



POLICY DELIVERY STATE: _____

DATE AUTHORIZATION (LIMITED INSURANCE AGREEMENT FOR PREPAID BUSINESS) SIGNED: _____

A. CASE DETAILS

1. General agency contract number: _____

B. PROPOSED INSURED (POLICYOWNER UNLESS OTHERWISE NAMED)

1. Name: _____

2. Social Security number: _____ 3. Gender: Female Male 4. Date of birth: ____ / ____ / ____

5. Date policy to Save Age? Yes No

6. Driver's license issuing state: _____ Number: _____ Expiration date: _____

If None, why not?: _____

7. Residence address (No PO boxes): Street _____ Apt _____

City _____ State _____ ZIP _____

8. If the mailing address is different than the residential address: _____ Apt _____

City _____ State _____ ZIP _____

9. e-mail address: _____

10. Is the proposed insured a permanent, legal U.S. resident? Yes No

If No, provide: Country of legal residence: _____ Length of U.S. residence: _____

Type of visa: _____ Visa number: _____ Expiration date: _____

11. Earned annual income: \$ _____ Unearned annual income: \$ _____ Net worth: \$ _____

12. Is anyone dependent on the proposed insured for financial support? Yes No

C. CLIENT INTERVIEW (SEE INSTRUCTIONS FOR SCHEDULING GUIDELINES.) PHONE INTERVIEWS CONDUCTED M-F 9 A.M. TO 9 P.M.

1. Contact phone numbers: Home: _____

Business: _____ Alternate: _____

Preferred contact number: Check one: Home Business Alternate

2. Best time to call (select one): Morning Afternoon Evening

3. If the proposed insured is younger than 18 years old, who will be completing the callback?: Parent Guardian

Name: _____

4. Special needs (hearing impaired, translator needed): _____

5. Do you plan on submitting, or have you recently submitted worksheets that are related to this one? Yes No

If Yes, provide names: _____

D. PLAN OF INSURANCE

1. Amount of insurance applied for: \$ _____

- 2. Product applied for: Term Essential®: 10 15 20 30 PruLife® Custom Premier II (PCP II)
 Term Elite®: 10 15 20 30 VUL ProtectorSM (VULP)
 ROP Term: 15 20 30 PruLife® Universal Life Plus (UL Plus)
 PruTerm WorkLife 65SM (includes Insured's Waiver of Premium Benefit) PruLife® Universal Life Protector (UL Protector)
 PruLife® Founders Plus (PFP) PruLife® Index Advantage (IAUL)
 Other: _____

3. For UL and VUL products only: Death Benefit type:
 Type A (Level) Type B (Variable)-N/A for UL Protector Type C (Return of Premium)-N/A for IAUL, UL Protector & VULP-Interest rate: _____%

4. For UL and VUL products only: Definition of life insurance:
 Cash Value Accumulation Test (CVAT) Guideline Premium Test (GPT)

- 5. Requested Optional Benefits (Not all benefits are available for all products.):
 Waiver of Premium/Enhanced Disability Benefit Overloan Protection Rider
 Acceleration of Death Benefit (Living Needs Benefit) Child Rider: Amount \$ _____
 Accidental Death Benefit: Amount \$ _____ Automatic Premium Loan
 BenefitAccess Rider Enhanced Cash Value Rider
 Other Riders/Benefits (indicate amount where applicable): _____



E. PREMIUM

1. Send notices (check one): Policyowner Other recipient: _____
 Send notices (check one): Policyowner's residence Other address:
 Street _____ Apt _____
 City _____ State _____ ZIP _____
2. Premium payment mode: Annually Semiannually Quarterly Monthly – Electronic Funds Transfer (EFT)
3. For non-term plans, billed premium: \$ _____

F. BENEFICIARY DETAILS

If beneficiary is a trust, provide name of trust and trustee(s), date of trust and if trust is revocable or irrevocable. If beneficiary is a business, list name of business, city and state where located and the form of business.

Name: First	Middle	Last	Relationship to Proposed Insured	Age	Beneficiary Class	
					Primary	Secondary/Contingent
_____	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>

G. INSURANCE HISTORY

1. Do you have any existing life insurance or annuities? Yes No
 Note: Existing coverage includes any life insurance policies that have been assigned, sold or transferred.
2. Will this insurance replace* any existing insurance or annuity? Yes No
3. List the following details for all existing coverage. (List only annuities to be replaced*, list all in force life insurance.):

Insurance Company	Face Amount	Type	Product	To Be Replaced?*	1035 Exchange?
a. _____	\$ _____	<input type="checkbox"/> Group <input type="checkbox"/> Individual	<input type="checkbox"/> Annuity <input type="checkbox"/> Life	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>If Replacement, policy number:</i> _____					
b. _____	\$ _____	<input type="checkbox"/> Group <input type="checkbox"/> Individual	<input type="checkbox"/> Annuity <input type="checkbox"/> Life	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>If Replacement, policy number:</i> _____					
c. _____	\$ _____	<input type="checkbox"/> Group <input type="checkbox"/> Individual	<input type="checkbox"/> Annuity <input type="checkbox"/> Life	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>If Replacement, policy number:</i> _____					
d. _____	\$ _____	<input type="checkbox"/> Group <input type="checkbox"/> Individual	<input type="checkbox"/> Annuity <input type="checkbox"/> Life	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>If Replacement, policy number:</i> _____					
e. _____	\$ _____	<input type="checkbox"/> Group <input type="checkbox"/> Individual	<input type="checkbox"/> Annuity <input type="checkbox"/> Life	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>If Replacement, policy number:</i> _____					

*Replace or replaced means that the insurance being applied for may replace or cause a change in any existing insurance or annuity with any company, including the lapse or surrender of the existing policy, or the use of funds or values from the existing policy to pay for the new policy.

CA ONLY: Complete when requesting BenefitAccess Rider (BAR).

4. Will this rider replace any existing long-term care coverage presently in force? Yes No
If Yes, provide name of Company being replaced. _____
5. Will this rider replace any existing Acceleration of Death Benefit coverage presently in force? Yes No
If Yes, provide name of Company being replaced. _____

OH JUVENILE (AGE 0 - 17) ONLY:

6. Is the proposed owner considering the transfer or sale to an investor or other third party of: policy ownership; or, any interest in the policy benefits, either directly or indirectly as a beneficiary or owner of a trust or other entity? Yes No
If Yes, provide details: _____
7. Has the proposed owner been offered any money or other considerations by any person or entity in connection with this application? Yes No
If Yes, provide details: _____

All other states:

8. Is the proposed insured or proposed owner considering the transfer or sale to a life settlement company or other investor of: policy ownership; or, any interest in the policy benefits, either directly as a named beneficiary or indirectly as a beneficiary or owner of a trust or other entity? **In LA: If YES, always complete Section J (Policyowner Statement).** Yes No
If Yes, provide details: _____

G. INSURANCE HISTORY (CONTINUED)

NY ONLY: Complete when requesting BenefitAccess Rider (BAR).

9. Do you have any other accident and health care insurance policy, accelerated death benefit policy or rider, long term care insurance, nursing home insurance, home care insurance or long term care insurance provided under the Partnership for Long Term Care Program as defined by New York law? Yes No
10. Is this rider intended to replace the coverage identified in #9 above? Yes No
11. List the following details for all existing coverage:
- a. Company: _____ To Be Replaced?
 Policy/Certificate Number: _____ Amount: _____ Yes No
 Type of Benefit: Long Term Care Insurance provided under the Partnership for Long Term Care Program
 Accident and Health Care Insurance Accelerated Death Benefit Policy or Rider
 Long Term Care Insurance Nursing Home Insurance
 Home Care Insurance
- b. Company: _____ To Be Replaced?
 Policy/Certificate Number: _____ Amount: _____ Yes No
 Type of Benefit: Long Term Care Insurance provided under the Partnership for Long Term Care Program
 Accident and Health Care Insurance Accelerated Death Benefit Policy or Rider
 Long Term Care Insurance Nursing Home Insurance
 Home Care Insurance
- c. Company: _____ To Be Replaced?
 Policy/Certificate Number: _____ Amount: _____ Yes No
 Type of Benefit: Long Term Care Insurance provided under the Partnership for Long Term Care Program
 Accident and Health Care Insurance Accelerated Death Benefit Policy or Rider
 Long Term Care Insurance Nursing Home Insurance
 Home Care Insurance

H. TAX CERTIFICATION

1. Back-up withholding (select one):
 The policyowner is subject to backup withholding under Section 3406(a)(1)(C) of the Internal Revenue Code.
 The policyowner is **NOT** subject to backup withholding under Section 3406(a)(1)(C) of the Internal Revenue Code.
2. The policyowner is a U.S. person (including a U.S. resident alien). Yes No

I. FINANCIAL DETAILS (COMPLETE FINANCIAL SUPPLEMENT WITH FACE AMOUNTS OF \$5,000,000 OR MORE UP TO AGE 70, \$2,500,000 OR MORE AGES 71-80, \$1,000,000 OR MORE AGES 81 AND UP.)

Submit copies of material that supplements the information requested, such as loan commitments, written buy-sell agreements, audited financial statements or letters.

Financial Information

1. Source of Financial Information. (Check all that apply.):
 Proposed Insured Accountant/CPA Banker Attorney Producer Other: _____
2. Who determined the amount of insurance applied for? (Check all that apply.)
 Proposed Insured Accountant/CPA Banker Attorney Producer Other: _____
3. Current Annual Household Income:
 a. Gross Compensation (e.g., Salary, Commissions, Bonuses, etc.): \$ _____
 b. Other Income (e.g., Dividends, Interest, Net Real Estate Income, etc.): \$ _____
 c. Total Annual Cash Income before taxes: \$ _____
4. Net Worth (excluding any business interest)
 a. Liquid Assets (assets that can be easily changed to cash): \$ _____
 b. Other Assets: \$ _____
 c. Liabilities: \$ _____
 d. Net Worth (excluding business): \$ _____
5. Business Related Assets: \$ _____

I. FINANCIAL DETAILS (CONTINUED)

6. Have either the Proposed Insured or owner filed for bankruptcy within the past five years? Yes No

If Yes, please provide details including whether bankruptcy was dismissed or discharged; type of bankruptcy (chapter); whether it was personal or business related; current status; single or multiple occurrences; any outstanding judgments, liens or garnishments, etc :

Additional comments: _____

J. POLICYOWNER STATEMENT

OH ONLY: FOR UL AND VUL: COMPLETE IF PROPOSED INSURED IS AGE 18 OR ABOVE & FACE AMOUNT OF \$50,000 AND ABOVE.

FOR TERM: COMPLETE IF PROPOSED INSURED IS AGE 70 OR ABOVE & FACE AMOUNT OF \$1,000,000 AND ABOVE.

ALL OTHER STATES: COMPLETE IF PROPOSED INSURED IS AGE 70 OR ABOVE & FACE AMOUNT OF \$1,000,000 AND ABOVE FOR UL AND TERM.

Prudential will not knowingly participate in a life insurance sale where the sale of the policy in a secondary market or the participation of investors in the policy death benefits is being considered.

1. Has the policyowner or the proposed insured been offered "free insurance" or any inducement such as a cash payment, gifts, loan proceeds in excess of the amount necessary to fund the policy, or anything else of value as an encouragement to apply for this life insurance policy? Yes No

2. **Not applicable in LA:** Has the policyowner or the proposed insured been solicited to sell or transfer, or had any discussions about selling any of the following to a life settlement company or group of investors in the next five years: the proposed life insurance policy; any other life insurance policy on the life of the proposed insured; or, a trust, limited liability company or other entity that has been or will be established to own the policy? Yes No

3. Has the policyowner or the proposed insured entered into or been offered a financing arrangement where a lender or other third party, other than your employer or family member, will receive any portion of the death benefit of the policy applied for in excess of repayment of the principal and interest Yes No

If Yes to questions 1, 2, or 3, please provide details.

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

For multiple owners, list details in Remarks.

1. Name of owner: _____

2. Social Security/Tax identification number (SSN/TIN): _____

3. Residence address (No PO boxes): Street _____ Apt _____
City _____ State _____ ZIP _____

4. If the mailing address is different than the residential address: _____ Apt _____
City _____ State _____ ZIP _____

5. Owner's email address: _____

6a. 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

6b. For business owner:

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

6c. For personal owner:

Total insurance program: Currently in-force: \$ _____ Pending applications: \$ _____

Relationship to Proposed Insured: _____ Date of birth: ____ / ____ / ____

Earned annual income: \$ _____ Unearned annual income: \$ _____ Net worth: \$ _____

Why will this person own the contract?

Business Insurance Estate Tax Support for Insured
 Final Expenses Other _____

(CONTINUED)

L. BUSINESS INFORMATION (COMPLETE THIS SECTION WHEN THE APPLICATION IS FOR BUSINESS INSURANCE.)

Submit copies of material that supplements the information requested, such as loan commitments, written buy-sell arrangements, audited financial statements or letters.

1. Source of Financial Information. (Check all that apply.):

Proposed Insured Accountant/CPA Banker Attorney Producer Other: _____

2. Who determined the amount of insurance applied for? (Check all that apply.)

Proposed Insured Accountant/CPA Banker Attorney Producer Other: _____

3. Name of company: _____

4. When was the business established? (mm/yyyy) _____ / _____

5. The Proposed Insured is an: Employee Owner If owner, percentage of ownership: _____%

6. List amount of business insurance in force & applied for in all companies on each officer/member of the business.

Name	Age	Ownership %	In force Amount	Amount Applied For
_____	_____	_____ %	\$ _____	\$ _____
_____	_____	_____ %	\$ _____	\$ _____
_____	_____	_____ %	\$ _____	\$ _____
_____	_____	_____ %	\$ _____	\$ _____

7. Purpose: (Check all that apply and answer all supplemental questions.)

a. Buy-Sell Arrangement

1. Is there a written buy-sell agreement? Yes No

2. Are all other parties to agreement already covered by or applying for comparable amounts of insurance? Yes No

If No, explain : _____

b. Key Person

1. Are all other key persons covered by or applying for comparable amounts of insurance? Yes No

If No, explain : _____

2. Why is the Proposed Insured considered "key"? (Detail special skills/knowledge/ability.)

c. Business Loan Collateral

1. Is the insurance required by the creditor? Yes No

2. Is the Proposed Insured personally responsible for the loan? Yes No

3. Name of creditor/lending institution: _____

4. What is the purpose of the loan? _____

5. What is the amount of the loan? \$ _____

6. What is the repayment schedule? _____

7. Date loan was committed: _____ / _____ / _____

If not yet committed, please explain : _____

8. What is the total fair market value of the business? \$ _____

9. Business values:

Assets: \$ _____ Gross annual sales and/or revenue: \$ _____

Liabilities: \$ _____ Net profit after taxes: \$ _____

10. Additional comments: _____



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

For Life New Business only

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

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

CLIENT INFORMATION

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

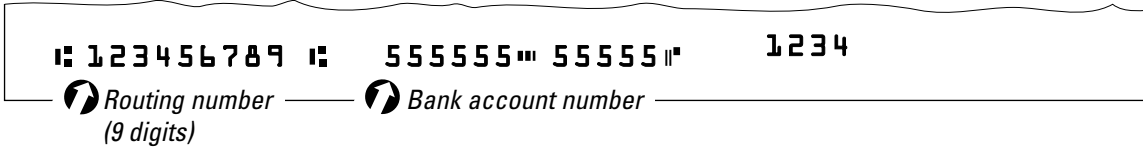
Policy number _____

INSTRUCTIONS

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

Please follow these steps:

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



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

1 INITIAL PREMIUM (E-PAY) INFORMATION

Account owner type: Individual Corporate Trust Other _____

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

Address _____

City/State/ZIP code _____

Bank Information

Account type: Savings Checking Withdrawal amount \$ _____

Name of financial institution _____ Telephone number _____

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

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

ORD 114416 Ed. 8/2009



2 MONTHLY ELECTRONIC FUNDS TRANSFER (EFT) INFORMATION

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

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

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

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

Account owner type: Individual Corporate Trust Other _____

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

Address _____

City/State/ZIP code _____

Bank Information

Account type: Savings Checking

Name of financial institution _____ Telephone number _____

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

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

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

For Initial Premium E-Pay

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

For Monthly EFT

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

For Initial Premium E-Pay or Monthly EFT

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

X

Account owner's signature

Date (month/day/year)

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

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION



Producer Resources Inc.

Proposed Insured's Name	Date of Birth	Social Security Number	This form is HIPAA Compliant
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Records and information obtained from the Proposed Insured or other parties may be disclosed to and between the insurance companies or the insurance agencies list below, **Producer Resources, Inc.**, brokers, contractors, employees, representative and agents working through **Producer Resources, Inc.** for the Proposed Insured applying for or evaluating insurance coverage

Insurance Companies and Agencies			
Accordia	First Global Financial & Insurance	Metropolitan Life	Producer Resources Inc.
Advantage Insurance Network, Inc.	First Insurance Funding	MetLife Investors USA Ins. Co.	Professional Underwriting Services
Allianz	First Penn	Minnesota Life/Securian	Protective Life Ins. Co
American General Life (AIG)	Foresters	Mutual of Omaha	Prudential Life Ins. Co/ Pruco Life
American National	General American Life Ins. Co.	National Life of Vermont	RSA Medical
Americo	Global Insurance Underwriters	National Western	SBLI
Assurity Life	GE Financial Assurance Co.	Nationwide Life & Annuity Co.	Security Mutual
Aviva/Indianapolis Life	Genworth Life Insurance Co.	New Investor World, Inc.	Standard Life
Ameritas	Genworth Life and Annuity	New York Life Insurance Co.	Superior Medical Group
AVS, LLC	Guardian Life Ins. Co	North American Co.	Symetra Financial
AUS Underwriting	ING – ReliaStar	One America	Transamerica Life Ins. Co.
AXA/MONY/AXA Equitable	John Hancock Life Ins. Co.	Pacific Life	Travelers Life & Annuity
Banner Life	John Hancock USA	Penn Mutual	21 st Services
AIN Member Firm	Lafayette Life	Premium Funding Group (PFG)	Union Central Life
Columbus Life	Life Insurance of the Southwest	Pioneer Mutual	United of Omaha
Concord Capital/INSCAP	LifeShare	Portamedic	USG Annuity & Life
Coventry First, LLC	Lincoln Financial/Lincoln Life	Presidential Life	Voya
EMSI	Lincoln National Life Ins. Co.	Principal Life Insurance Company	West Coast Life Insurance Co.
Equity Key, LLC	Massachusetts Mutual	Principal National Life Ins. Co.	Western Reserve Life
Equity Release			William Penn Life Ins. Co.
Fidelity & Guaranty Life Ins. Co.			Zurich American Life Ins. Co.

Additional Insurers and Agencies:
Broker/Agent/Financial Professional:

The purpose of this Authorization is to assist in the evaluation and placement of my application for insurance. I hereby authorize the release of any and all records and information regarding me, the proposed insured, pursuant to this Authorization. This includes, without limitation, any and all records and protected health information regarding diagnosis, testing, treatment and prognosis of my physical or mental condition, with the exclusion of psychotherapy notes. Such records and information to be release may include, but are not limited to, facts about my: (1) mental and physical health; (2) alcohol/drug abuse treatment, (3) pharmacy prescriptions, (4) HIV testing and treatment, except where prohibited by law, (5) sexually transmitted diseases, (6) Sickle Cell testing and treatment, (7) laboratory test results, (8) other insurance coverage, (9) hazardous activities, (10) character, (11) general reputation, (12) mode of living, (13) finances, (14) occupation, and (15) other personal traits.

I understand that any Insurer or Agency named afore, its reinsurers, and insurance support organizations, and those persons authorized to represent them may need to collect such information for proposed insurance coverage. The Insurers and Agencies named afore and their reinsurers will use the information in order to determine whether I am insurable or to assist in the application and underwriting process. The insurance producer may also use the information to help update and improve my insurance program.

I hereby authorize any medical practitioner, including my primary care physician listed below,
 Physician Name(s): _____

Physician Address: _____
 any medical facility, health plan, health care professional, laboratory, other medical entity, insurance support organization, financial institution, consumer reporting agency and my employer, to give the information described above to **Producer Resources, Inc.**, the Insurers and Agencies listed afore and to:

Agent/Producer Name: _____
 I understand that my information will be kept confidential, and will not be disclosed to other persons or organizations without this written permission for the purposes referenced herein, except to the extent that is necessary for (1) the Insurers and Agencies named afore and their reinsurers and other entities required to conduct business; (1) other insurers to which I have applied or may apply; (3) reinsurers; or (4) other persons whom perform business, professional or insurance services for them. They may also disclose this information as allowed by law. The information will be used by the insurance and/or settlement companies named below and their reinsurers to determine eligibility for insurance and/or by the insurance agent to aid in updating and improving my insurance program. The information collected ma be disclosed to other insurance companies to which I have applied or may apply, settlement companies, reinsurance companies, the Medical Information Bureau, or other persons or organizations performing business, professional, or insurance functions for the insurance and/or settlement companies named below, or as may be otherwise legally allowed.

I understand that when information is used or disclosed pursuant to this Authorization, it may be subject to re-disclosure by the insurance company and may no longer be protected by the federal and state laws and regulations that may have applies in the first instance. This Authorization will remain in effect for 24 months from the date of my signature below.

I understand I may revoke this Authorization at any time by requesting such of my agent/broker in writing and sent to the healthcare provider, if required. I understand that such revocation would not be effective to the extent any of the parties herein have already relied upon this authorization.

A photocopy of this Authorization is as valid as an original. I acknowledge that I have received a copy of this Authorization and the Notice to Proposed Insured(s). If minor children are proposed for coverage, the above statements are made by the person authorized to act on their behalf.

I understand that I am not required to sign this Authorization. I understand, however, that if I do not sign this Authorization to release my records and information that the insurers and agencies listed herein may not be able to evaluate and place my application for insurance. I understand that any health care provider who receives this authorization will not condition treatment, payment, enrollment or eligibility for benefits on whether I provide this Authorization.

Signature of Proposed Insured/Guardian or Custodian/Authorized Representative

X _____ Printed Name: _____

Date: _____



CALLBACK APPOINTMENT TIME: _____

Informational and Underwriting Callback

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

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

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

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

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

Medical Exam

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

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

Policy Issue

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



Prudential Xpress QuickForm – It is the responsibility of the producer to complete the QuickForm and the Agent’s Report. Under no circumstances should the forms be provided directly to the client for completion.

Before submitting the Xpress QuickForm, DO remember to:

- Confirm that you are appropriately licensed and appointed in the applicable state(s).
- Provide your client with the *What to Expect Next* brochure and the *Important Notice About Your Application for Insurance*, which are part of the Xpress QuickForm package available on www.pruxpress.com.
- Provide the *Privacy Notice* to the proposed insured on ALL variable cases.
- Print in BLACK or BLUE ink only.
- Complete **ALL** data fields in sections A – H and additional sections I – O, as applicable.
- Select Premium Payment Mode and fill in the billed premium amount for non-term plans in section E.

Where approved for sale, when submitting for the BenefitAccess Rider, DO:

- Only select one of the following products: PruLife® Universal Life Protector (UL Protector); PruLife® Index Advantage UL (IAUL); PruLife® Founders Plus UL (FPF); PruLife® Custom Premier II (PCP II) or VUL Protector (VULP).

For Non Face to Face Sales:

The collection of the worksheet information must be conducted by the writing Producer with both the proposed insured and the owner, if the owner is other than the proposed insured.

- The producer securely sends the required forms and illustration requirements (if needed) to the insured / owner to be signed.
- The insured/owner reviews and signs the forms package, and sends back to the Producer.
- Producer reviews forms to ensure they are in good order, signs any applicable forms and submits the forms and PXB worksheet via their normal submission process.
- Producer to select “No” in section I, question 1 of the Agent’s Report, noting the insured was NOT seen at the point of sale.

It is the responsibility of the producer to complete and sign the Agent’s Report for ALL cases. Under no circumstances should the form be provided directly to the client. **NOTE: Refer to the Non Face to Face Highlighter for eligibility requirements and additional information.**

When submitting for PruTermSM One, DO:

- List the product in Section D. Plan of Insurance, on the “Other” line.

When ordering an exam, DO:

- Request a Modified Exam for **ALL** Xpress cases.
- Use the *Age and Amount Chart* on www.pruxpress.com and specify the submission type.

LIMITED INSURANCE AGREEMENT (LIA)

- Complete all information requested on the LIA (ORD 96200A).
- If a prepayment is permitted under the terms of the Limited Insurance Agreement (LIA), make the prepayment check payable to Prudential Insurance Company, OR complete the *Request for Initial Premium (E-Pay) and/or to Establish Monthly Electronic Funds Transfer* (ORD 114416).

DO NOT accept prepayment if:

- ✗ Submitted in the form of cash.
- ✗ Check is made payable to you or with the payee field left blank.
- ✗ The proposed insured is unable to certify the health attestations.
- ✗ The proposed insured’s age is greater than 75 years.
- ✗ The total amount of insurance requested in all applications on the proposed insured is greater than \$5,000,000.
- ✗ The case is a non face to face sale.

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

AUTHORIZATION TO RELEASE INFORMATION

- Always have the client sign an *Authorization to Release Information* (ORD 96200C).
- Encourage the client to sign an *Authorization to Disclose Medical Information to General Agent or Broker* (ORD 112719).

When the Xpress QuickForm is completed:

- Retain the original document for all imaged forms, per the imaging agreement.



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
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	<input type="checkbox"/>	<input type="checkbox"/>
CDs or savings	<input type="checkbox"/>	<input type="checkbox"/>
Mutual funds or brokerage account	<input type="checkbox"/>	<input type="checkbox"/>
Existing life insurance policy(ies) or annuity contract(s)	<input type="checkbox"/>	<input type="checkbox"/>
1035 Exchange	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/> _____	<input type="checkbox"/> _____

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

IMPORTANT NOTICE ABOUT YOUR APPLICATION FOR INSURANCE

The Prudential Insurance Company of America
Pruco Life Insurance Company

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

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

COLLECTING INFORMATION FOR UNDERWRITING

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

DISCLOSING INFORMATION

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

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

YOUR RIGHT TO INFORMATION

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

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

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



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

POLICY NUMBER (IF KNOWN): _____

PROPOSED INSURED NAME (PRINT): _____

This Authorization was intended to comply with the HIPAA Privacy Rule

- I authorize any licensed physician, medical practitioner, hospital, clinic, other health care provider, pharmacy benefit manager, insurance company or producer, financial or legal advisor, government agency, MIB Inc, consumer reporting agency, or other organization or person to give any information about me, or my mental or physical health to the Company and/or its authorized agents to determine my eligibility for insurance and/or benefit payment, and/or to contest coverage and/or to conduct legally permissible actuarial, audit and research activities. It also includes motor vehicle records.
The information authorized for release includes:
My entire medical record, including any information regarding medications used, drug and alcohol treatment, and communicable or venereal diseases, such as hepatitis, syphilis, gonorrhea, the human immunodeficiency virus (HIV), and Acquired Immune Deficiency Syndrome (AIDS), and the diagnosis and treatment of mental health conditions, excluding psychotherapy notes.
For purposes of this Authorization, I hereby revoke any prior restriction on disclosure of my medical records, and authorize the release of my entire medical record to the Company, excluding psychotherapy notes.
This Authorization may be revoked at any time by writing us at the Customer Service Office address provided in the Important Notice. The revocation will not be valid to the extent we relied on the authorization prior to the notice of revocation. In addition, the revocation does not effect our legal rights under the policy to contest a claim or the policy itself. Revocation or alteration of this Authorization may mean that we will not be able to complete the application process and may deny a claim for insurance.
Once disclosed to the Company, the information will no longer be protected by the Health Insurance Portability and Accountability Act, but will be protected by other applicable federal and state laws relating to the protection of personal information.
This Authorization also applies to any member of my family proposed for coverage in the application & is valid for 2 years after the date below for the purposes stated above.
A copy of this Authorization will be provided to me or my authorized representative by my insurance representative or the Company, either at the time of execution or shortly thereafter. I understand my representative can tell me how and when I will receive a copy. A photocopy of this Authorization is as valid as the original.
Treatment, payment, enrollment in a health plan, or eligibility for health benefits may not be conditioned on signing this authorization.

SIGNATURES

- I acknowledge that I have received the Important Notice About Your Application for Insurance.
I authorize the Company to retain and disclose information to the MIB, reinsurers, or for insurance underwriting, policyholder service or claim handling, to others who perform services for us, or as otherwise allowed by law. Any revocation of this authorization will not impact these rights of disclosure.

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





Prudential

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

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

Policy Number: _____

To determine your insurability, the Insurance Company named above has requested that you provide a sample of your bodily fluid(s) for testing and analysis. All tests will be performed by a licensed laboratory.

Unless precluded by law, tests may be performed to determine the presence of antibodies or antigens to the Human Immunodeficiency Virus (HIV), also known as the AIDS virus. The HIV antibody test is actually a series of related tests designed for corroboration. The HIV antigen test directly identifies AIDS viral particles. These tests are extremely reliable.

All test results will be treated confidentially. They will be reported by the laboratory to us. When necessary in connection with insurance you have or have applied for with us, we may disclose test results to others such as our affiliates, reinsurers, and employees to whom disclosure is reasonably necessary in the ordinary course of business to carry out the purposes for which that disclosure is authorized or required. We are a member of the Medical Information Bureau Inc. (MIB), and if the test results for HIV antibodies/antigens are other than normal, we will report to the MIB a generic code which signifies only a non-specific test abnormality. The test results may also be disclosed to any member company that receives an application for health or life insurance on you. If your HIV test is normal, no report will be made about it to the MIB. The organizations described in this paragraph may maintain the test results in a file or data bank. The Insurer will make no other disclosure of the test results or even that the tests have been performed except as may be required (or permitted by law) or as specifically authorized by you.

If your HIV results are normal, no routine notification will be sent to you. If your test results are reported by the laboratory to the Insurer as being positive, the results will be disclosed to a physician you designate. 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 the test result: _____

Address: _____

A positive HIV antibody/antigen test does not mean that you have AIDS; it does mean that you are at significantly increased risk of developing AIDS or AIDS-related conditions. Federal authorities say that persons who are HIV antibody/antigen positive should be considered infected with the AIDS virus and capable of infecting others.

Positive HIV antibody or antigen results or other significant abnormalities will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged, or that other policy changes may be necessary.

Consent for Testing and Disclosure of Test Results

I have read and understand the Notice and Consent for AIDS virus (HIV) Antibody/Antigen Testing set forth above. I 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) Date

Signature of Proposed Insured or Parent/Guardian





Prudential

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

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The Prudential Insurance Company of America
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All test results will be treated confidentially. They will be reported by the laboratory to us. When necessary in connection with insurance you have or have applied for with us, we may disclose test results to others such as our affiliates, reinsurers, and employees to whom disclosure is reasonably necessary in the ordinary course of business to carry out the purposes for which that disclosure is authorized or required. We are a member of the Medical Information Bureau Inc. (MIB), and if the test results for HIV antibodies/antigens are other than normal, we will report to the MIB a generic code which signifies only a non-specific test abnormality. The test results may also be disclosed to any member company that receives an application for health or life insurance on you. If your HIV test is normal, no report will be made about it to the MIB. The organizations described in this paragraph may maintain the test results in a file or data bank. The Insurer will make no other disclosure of the test results or even that the tests have been performed except as may be required (or permitted by law) or as specifically authorized by you.

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Name of Proposed Insured (Please Print) Date

Signature of Proposed Insured or Parent/Guardian





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

