

Name _____ Policy number _____

Authorization to Release Information Acknowledgment. I have received the **Important Notice About Your Application for Insurance.**

I authorize any licensed physician, medical practitioner, hospital, clinic, other health care provider, pharmacy benefit manager, insurance company, government agency, or the Medical Information Bureau or other organization or person to give any information about me or my mental or physical health to the Company and/or its authorized agents to determine my eligibility for insurance and/or benefit payment. The information authorized for release includes my entire medical record, excluding psychotherapy notes, but includes any information regarding medications used, drug and alcohol treatment, and communicable or venereal diseases, such as hepatitis, syphilis, gonorrhea, the human immunodeficiency virus (HIV), and Acquired Immune Deficiency Syndrome (AIDS). It also includes motor vehicle records.

For purposes of this Authorization, I hereby revoke any prior restriction on disclosure of my medical records, and authorize the release of my entire medical record to the Company, excluding psychotherapy notes.

This Authorization may be revoked at any time by writing us at any of the Service Offices in the Important Notice. The revocation will not be valid to the extent we relied on the authorization prior to the notice of revocation. In addition, we may continue to use the Authorization to contest coverage. Revocation or alteration of this Authorization may mean that we will not be able to complete the application process and may deny a claim for insurance.

The Company may retain and disclose information to the Medical Information Bureau, reinsurers, or for insurance underwriting, policyholder service or claim handling, to others who perform services for us, or as otherwise allowed by law. Any revocation of this authorization will not impact these rights of disclosure.

Once disclosed to the Company, the information will no longer be protected by the Health Insurance Portability and Accountability Act, but will be protected by other applicable federal and state laws relating to the protection of personal information.

This Authorization also applies to any member of my family proposed for coverage in the application and is valid for two years after the date below.

A copy of this Authorization will be provided to me by my insurance representative or the Company, either at the time of execution or shortly thereafter. I understand my representative can tell me how and when I will receive a copy. A photocopy of this Authorization is as valid as the original.

Variable Contract Acknowledgement: (if applicable) I believe this contract meets my insurance needs and financial objectives. I acknowledge receipt of a current prospectus for the contract. I understand that the contract's values and death benefit may vary depending on the contract's investment experience. An illustration of values is available upon request.

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

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

- (1) Within the past 90 days been hospitalized or been advised by a member of the medical profession that he or she needs hospitalization for any reason (other than for normal pregnancy or well-baby care).
- (2) Within the past 12 months received treatment or advice from a member of the medical profession for heart disease, chest pain, stroke or cancer (except skin).

Amount of insurance requested \$ _____ Amount of prepayment \$ _____ Person(s) proposed for coverage _____

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

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

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

Limited insurance ends when any of the following occurs:

1. We issue a policy as applied for and the application has been signed.
2. We deliver a policy other than as applied for. The limited insurance will end on delivery of the policy regardless of whether the policy is accepted. If you do not accept the policy, the prepayment will be refunded.
3. We mail you a letter notifying you that we have declined to issue you a policy or that we will not provide life insurance coverage on a prepaid basis.
4. 60 days have passed since the date of this agreement, and the limited insurance provided under this agreement has not ended for any of the reasons listed above.

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

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

No Company representative has any right to accept risks, waive or change policies, give up any of our rights or requirements, or change the provisions of this agreement. **There is no coverage under this Limited Insurance Agreement if the Health Certification is materially mis-represented or fraudulent. If death is due to suicide or intentionally self-inflicted injury, payment will be limited to the return of the amount paid.**

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

Customer Service Office 2101 Welsh Road Dresher, PA 19025

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

PENNSYLVANIA ONLY: The writing representative certifies that the Disclosure Statement as required by the Commonwealth of Pennsylvania Insurance Department was delivered to the applicant.

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

Signature of primary proposed insured _____ Date _____

If age 15 or over, otherwise applicant (In Pennsylvania: If age 18 or over, otherwise applicant)

Signature of spouse, if proposed for coverage _____

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

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

Officer of company (Must sign here and give his or her title) _____

Writing representative _____ Contract number _____ Field Office _____



Policy Delivery State: _____ Date "Authorization, Acknowledgement & Limited Insurance Agreement" signed: _____

Case Details General Agency Name: _____ Contract No.: _____Who is responsible for the requirement ordering:
Age and amount requirements Prudential Producer/GA
APS Prudential Producer/GAOnly complete if requested: Date Policy to Save Age**Proposed Insured** Name (F/M/L): _____Gender: Male Female SSN: _____ Date of Birth: ____/____/____Residential Address (No PO Boxes): Street _____
City _____ State _____ ZIP _____Driver's License State and Number: _____ Check here if None

Earned Annual Income: \$ _____ Unearned Annual Income: \$ _____

Spouse/Domestic Partner's Annual Income: \$ _____

Within the past 90 days, has any proposed insured been hospitalized or been advised by a member of the medical profession that he/she needs hospitalization for any reason (other than for normal pregnancy or well-baby care)?.. Yes NoWithin the past 12 months, has any proposed insured received treatment or advice from a member of the medical profession for heart disease, chest pain, stroke or cancer (except skin)?..... Yes No**If either of the above questions are answered yes, do not collect prepayment.**Is this application for additional coverage on a person already covered by a Prudential or Pruco policy with an application date within three months of the date of this application?..... Yes (Policy number: _____) NoIs the Owner a US Citizen?..... Yes NoIf No: Is the owner a US resident alien (defined as someone who either has a green-card, or passes the IRS substantial presence test [physically present in the US for 31 days during the current calendar year or 183 days during the current calendar year & two preceding calendar years] Yes No-if No, what country is the owner a resident of? _____Is the Owner subject to back-up withholding?..... Yes No**Product Information** Face Amount \$ _____ For UL/VUL: Billed premium amount \$ _____Select Product: Term Essential: 10 15 20 30 Term Elite: 10 15 20PruLife Return of Premium Term: 15 20 30PruLife Universal: Plus Protector PruLife Custom Premier (VUL): Death Benefit Option (choose one, if applicable): Level Variable Return of PremiumDefinition of Life Insurance Test (choose one, if applicable - **NEW YORK ONLY: SUBMIT FORM ORD 99767**): Cash Value Accumulation Test (CVAT) Guideline Premium Test (GPT)**Requested Optional Benefits** Acceleration of Death Benefit (Living Needs Benefit [N/A IN MASS.]) Automatic Premium Loan Waiver of Premium/Enhanced Disability Benefit (if applicable) Accidental Death Benefit: \$ _____ (if applicable) Child Protection Rider: \$ _____ (if applicable) Target Term Rider: \$ _____ (if applicable)**Underwriting Category Quoted** Preferred Best Preferred Non-Tobacco Non-Smoker Plus Non-Smoker Preferred Smoker Smoker Special Class (Indicated Class A through H): _____ Flat Extra Premium (both Temporary & Flat): \$ _____**Beneficiaries** (use REMARKS to list additional Beneficiary information)

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
_____	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>

Payment Prepayment amount: \$ _____ Check Date: ____/____/____Payment Mode: Annually Semiannually Quarterly EFT - **If EFT:**

Name of Financial Institution: _____ Routing Number: _____

Account Number: _____ Checking Savings Withdrawal Date: 1 7 15 23 28Account Owner: Same as Policy Owner Other: Name & Address: _____

Existing Insurance

List all existing insurance and/or annuities in all companies (Use REMARKS for additional contracts): Check here if None:

Company Name	Policy Number	Amount	Year Issued	Type of Insurance
_____	_____	_____	_____	<input type="checkbox"/> Group <input type="checkbox"/> Individual
_____	_____	_____	_____	<input type="checkbox"/> Group <input type="checkbox"/> Individual
_____	_____	_____	_____	<input type="checkbox"/> Group <input type="checkbox"/> Individual

For each proposed insured:

(a) would this insurance replace or cause a change in an existing insurance policy/annuity in any company?..... Yes No

(b) do you (the producer) have any information, other than what is stated on this worksheet, that any current life insurance or annuity in any company may be replaced or changed?..... Yes No

If YES to (a), Additional details required regarding replacement (Use REMARKS to list additional contracts to be replaced):

Policy Number:	Pl's Role in Existing Contract	1035 Exchange	Plan
_____	<input type="checkbox"/> Primary Insured <input type="checkbox"/> Spouse <input type="checkbox"/> Child	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Life <input type="checkbox"/> Annuity
_____	<input type="checkbox"/> Primary Insured <input type="checkbox"/> Spouse <input type="checkbox"/> Child	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Life <input type="checkbox"/> Annuity

Is the policy to be replaced a Term policy (required for new Term plans only)..... Yes No

Have you discussed the advantages and any disadvantages of the replacement with the applicant?..... Yes No

Have you determined that the replacement transaction is appropriate for the applicant?..... Yes No

Client Interview - Phone Interviews conducted M-F 9am - 9pm local time

Best time to Call (please select one): Morning Afternoon Evening

Preferred Contact Number (must be in the USA): Home Work Alternate (_____)

Special Needs (hearing impaired, translator needed) : _____

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

If YES: Provide names: _____

Purpose of Insurance (Check all that apply - Personal or Business should be completed)

- Personal:* Death Benefit Basic Last Expenses Income Replacement Mortgage Protection
 Estate Conservation Charitable Giving Potential Cash Accumulation (permanent plans only)
 Retirement Income Needs Other: _____
- Business:* Deferred Compensation Buy/Sell Key Person Loan Indemnification Split Dollar
 Retirement Income Needs Other: _____
 Executive Bonus (section 162) Business Continuation Other: _____

Producer Information (for splits greater than two, use an additional page with all details)

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: _____ Producer Contract No.: _____ Producer SSN: _____ - _____ - _____

GA Name: _____ GA Contract No.: _____ GA EIN: _____ - _____

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 No.: _____ Firm EIN: _____ - _____

PRODUCER #2 Split Commission %: _____

Producer Name: _____ Producer Contract No.: _____ Producer SSN: _____ - _____ - _____

GA Name: _____ GA Contract No.: _____ GA EIN: _____ - _____

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 No.: _____ Firm EIN: _____ - _____

Case manager e-mail _____

What is the source of initial premiums? Current income or savings account Other: _____

What is the source of future premiums? Current income or savings account Other: _____

Remarks

Owner Information (Complete this section only when the policy owner is other than the primary proposed insured)

If Owner is a **TRUST**, provide the following:

Name of Trust & Address: _____

Tax ID of Trust: _____ Date of Trust : ____ / ____ / ____

Trustee Name(s): _____

Trust is: Irrevocable Revocable (If Revocable, Grantor's Name: _____)

If Owner is other than a Trust and different from Proposed Insured, provide the following

If there are joint policyowners, provide details for the policyowner who assumes tax reporting liability below, listing additional policyowners in REMARKS

Owner Name (F/M/L): _____

SSN: _____ Date of Birth: ____ / ____ / ____

Residential Address (No PO Boxes): Street _____
City _____ State _____ ZIP _____

Current annual income of Owner: \$ _____ Current net worth of Owner: \$ _____

How much insurance does the Owner currently have: in force? \$ _____ ; pending? \$ _____

Relationship to PI: _____

Why will this person own the contract? Business Insurance Estate Tax Support for Insured
 Final Expenses Other: _____

Business Information (This section must be completed when the application is for Business Insurance)

Type of firm: corporation partnership sole proprietorship

Has the business been established for less than two (2) years? Yes No Unknown

What is the net worth of the business? \$ _____

Is this a split dollar arrangement? Yes No

Is the primary proposed Insured an: employee owner If owner, % of ownership _____%

Are there any additional owners of this business? Yes No

If "YES": Other owner names	Insurance in force	Amount applied for	Percent ownership
_____	\$ _____	\$ _____	_____%
_____	\$ _____	\$ _____	_____%

Complete if face amount of policy is \$5,000,000 or greater (submission of a cover sheet is recommended):

Assets: \$ _____ Liabilities: \$ _____ Fair Market Value: \$ _____

Gross Annual Sales: \$ _____ Net Profit After Taxes: \$ _____

Variable Information (This section must be completed when the application is for a variable product)

Telephone Reallocations/Transfer Privileges: (If more than one owner, telephone reallocations/transfer privileges are NOT allowed.)

The applicant does not wish to authorize telephone reallocations/transfers. He/She understands that by not taking this option any future request for this option must be submitted in writing.

Investment Options and Allocations (Use REMARKS to list additional fund details): **THE TOTAL ALLOCATION MUST EQUAL 100%**

Investment Option	Code	Allocation %	Investment Option	Code	Allocation %
_____	_____	_____%	_____	_____	_____%
_____	_____	_____%	_____	_____	_____%

Allocated Charges (Must be in whole percentages, Fixed Rate Option may not be chosen, Max of 2):

Investment Option: _____ % Investment Option: _____ %

Auto Rebalancing: If requested, please submit a completed, unsigned form with this worksheet

Dollar Cost Averaging: If requested, please submit a completed, unsigned form with this worksheet

- Suitability Checklist:
- This application is submitted in the belief that the purchase of this policy is suitable for the applicant based on the information furnished Yes No
 - Reasonable inquiry has been made of the applicant concerning the applicant's insurance and investment objectives, financial situation and needs. Yes No
 - The applicant 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
 - I provided the applicant with the brochure "What every consumer should know about life insurance" and answered any questions they had about the purchase. Yes No



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:

- Beneficiaries' information such as social security numbers and dates of birth
- Policyowner(s) information (if policyowner(s) is someone other than yourself) such as social security number and date of birth
- Your physician's name, address and phone number
- Date of your most recent visit to your Primary Care Physician (if it wasn't with your Primary Care Physician, we will still need your Primary Care Physician's information), plus:
 - Reason for that visit
 - Your height and weight
 - Current prescriptions
 - Your driver's license number
 - 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)
- A Chest X-Ray

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.

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

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

Collecting Information for Underwriting

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

Disclosing Information

We will treat any information we obtain or have obtained about you as confidential. We may disclose information we have collected as follows: to affiliates or third parties that perform services for us, or on our behalf, or that are providing service to you; to your doctor; to insurance regulators; to law enforcement or other governmental authorities under limited circumstances; for actuarial or research studies; or as otherwise permitted or required, with or without your authorization, by applicable law. Prudential or its reinsurers may make a brief report to the MIB, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the MIB, upon request, will supply such company with the information in its file. Information about MIB may be obtained on its website at www.mib.com. Prudential, or its reinsurers, may also release information in its file to other life insurance companies to which you may apply for life or health insurance or to which a claim for benefits may be submitted. A consumer reporting agency that prepares a consumer report may keep the information it has gathered and disclose it to others.

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

Your Right to Information

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

Upon receipt of a request from you, the MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of the information in the MIB's file, you may contact the MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734, toll-free telephone number (866-692-6901) [TTY # 866-346-3642 for the hearing impaired].

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

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

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

