim.

If you accelerate a death benefit under this option, you will no longer be eligible for the Chronic Illness Option and any benefit payments you may be receiving under that option will end.

CHRONIC ILLNESS OPTION

The maximum amount of your life insurance that can be accelerated is the lifetime benefit amount, which is equal to the policy's basic insurance amount and will be fixed at the time you make your initial claim. This amount will not change after benefit payments begin, but it will be affected by any transactions that have been made that affect the basic insurance amount of your policy prior to the initial claim. After benefit payments begin, the portion of the lifetime benefit amount that remains will change to reflect payments that have been made.

You have the option to receive your benefit payments monthly or annually and payments will begin no later than the monthly date on or following the date the claim is approved.

If you choose to receive monthly benefit payments, the maximum monthly benefit payment for that year will be calculated at the beginning of each benefit year and recalculated at the beginning of each subsequent benefit year. Subject to a minimum payment of $500, you have the option to receive less than the maximum monthly benefit payment amount, but the amount may not be changed during the benefit year. An amount that is less than the maximum may extend your payment period.

The first benefit payment will be made no later than the monthly date on or after we approve the claim and will continue to be made until the earliest of: (1) You discontinue benefit payments; (2) The Insured no longer meets the eligibility requirements, including recertification; (3) The lifetime benefit amount is exhausted; (4) A claim is approved under the Terminal Illness Option; or (5) the Rider terminates.

The Rider terminates when you request that we remove it, the grace period ends if the contract is in default, the Insured dies; or the Rider or contract ends for any other reason. When the Rider is terminated, or you request that we stop benefit payments after a claim has been made, the policy may still be in force. Your death benefit and policy values will have been reduced as a result of any payments made prior to the date we stop payments or the Rider terminates. If you request that we discontinue benefit payments, you will have the option to resume payments at a later date, if you meet all eligibility requirements.

If you choose to receive your benefit payments on an annual basis, the annual benefit payment will equal the sum of the present value of each maximum monthly benefit payment for the benefit year.

If the policy is in default but not past the grace period at the time of claim, the first benefit payment will be reduced by the amount needed to bring the contract out of default (see Default). If the amount needed to bring the policy out of default is more than the amount of the first benefit payment net of the amount allocated to reduce any policy loan, the first benefit payment will be increased to an amount that will bring the policy out of default.

Under either the Terminal Illness Option or the Chronic Illness Option, if there is an outstanding loan on the contract, a portion of each benefit payment will be used to reduce the loan.

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4. What are the Rider Charges?

TERMINAL ILLNESS OPTION

There is no monthly charge, however, when we make a benefit payment under this option, we will deduct a processing charge of up to $150.

CHRONIC ILLNESS OPTION

Each month, we will deduct a charge for the chronic illness coverage of this Rider from the contract fund and, if your contract includes the Rider To Provide Lapse Protection, from the no-lapse contract fund. The monthly charge is equal to the product of the factors A, B, and C, where: (A) Equals the cost of insurance rate per $1,000 for this Rider; (B) Equals the Benefit Size Discount Factor; and (C) Equals the Rider amount at risk (equals the lifetime benefit amount minus the contract fund) divided by $1,000.

If your contract includes the Rider To Provide Lapse Protection, the monthly charge for the Rider will be deducted from the no-lapse contract fund using the no-lapse amount at risk (which equals the lifetime benefit amount minus the no-lapse contract fund), the Benefit Size Discount Factor, and the no-lapse cost of insurance charges for this rider.

Under either the Terminal Illness Option or the Chronic Illness Option, all Rider charges will end if the contract to which this Rider is attached ends, you request that we remove the Rider, an acceleration of death benefit is made due to terminal illness, or the Insured dies.

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5. How will accelerations under the TERMINAL ILLNESS OPTION impact my contract and riders?

- A one-time acceleration of a partial amount of the death benefit results in the following:

  a. A proportionate reduction in the basic insurance amount, death benefit, contract fund, surrender charge, no-lapse contract fund and contract debt;
  b. Premiums or charges to keep the policy in force will be recalculated based on the Insured's age and the reduced death benefit amount;
  c. If your contract includes the Rider To Provide Lapse Protection or the Rider for Level Term Insurance Benefit on Dependent Children, these riders will stay in effect; and
  d. Any accidental death benefit rider on the contract will not be affected.

- Acceleration of the full death benefit results in the following:

  a. The policy and all benefits under the contract based on the Insured's life, including any accidental death benefit rider, will end; and
  b. If your contract includes the Rider for Level Term Insurance Benefit on Dependent Children, it will become paid up.

Shown below is an **example** of how an accelerated benefit under the Terminal Illness Option will impact the Policy. The figures used are for illustrative purposes only and are not guaranteed.

Sex & Issue Age:	Male 45	**Rating:**	Preferred Best
Policy Date:	12/20/2013	**Claim Date:**	12/20/2023

	Contract Values as of 12/20/2023 before Acceleration of Death Benefit:	**Contract Values as of 12/20/2023 after Acceleration of Death Benefit:**	
		100% of Death Benefit	**50% of Death Benefit**
Terminal Illness Benefit payable:		$191,260	$ 95,555
Basic Insurance Amount:	$200,000	$ 0.00	$100,000
Loan Balance:	$ 1,040	$ 0.00	$ 520
Death Benefit:	$198,960	$ 0.00	$ 99,480
Contract Fund:	$ 12,200	$ 0.00	$ 6,100
Surrender Charge:	$ 860	$ 0.00	$ 430
Cash Value:	$ 11,340	$ 0.00	$ 5,670
Net Cash Value:	$ 10,300	$ 0.00	$ 5,150
Annual Premium:	$ 1,588	$ 0.00	$ 857

A six-month discount at an annual rate of 8% has been applied for early payment. A processing charge of $150 has been deducted following each acceleration.

6. How will accelerations under the CHRONIC ILLNESS OPTION impact my contract and riders?

Accelerating the death benefit under this option will impact the benefits and values under the policy and Rider as shown below based on the following information and the **example** below. The figures used are for illustrative purposes and are not guaranteed.

Sex & Issue Age:	Male 45	**Rating:**	Preferred Best
Policy Date:	07/01/2013	**Claim Date:**	10/04/2016
Basic Insurance Amount:	$500,000		

Lifetime Benefit Amount is equal to the Basic Insurance Amount at the time of initial claim.

Maximum Monthly Benefit Payment calculated at the beginning of each year using the Internal Revenue Service's (IRS) per diem limitation and your lifetime benefit amount, is equal to the **lowest** of :

1. The lifetime benefit amount multiplied by the Monthly Benefit Percent (2%): $500,000 x 0.02 = **$10,000**;
2. Per diem limitation (a maximum allowable amount declared annually by the IRS for chronic illness payments under section 7702B) in effect at the start date of the current benefit year ($320 for 2013) times 30: $320 x 30 = **$9,600**; and
3. Initial Daily Benefit Limit (which is the per diem limitation in effect on the contract date) compounded annually on each anniversary at the Daily Benefit Limit Compound Rate times 30. This limit o**n the** policy date was $320, increased annually on each succeeding policy anniversary by the daily benefit limit compound rate, resulting in a current daily benefit limit in policy year 4 of $359.96: $359.96 x 30 = **$10,798.80**.

The Monthly Benefit Percent, Initial Daily Benefit Limit and the Daily Benefit Limit Compound Rate can be found in the policy.

Following each benefit payment while there is a death benefit remaining, benefits and values under the policy and Rider will be impacted as follows:

a. The policy will remain in force in accordance with policy terms, with a proportionate reduction (using the reduction factor), in the basic insurance amount, contract fund, surrender charges, no-lapse contract fund (if applicable), and any outstanding loan;
b. Any accidental death benefit rider on the contract will not be affected;
c. If your contract includes the Rider To Provide Lapse Protection or the Rider for Level Term Insurance Benefit on Dependent Children, these riders will stay in effect;
d. You may not take a withdrawal or decrease the policy's basic insurance amount;
e. You may continue to make premium payments but it is not necessary while you are receiving benefits;
f. The monthly charge for the Rider will be permanently waived following approval of the initial claim; and
g. While you are receiving benefit payments, all monthly charges deducted from the contract fund and no-lapse contract fund, if applicable, will be waived in order to prevent the policy from going into default. We will do so until you notify us to discontinue benefit payments, the Insured fails to recertify, or the Rider terminates. Once you have received 25 monthly benefit payments or the annual equivalent, all monthly charges for the contract will be permanently waived as long as this Rider is in effect.

The reduction factor equals 1 minus the quotient of the gross chronic illness benefit payment divided by the death benefit prior to payment): 1 - (9,600/500,000) = 1 - 0.0192 = 0.9808

The Chronic Illness Benefit payable is equal to the Maximum Monthly Benefit Payment minus the loan amount. ($9,600 - $20 = $9,580)

	Contract Values as of 10/04/2016 *before* Acceleration of Death Benefit:	**Contract Values as of 10/04/2016 *after* Acceleration of Death Benefit:**	
Chronic Illness Benefit payable:		$ 9,580	
Basic Insurance Amount:	$500,000	$490,400	(500,000x0.9808)
Loan Balance:	$ 1,040	$ 1,020	(1,040x0.9808)
Death Benefit:	$498,960	$489,380	
Contract Fund:	$ 20,000	$ 19,616	(20,000x0.9808)
Surrender Charge:	$ 3,350	$ 3,286	(3,350x0.9808)
Cash Value:	$ 16,650	$ 16,330	
Net Cash Value:	$ 15,610	$ 15,310	
Annual Premium:	$ 3,816	$ 3,738	

When you receive monthly benefit payments the remaining amount that can be accelerated will be reduced each month by the amount of the monthly benefit payment. An annual benefit payment will reduce the remaining amount by twelve times the maximum monthly benefit payment amount for that benefit year.

After an acceleration of the lifetime benefit amount, any Rider for Level Term Insurance Benefit on Dependent Children will become paid up and any benefits under the contract based on the Insured's life, including any accidental death benefit rider will end.

DEFINITIONS

Activities of Daily Living - include the following activities: Bathing – which means washing oneself by sponge bath or in either a tub or shower. Continence – which means the ability to maintain control of bowel or bladder function, or when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene, including caring for a catheter or colostomy bag. Dressing – which means putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs. Dressing does not include putting on or tying shoes. Eating – which means feeding oneself by getting food into the body from a receptacle, such as a plate, cup, or table or by a feeding tube or intravenously. Eating does not include preparing a meal. Toileting – which means getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene. Transferring - which means moving into or out of a bed, chair or wheelchair. Transferring does not include the task of getting into and out of the tub or shower.

Benefit Payment - the periodic or lump sum payment of the accelerated benefit under the Rider.

Benefit Year - a period of twelve months that begins on the monthly date on or following the date you have satisfied all conditions for eligibility, including recertification. Subsequent benefit years will begin no earlier than the end of the current benefit year.

Benefit Size Discount Factor – a discount factor applies to policies with high basic insurance amount.

Licensed Health Care Practitioner - a physician (as defined in section 1861(r)(1) of the Social Security Act) and any registered professional nurse, licensed social worker or other individual who meets such requirements as may be prescribed by the Secretary of Treasury, residing and practicing in the United States, legally authorized to practice medicine by the State in which he/she performs such function or action and who is acting within the scope of his/her license when he/she performs such function. May not be the Insured, the policyowner, or a family member of the policyowner or Insured.

Lifetime Benefit Amount - the maximum amount that can be accelerated during the lifetime of the Insured under the Chronic Illness Option of the Rider. For purposes of benefit payments, it is fixed at time of initial claim.

Maximum Monthly Benefit Payment - the maximum amount that may be paid to you on a monthly basis once a claim has been approved. This payment amount will be recalculated at the beginning of every benefit year.

Plan of Care - means a written plan for care designed especially for a chronically ill individual by a licensed health care practitioner. The plan of care should recommend the frequency and type of services most suitable to meet the chronically ill individual's need for substantial assistance or substantial supervision and the most appropriate type of providers for such services.

Recertification - means written documentation in a form satisfactory to us completed by a licensed health care practitioner, at your or the Insured's expense, certifying that the Insured continues to meet all eligibility requirements. Recertification must be received prior to the start of each benefit year following the initial benefit year in order for you to continue receiving benefit payments under the Chronic Illness Option.

Services - means the necessary diagnostic, preventive, curing, treating, mitigating and rehabilitative services, and maintenance or personal care services which are required by a chronically ill individual and are provided pursuant to a plan of care prescribed by a licensed health care practitioner.

Substantial Assistance - means hands-on assistance from another person without which an individual receiving such assistance would be unable to perform the activity of daily living. Hands-on assistance means the direct physical assistance of another person.

Substantial Supervision - means requiring continual supervision by another person to protect the individual from threats to health or safety due to severe cognitive impairment and may include cueing by verbal prompting, gestures, or other similar demonstrations.

Written Certification - means written documentation in a form satisfactory to us from a licensed health care practitioner, at your or the Insured's expense, certifying that the Insured is terminally ill or chronically ill as defined in this disclosure. Certification for chronically ill insureds must indicate whether the Insured has a plan of care.

POLICY NUMBER (IF KNOWN) _____

PROPOSED INSURED: _____

ACKNOWLEDGEMENT

Producer's Statement

I acknowledge that the Disclosure for the Rider to Provide Acceleration of Death Benefit was provided to the policy owner(s) prior to or concurrently with the application for life insurance for the proposed Insured.

Signature of Producer: _____ Date Signed _____

Policyowner(s) Acknowledgement:

I confirm that I have read and received a copy of the Disclosure for the Rider to Provide Acceleration of Death Benefit (ORD 115170-2013) and I understand the provisions explaining the following:

- **There is a monthly charge for chronic illness coverage that is deducted from the contract fund. That monthly charge will be permanently waived following approval of the initial chronic illness claim. There is no monthly charge for the terminal illness coverage. If I accelerate a death benefit and receive benefit payments under the terminal illness option, a processing charge will be deducted and any charges for the Rider, including the monthly charge for chronic illness coverage, will end.**

- **Exercise of an accelerated benefit option under the Rider will cause a reduction in, or elimination of, the contract's death benefit, cash value and loan value. Premiums or charges needed to keep the contract in force will also be reduced based on the reduced death benefit.**

- **Any benefit I receive under the Rider may impact my eligibility for Medicaid or other government benefits.**

- **Any accelerated benefits paid under the Rider may be taxable as income and I am advised to seek the help of a professional tax advisor if I have any questions.**

Signature of Policyowner: _____ Date Signed _____

Signature of Policyowner: _____ Date Signed _____

Signature of Policyowner: _____ Date Signed _____

Signature of Policyowner: _____ Date Signed _____