

**THIS WORKSHEET PACKET IS FOR USE FOR THE FOLLOWING PRODUCTS, IN ALL STATES EXCEPT:**

Florida, Kansas, Massachusetts, Minnesota, Missouri, New Jersey, New Mexico, New York, North Carolina & Vermont (Use appropriate state specific packet)

**PruLife Custom Premier (VUL)  
Term Essential****PruLife Universal Protector  
Term Elite****PruLife Universal Plus  
PruLife Return of Premium Term**

Please be sure to read the following instructions to help you expedite the completion of the Prudential Xpress QuickForm.

**EXCLUSIONS:**

The **Prudential Xpress QuickForm** is designed to provide an efficient means of recording basic client information to submit a case for underwriting. The QuickForm should not be used for juvenile applications.

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**CONTACT INFORMATION: FAX QuickForm to : 888-271-6661**

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**INSTRUCTIONS****THIS IS NOT AN APPLICATION**

- Step 1: Please provide your client with the *What to Expect Next* brochure and *Important Notice About Your Application for Insurance* **before** completing the QuickForm.
- Step 2: Have the client read and sign the *Authorization to Release Information, Limited Insurance Agreement and Variable Contract Acknowledgement*, plus any other required state or Pruco Life pre-issue forms as listed below.
- Step 3: Complete the QuickForm.

**PruLife Custom Premier**

**CA:** Elder Disclosure Statement  
(PPI or owner is  $\geq$  age 65)  
Replacement Forms (*if applicable*)  
Request for Auto-Rebalancing  
(*if applicable*)  
Request for Dollar Cost Averaging  
(*if applicable*)

**PruLife Universal Protector & Plus**

**CA:** Elder Disclosure Statement  
(PPI or owner is  $\geq$  age 65)  
**PA:** Pennsylvania Disclosure  
**MD:** PruLife Universal Protector MD  
Disclosure  
Replacement Forms (*if applicable*)  
Illustration or Illustration Certification  
as appropriate

**Term Essential**

**CA:** Elder Disclosure Statement  
(PPI or owner is  $\geq$  age 65)  
**PA:** Pennsylvania Disclosure  
**ME:** Prelim. Statement of Policy Cost  
**MT & TX:** Premium Provisions of  
Indeterminate Premium  
Contracts  
Replacement Forms (*if applicable*)

**Term Elite/ROP Term**

**CA:** Elder Disclosure Statement  
(PPI or owner is  $\geq$  age 65)  
**PA:** Pennsylvania Disclosure  
**ME:** Prelim. Statement of Policy Cost  
Replacement Forms (*if applicable*)

Complete a cover sheet regarding any of the following:

- For special requests or more complete information.
- If the client's health, mental or physical condition has changed from a Prudential or Pruco Life policy received within the last 3 months.
- If a proposed owner is not a trust nor individual(s), provide the following data:
  - Owner name
  - Owner address – no PO Boxes
  - Owner's Tax ID number
  - If applicable, type of firm (corporation, LLC, partnership, LLP or sole proprietorship)
- If a named beneficiary is not a trust nor individual(s), provide the following data:
  - Beneficiary name
  - Beneficiary class
  - Business address – no PO Boxes
  - If applicable, type of firm (corporation, LLC, partnership, LLP or sole proprietorship)

Step 4: Please fax or image the completed QuickForm, *Authorization to Release Information, Limited Insurance Agreement and Variable Contract Acknowledgement* and any applicable replacement forms to **888-271-6661**, or via your applicable imaging platform.

Step 5: If imaging, the original file documents should be retained per the imaging agreement. If faxing, please mail the QuickForm, the original signature *Authorization to Release Information, Limited Insurance Agreement and Variable Contract Acknowledgement*, plus any other necessary forms (see above) to:

**Prudential Financial  
ATTN: Life New Business  
Suite DTY, 2101 Welsh Road  
Dresher, PA 19025**

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 &amp; Limited Insurance Agreement" signed: \_\_\_\_\_

**Case Details** General Agency Name: \_\_\_\_\_ Contract No.: \_\_\_\_\_

Who is responsible for the requirement ordering:

- |                             |                                     |                                      |
|-----------------------------|-------------------------------------|--------------------------------------|
| Age and amount requirements | <input type="checkbox"/> Prudential | <input type="checkbox"/> Producer/GA |
| APS                         | <input type="checkbox"/> Prudential | <input type="checkbox"/> Producer/GA |

Only 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:

Table with 5 columns: Company Name, Policy Number, Amount, Year Issued, Type of Insurance. Includes checkboxes for Group and Individual insurance types.

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):

Table for replacement details with columns: Policy Number, Pl's Role in Existing Contract, 1035 Exchange, Plan. Includes checkboxes for various roles and plan types.

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**

Blank lines for entering 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: (check if requested) - if requested, please submit a completed, unsigned form with this worksheet

Dollar Cost Averaging: (check if requested) - 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. 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 Post Office Box 105, Essex Station, Boston, Massachusetts 02112, 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

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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**

**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

To determine your insurability, we request that you provide a sample of your bodily fluid(s) for testing and analysis. All tests will be performed by a licensed laboratory.

Many public health organizations have recommended that before taking a test to determine the probable causative agents of AIDS, a person should seek counseling in order to become informed concerning the implications of such a test. In the event the test result is positive or indeterminate, post-test counseling is required by Washington law. A listing of those public and private health care facilities providing such counseling is listed on the reverse side of the proposed insured's copy of this form.

Tests may be performed to determine the presence of antibodies to the Human Immunodeficiency Virus (HIV); the tests do **not** detect the presence of the AIDS virus. These tests include an enzyme-linked immunosorbent assay (ELISA) serologic test and the Western Blot Assay. Both of these tests have been approved by the Federal Food and Drug Administration, are extremely reliable and false positive reports are rare. If a person's initial ELISA test is positive, that test will be repeated. If the repeat ELISA also results in a positive report, the Western Blot Assay will be performed. A person will be considered to have the HIV antibodies present in his/her bodily fluids(s) only after positive results on two ELISA tests and a Western Blot.

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 or claims process such as its 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 mentioned in this paragraph may maintain the test results in a file or data bank. Except as noted below, the Insurer will make no other disclosure of the test results or even that tests have been done except as may be required or permitted by law or as authorized by you.

If your test results are negative, no routine notification will be sent to you. If your test results are reported by the laboratory to us as being positive or indeterminate, you are entitled to that information (but it will not be sent directly to you). Therefore, a trained person should deliver that information so that you can understand clearly what the test results mean. You are asked to list your health care provider or health care agency so that we can them tell you the test result, explain its meaning and proceed you with post-test counseling.

Name of health care provider/agency for reporting possible positive or indeterminate test results: \_\_\_\_\_

Address: \_\_\_\_\_

If you have not given written consent authorizing the health care provider/agency to receive positive test results, we will provide the test results to the local Department of Health for interpretation and post-test counseling.

A positive test result may cause significant anxiety. A positive test result may result in uninsurability for life, health and disability insurance policies for which you may apply in the future. Although prohibited by law, discrimination in housing, employment, or public accommodations may result if your test results were to become known to others. A negative result may create a false sense of security.

**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**

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

To determine your insurability, we request that you provide a sample of your bodily fluid(s) for testing and analysis. All tests will be performed by a licensed laboratory.

Many public health organizations have recommended that before taking a test to determine the probable causative agents of AIDS, a person should seek counseling in order to become informed concerning the implications of such a test. In the event the test result is positive or indeterminate, post-test counseling is required by Washington law. A listing of those public and private health care facilities providing such counseling is listed on the reverse side of the proposed insured's copy of this form.

Tests may be performed to determine the presence of antibodies to the Human Immunodeficiency Virus (HIV); the tests do **not** detect the presence of the AIDS virus. These tests include an enzyme-linked immunosorbent assay (ELISA) serologic test and the Western Blot Assay. Both of these tests have been approved by the Federal Food and Drug Administration, are extremely reliable and false positive reports are rare. If a person's initial ELISA test is positive, that test will be repeated. If the repeat ELISA also results in a positive report, the Western Blot Assay will be performed. A person will be considered to have the HIV antibodies present in his/her bodily fluids(s) only after positive results on two ELISA tests and a Western Blot.

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 or claims process such as its 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 mentioned in this paragraph may maintain the test results in a file or data bank. Except as noted below, the Insurer will make no other disclosure of the test results or even that tests have been done except as may be required or permitted by law or as authorized by you.

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Name of health care provider/agency for reporting possible positive or indeterminate test results: \_\_\_\_\_

Address: \_\_\_\_\_

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\_\_\_\_\_  
Name of Proposed Insured (Please Print) Date

\_\_\_\_\_  
Signature of Proposed Insured or Parent/Guardian

**Adams County Health Department**108 West Main  
Ritzville, WA 99169  
(509) 659-3315**Asotin County Health District**431 Elm Street  
Clarkston, WA 99403  
(509) 758-3344**Benton-Franklin District Health Department**506 McKenzie  
Richland, WA 99352  
(509) 943-2614 (Richland)  
(509) 586-0207 (Pasco)**Bremerton-Kitsap County Health District**109 Austin Drive  
Bremerton, WA 98312  
(360) 337-5235, (800) 874-2437**Chelan-Douglas Health District**200 Valley Mall Parkway  
East Wenatchee, WA 98802  
(509) 886-6400**Challam County Health Department**223 East Fourth Street  
Port Angeles, WA 98362  
(360) 417-2274**Cowlitz County Health & Human Services**1952 9th Avenue  
Longview, WA 99169  
(360) 414-5599**Grant County Health District**First & C Street NW  
Ephrata, WA 98823  
(509) 754-6060, (800) 708-6646**Grays Harbor County Health Department**2109 Sumner Avenue  
Aberdeen, WA 98520  
(360) 532-8631**Harborview Hospital**Sexually Transmitted Disease Clinic  
329 9th Avenue, 3rd Floor, South Wing  
Seattle, WA 98104  
(206) 731-3590

Harborview Women's Clinic: (206) 731-3367

**Island County Health Department**410 North Main  
Coupeville, WA 98239  
(360) 679-7351**Jefferson County Health Department**Castle Hill Center  
615 Sheridan  
Port Townsend, WA 98368-2439  
(360) 385-9400, (800) 291-3521**Kittitas County Health Department**507 Nanum (Room 102)  
Ellensburg, WA 98926  
(509) 962-7515**Klickitat County Health Department**228 W. Main St MS CH-14  
Goldendole, WA 98620  
(509) 773-4565, (888) 291-3521**Lewis County Health District**Health Services Building  
360 N.M. North Street  
Chehalis, WA 98532  
(206) 748-9121, (800) 562-6130**Lincoln County Public Health Coalition**507 7th Street (P. O. Box 215)  
Davenport, WA 99122  
(509) 725-1001**Mason County Health Department**303 North 4th  
Shelton, WA 99584  
(360) 427-9670**Northeast Tri-County County Health District**240 East Dominion  
Colville, WA 99114  
(509) 684-6209, (800) 827-3218**Okanogan County Health District**Administration Building  
1234 52nd Street  
Okanogan, WA 98840  
(509) 422-7140, (800) 222-6410**Pacific County Health Department**1216 W. Robert Bush Dr.  
South Bend, WA 98586  
(360) 875-9343**San Juan County Health Department**145 Rhone Street  
Friday Harbor, WA 98520  
(360) 378-4474**Seattle Gay Clinic**500 - 19th Avenue E  
Seattle, WA 98102  
Tues 6:30 - 9:00 pm, Sat noon-3:00 pm  
(206) 461-4540**Seattle-King County Health Department**AIDS Prevention Project  
*(gay/bisexual men preferred)*  
2124 Fourth Street, 4th Floor  
Seattle, WA 98121  
(206) 296-4999, TYY (206) 296-4843  
(800) 678-1595**Low Risk Testing Sites (Seattle-King Co)**

- North Seattle Public Health Center  
10501 Meridian Avenue North  
Seattle, WA  
(206) 296-4990
- Southeast Public Health Center at Renton  
3001 N. E. 4th Street  
Renton, WA  
(206) 296-4700, (800) 325-6165
- Southwest Public Health Center  
10821 8th Avenue S.W.  
Seattle, WA  
(206) 296-4620
- East Public Health Center  
14350 S. E. Eastgate Way  
Bellevue, WA  
(206) 296-4920
- Southeast Public Health Center  
20 Auburn Avenue  
Auburn, WA  
(206) 296-8400
- Central Clinic  
Public Safety Building  
610-3rd Avenue, 14th Floor  
Seattle, WA  
(206) 296-4772

**Snohomish Health District**3020 Rucker Avenue, Suite #205  
Everett, WA 98201  
(425) 339-5251**Southwest Washington Health District**Vancouver-Clark County Health Center  
2000 Fort Vancouver Way  
Vancouver, WA 98663  
(360) 397-8098**Spokane Regional Health District**1101 West College Avenue  
Spokane, WA 99201  
(509) 324-1524, (800) 456-3236**Tacoma-Pierce County Health Department**3629 South "D" Street  
Tacoma, WA 98408  
(253) 798-6405, (800) 992-2456**Thurston County Public & Social Services Health Department**529 West Fourth (MS: FQ11)  
Olympia, WA 98501  
(360) 786-5581**Walla Walla County-City Health Department**310 West Poplar  
Walla Walla, WA 99362  
(509) 527-3290**Whatcom County Health Department**1500 N. State Street  
Bellingham, WA 98225  
(360) 676-4593**Whitman County Department of Public Health**Public Service Building  
North 310 Main Street  
Colfax, WA 99111  
(509) 397-6280**Yakima County Health District**104 North First Street  
Yakima, WA 98901  
(509) 575-4040, (800) 535-2271

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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



A sample generic Acknowledgment and Consent to Employer-Owned Life Insurance form appears below. Please be aware that this form has not been adapted to the specific circumstances or objectives of an individual employer. Neither The Prudential Insurance Company of America nor its representatives provide tax or legal advice. We strongly urge you to consult with your attorney to understand the application of these rules to your situation prior to completing an employer-owned life insurance transaction.

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## **Sample Acknowledgment and Consent to Employer-Owned Life Insurance**

Proposed Insured Name: \_\_\_\_\_

Employer/Applicable Policyholder Name: \_\_\_\_\_

Employer/Applicable Policyholder Address: \_\_\_\_\_

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### **Employee Acknowledgment and Consent**

The employer/applicable policyholder has given me notice that it intends to purchase a life insurance policy or policies on my life. I understand and consent to the following:

- I will be the insured under the policy(ies).
- The employer/applicable policyholder will own the policy.
- The employer/applicable policyholder may, directly or indirectly, be a beneficiary of the policy(ies) and may receive proceeds payable on my death.
- The employer/applicable policyholder, or its successors, may continue to be the owner and/or may be a beneficiary of the policy even after my employment terminates.
- \$\_\_\_\_\_ is the maximum face amount for which I may be insured by the employer/applicable policyholder at time of issue.

**X**

---

Signature of the Proposed Insured

Date

**IMPORTANT NOTICE REGARDING REPLACEMENT OF LIFE INSURANCE**

Save this notice! It may be important to you in the future.

The decision to buy a new life insurance policy or annuity and discontinue or change an existing one is very important. Your decision could be a good one - or a mistake. It should carefully be considered. The Washington State Insurance Commissioner requires us to give you this notice to help you make a wise decision.

**STATEMENT TO APPLICANT BY AGENT OR BROKER:**

(Use additional sheets, as necessary)

I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following factors, which I call to your attention.

- 1. Can there be reduced benefits or increased premiums in later years?  No  Yes, explain:
- 2. Are there penalties, set up or surrender charges for the new policy?  
 No  Yes, explain, emphasizing any extra cost for early withdrawal.
- 3. Will there be penalties or surrender charges under the existing insurance as a result of the proposed transaction?  No  Yes, explain:
- 4. Are there adverse tax consequences from the replacement under current tax law?  No  Yes, explain:
- 5. a) Are interest earnings a consideration in this replacement?  No  Yes  
b) If "yes", explain what portions of premiums or contributions will produce limited or no earnings. As pertinent, include in your explanation the need for minimum deposits to enhance earnings, and the reduction of earnings that may result from set up charges, policy fees, and other factors
- 6. Are minimum amounts required to be on deposit before excess interest will be paid?  No  Yes, explain:
- 7. If the new program is based on a variable or universal life insurance policy or a single-premium policy or annuity:  
a) Are the interest rates quoted before \_\_\_ or after \_\_\_ fees and mortality charges have been deducted?  
b) Interest rates are guaranteed for now long? \_\_\_  
c) The minimum interest rate to be paid is how much? \_\_\_  
d) If applicable, the rate you pay to borrow is \_\_\_, and the limit on the amount that can be borrowed is \_\_\_  
e) The surrender charges are \_\_\_  
f) The death benefit is \_\_\_

8. Are there other short or long term effects from the replacement that might be materially adverse?  No  Yes, explain:

Signature of Agent or Broker \_\_\_\_\_ Date: \_\_\_\_\_

Name of Agent or Broker \_\_\_\_\_ Address: \_\_\_\_\_  
(Print or Type)

List of Policies or Contracts to be Replaced:

Company	Insured	Contract No.
_____	_____	_____
_____	_____	_____

**CAUTION:**

The insurance commissioner suggests you consider these points:

Usually, contestable and suicide periods start again under a new policy. Benefits might be excluded under a new policy that would be paid under existing insurance

Terminating or altering existing coverage, before new insurance has been issued, might leave you unable to purchase other life insurance or let you buy it only at substantially higher rates.

You are entitled to advice from the existing agent or company. Such advice might be helpful.

Study the comments made above by the agent or broker. They apply to you and this proposal. They are important you you and your future.

Completed Copy Received \_\_\_\_\_  
(Applicant's Signature) (Date)

**THIS COMPLETED FORM SHOULD BE FILED PERMANENTLY WITH YOUR NEW INSURANCE POLICY**

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



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b) Interest rates are guaranteed for now long? \_\_\_  
c) The minimum interest rate to be paid is how much? \_\_\_  
d) If applicable, the rate you pay to borrow is \_\_\_, and the limit on the amount that can be borrowed is \_\_\_  
e) The surrender charges are \_\_\_  
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Signature of Agent or Broker \_\_\_\_\_ Date: \_\_\_\_\_

Name of Agent or Broker \_\_\_\_\_ Address: \_\_\_\_\_  
(Print or Type)

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(Applicant's Signature)

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 No  Yes, explain, emphasizing any extra cost for early withdrawal.
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- 7. If the new program is based on a variable or universal life insurance policy or a single-premium policy or annuity:  
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c) The minimum interest rate to be paid is how much? \_\_\_  
d) If applicable, the rate you pay to borrow is \_\_\_, and the limit on the amount that can be borrowed is \_\_\_  
e) The surrender charges are \_\_\_  
f) The death benefit is \_\_\_
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Name of Agent or Broker \_\_\_\_\_ Address: \_\_\_\_\_  
(Print or Type)

List of Policies or Contracts to be Replaced:

Company	Insured	Contract No.
_____	_____	_____
_____	_____	_____

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Completed Copy Received \_\_\_\_\_  
(Applicant's Signature) (Date)

THIS COMPLETED FORM SHOULD BE FILED PERMANENTLY WITH YOUR NEW INSURANCE POLICY



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

- Establish EFT
- Add policy(ies) to existing EFT
- Change withdrawal amount(s)
- Change bank or account information

### Instructions

Complete the entire form in blue or black ink to establish a Prudential monthly Electronic Funds Transfer (EFT) payment program or to make a change to an EFT payment program. Check the accuracy of any section we completed. Initial any corrections or changes that you make. Retain the extra copy for your records.

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 Withdrawal Information

List the policies to be included and the withdrawal amount for each.

Policy to be added or changed	Monthly withdrawal amount*	Insured's name(s)
<input type="text"/>	\$ <input type="text"/> , <input type="text"/> . <input type="text"/>	_____
<input type="text"/>	\$ <input type="text"/> , <input type="text"/> . <input type="text"/>	_____
<input type="text"/>	\$ <input type="text"/> , <input type="text"/> . <input type="text"/>	_____
<input type="text"/>	\$ <input type="text"/> , <input type="text"/> . <input type="text"/>	_____

Withdrawal of premium payments from the identified account will be made monthly. Select the day of the month listed below on which Prudential should withdraw the premiums. For existing policies, the day of the month selected must be on or before the due date of your premium. If you do not specify a date, we will select one. You will be sent a notification 10 days in advance of the amount and the date of withdrawal.

- 1st     7th     15th     23rd     28th

We cannot establish an electronic funds transfer program if the dividend option is to reduce premiums. In that event, we will withdraw the full amount of the premiums from your account. Unless otherwise elected, any future dividends will be used to provide paid-up additional insurance, if available, or will otherwise accumulate at interest.

*\*Cannot exceed the monthly premium unless the policy has flexible payment arrangements.*

### 2 Enrollment Information

(See the attached Instructions for Completing Section 2.)

Name of financial institution

Local branch telephone number

 - 

Type of account

- Savings  
 Checking

Bank transit routing and account number

(Nine-digit bank transit routing number) (Bank account number)









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

**Instructions** Record all banking information on the form in section 2, **Enrollment Information**. Please follow these steps:

1. **Please enclose your blank, voided check for the checking account that you wish us to withdraw your payments from.** *Note: We cannot obtain acceptable banking information from deposit slips.*
2. Tape your voided check below so that the bottom right corners are lined up. This will help you identify the necessary bank information to initiate electronic withdrawals. The nine-digit transit routing number is how we recognize the bank you do business with.
3. Return this attachment with the voided check along with the signed copy of the form.
4. If a savings account is being used, you must first check with your bank to ensure that you do not exceed limits on how many electronic withdrawals can be made each month. Also ask them to provide you with the correct bank transit routing number and account number for electronic withdrawals.  
*Note: We cannot obtain acceptable banking information from deposit slips.*

**Customer's name** \_\_\_\_\_ **Check no.** 1234  
**Street address** \_\_\_\_\_  
**City, State ZIP** \_\_\_\_\_


**PAY TO THE ORDER OF** \_\_\_\_\_ \$  
 \_\_\_\_\_ **Dollars**

**Bank name** \_\_\_\_\_  
**Street address** \_\_\_\_\_  
**City, State ZIP** \_\_\_\_\_

⑆ 123456789 ⑆ 555555 ⑆ 55555 ⑆ 1234

- This is the bank transit routing number.
- It is always 9 digits and appears between the ⑆ symbols.
- Record this number in the boxes provided in section 2, "nine-digit bank transit routing number."

- This is your bank account number. It varies in number of digits and may include dashes or spaces.
- The ⑆ symbol indicates the end of the account number.
- Record the account number in the boxes provided in section 2, "Bank account number," and include any dashes and spaces that are within the account number.
- If there are any digits to the right of the ⑆ symbol (which do not represent the check sequence number), record them in the boxes provided.
- Do not include the check sequence number on the form.

  
**Place the bottom-right corner of your check here. Tape all four sides to form.**

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

**INSTRUCTIONS**

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

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**1. POLICY AND WITHDRAWAL INFORMATION**

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

Policy number \_\_\_\_\_ Withdrawal amount \$ \_\_\_\_\_

**2. BANK ACCOUNT INFORMATION**

**Account owner type:**  Individual/Joint  Corporate  Trust  Other \_\_\_\_\_

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

Address \_\_\_\_\_

City/State/ZIP code \_\_\_\_\_

**Account type:**  Savings  Checking

Name of financial institution \_\_\_\_\_

Local branch telephone number (optional) \_\_\_\_\_

Bank routing number (*9 digits*)\* \_\_\_\_\_ Bank account number\* \_\_\_\_\_

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

**3. AGREEMENT AND SIGNATURE**

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

- If a withdrawal request is not honored by the financial institution, Prudential will not consider the payment to be made.
- I have 60 days from the date of the withdrawal to notify Prudential of any errors related to a transfer under this agreement.
- Prudential will process this initial premium withdrawal request immediately upon receipt of this authorization.
- Except as required by the Electronic Funds Transfer Act and Regulation E, Prudential will not be liable for any exemplary, special, consequential, punitive, indirect or incidental damages, regardless of whether any claim is based on a contract or whether any such damages were foreseeable.

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

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



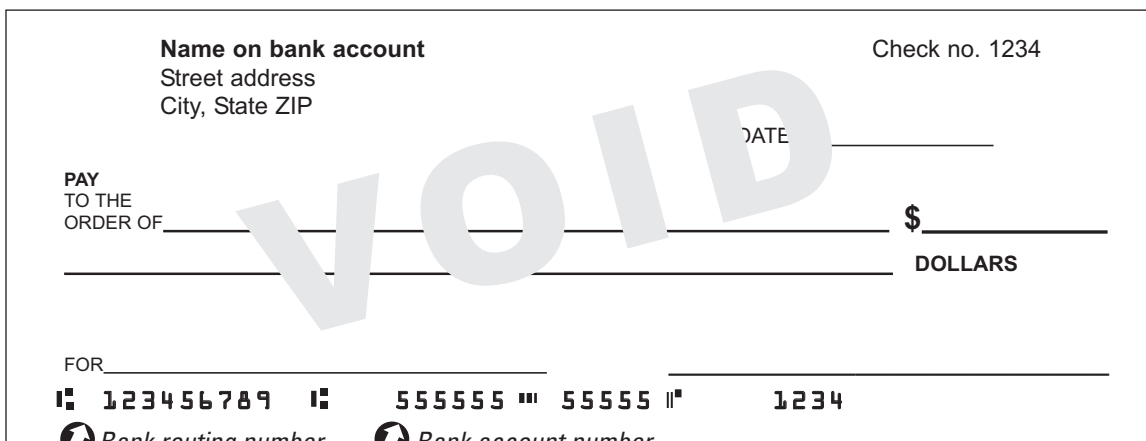
The Prudential Insurance Company of America  
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 Pruco Life Insurance Company  
*All are Prudential Financial companies.*

**INSTRUCTIONS**

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

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



**Name on bank account**  
 Street address  
 City, State ZIP

Check no. 1234

DATE \_\_\_\_\_

PAY TO THE ORDER OF \_\_\_\_\_ \$ \_\_\_\_\_  
 \_\_\_\_\_ DOLLARS

FOR \_\_\_\_\_

⑆ 123456789 ⑆ 555555 ⑆ 5555 ⑆ 1234

⑆ Bank routing number — ⑆ Bank account number

⑆ Bank routing number (9 digits) appears between the ⑆ symbols.

- The bank account number varies in number of digits and may include dashes or spaces.
- The ⑆ symbol indicates the end of the account number.
- Include any dashes and spaces that are within the account number in section 2.
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Policy number \_\_\_\_\_ Withdrawal amount \$ \_\_\_\_\_

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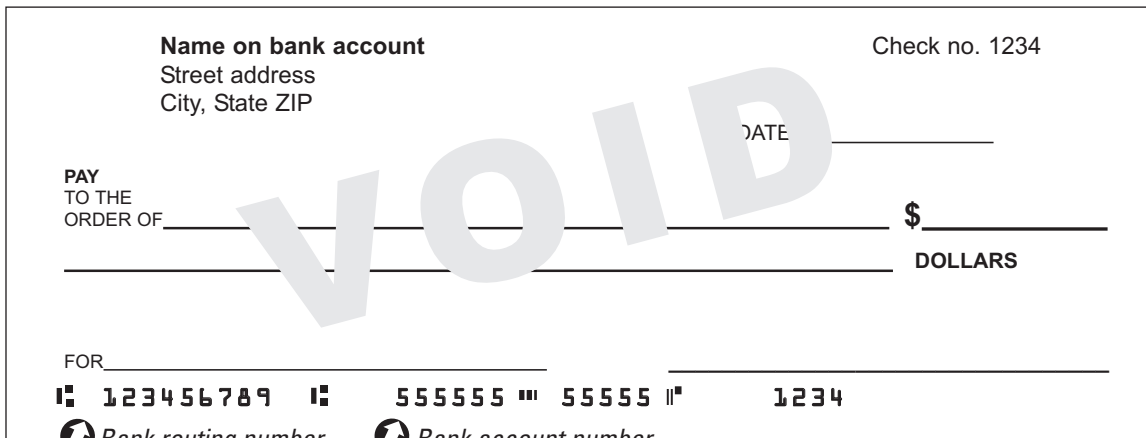
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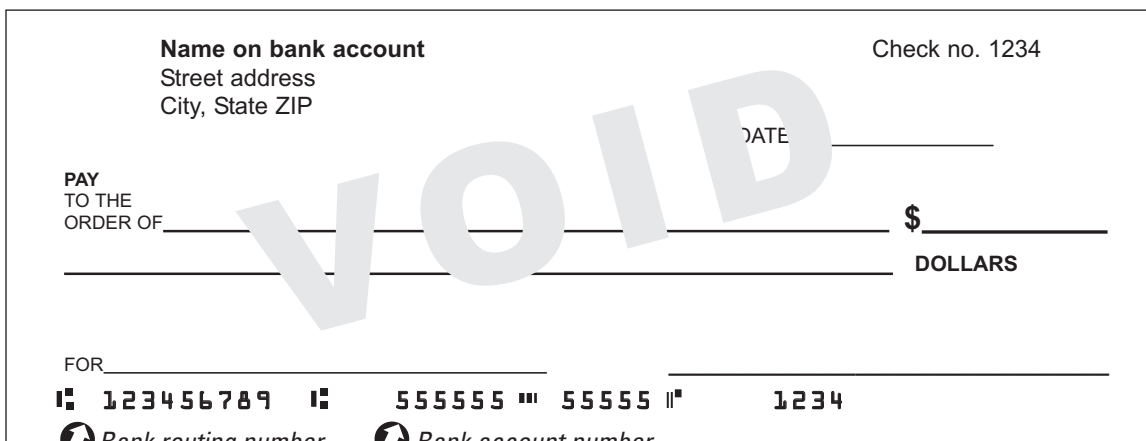
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