Life Insurance Inquiry

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

Date of Inquiry: ______/______/______
month day year

THIS INQUIRY IS NOT AN APPLICATION FOR INSURANCE

The purpose of this request is to obtain a tentative, nonbinding insurance quote. In order for Prudential to order any medical records each Proposed Client must sign an "Authorization for the Release of Information" (COMB 1167A Ed. 2015) and be given a copy of the Important Notice (COMB 83961).

SECTION A - SUBMISSION INFORMATION

1. Why is this case being submitted informally vs formally at this time? *(Check all that apply)*

☐ Previous rating or rejection ☐ NY Reg 60
☐ Health history ☐ Avocation ☐ Other: **(Describe)** ____________________
☐ Aviation ☐ Trust pending

2. Who will be obtaining medical records for review? ☐ Producer ☐ Prudential
3. Note: Paramedical exams are only ordered as an exception on Inquiries. Please indicate if you need/want Prudential to order a paramedical exam at this time. ☐ Yes ☐ No

SECTION B - PRODUCER INFORMATION

1. Firm name *(If applicable)* ____________________
2. Producer name ____________________
3. Producer Social Security Number ___ ___ ___ ___ ___ ___ ___ ___ ___
4. Producer contract number *(If available)* ____________________
5. Email for case communication ____________________

SECTION C - PROPOSED COVERAGE INFORMATION

1. Face Amount ____________________
2. Product or type of coverage ____________________
3. Beneficiary name and relationship ____________________
4. Is potential coverage for business purposes? ☐ Yes ☐ No

If Yes, ☐ Buy/Sell ☐ Keyperson ☐ Other ____________________

SECTION D - PROPOSED CLIENT 1 INFORMATION

1. Name of Client *(first, middle, and last)* ____________________
2. Residential Address *(Street, City, State, Zip)* ____________________
3. Gender ☐ Male ☐ Female 4. Date of Birth ______/______/______ 5. State of Birth *(Country if not U.S.)* ____________________

month day year

6. Contact Phone Number for Exam Scheduling *(If applicable)* ____________________
7. Height: _______feet _______inches Weight:______pounds
8. Has the client's weight changed more than 10 pounds in the last year? ☐ Yes ☐ No

Details, including how long weight has been stable ____________________

9. Occupation/Job Duties ____________________ 10. Annual income $____________________
11. Annual household income $____________________ 12. Household net worth $____________________
13. Total life insurance currently in force $____________________
14. Does the client intend to replace or change any existing coverage? ☐ Yes Amount $____________ ☐ No
15. Name, address and phone of primary physician ____________________

a. Date, reason and results of last visit

____

____

SECTION E - PROPOSED CLIENT 2 INFORMATION (SUL CASES ONLY)

1. Name of Client *(first, middle, and last)* ______________________________
2. Residential Address *(Street, City, State, Zip)* ______________________________
3. Gender ☐ Male ☐ Female 4. Date of Birth ____/____/______ 5. State of Birth *(Country if not U.S.)* ______________
month day year
6. Contact Phone Number for Exam Scheduling *(If applicable)* ______________________
7. Height: _______feet ________inches Weight:______pounds
8. Has the client's weight changed more than 10 pounds in the last year? ☐ Yes ☐ No
Details, including how long weight has been stable ______________________
9. Occupation/Job Duties ______________________ 10. Annual income $______________________
11. Annual household income $______________________ 12. Household net worth $______________________
13. Total life insurance currently in force $______________________
14. Does the client intend to replace or change any existing coverage? ☐ Yes Amount $______________ ☐ No
15. Name, address and phone of primary physician ______________________
a. Date, reason and results of last visit
____
____

SECTION F - GENERAL INFORMATION (PROVIDE DETAILS IN ADDITIONAL DETAILS, SECTION G)

1. In the last five years, has the client:
   a. had any duties aboard an aircraft or does s/he intend to? Client 1 ☐ Yes ☐ No Client 2 ☐ Yes ☐ No
   b. participated in any hazardous activities or does s/he intend to? Client 1 ☐ Yes ☐ No Client 2 ☐ Yes ☐ No
   c. had any driving violations (e.g. moving violations, DUI, accidents, suspensions)? Client 1 ☐ Yes ☐ No Client 2 ☐ Yes ☐ No
   d. used any drugs not prescribed by a medical professional or been advised to or received treatment for drugs or alcohol abuse? Client 1 ☐ Yes ☐ No Client 2 ☐ Yes ☐ No
   e. had any life or health insurance changed as to plan, rate or amount? Client 1 ☐ Yes ☐ No Client 2 ☐ Yes ☐ No

2. Has the client ever used tobacco or nicotine products such as cigarettes, cigars, pipe, chewing tobacco, snuff, nicotine gum or nicotine patches?
Client 1 ☐ No ☐ Yes Product type ____________ Date last used ____________ Frequency of use ____________
Client 2 ☐ No ☐ Yes Product type ____________ Date last used ____________ Frequency of use ____________

3. Is the client a legal US resident? *(Provide details if "No" in Section G)*
Client 1 ☐ Yes ☐ No Client 2 ☐ Yes ☐ No

4. Family History:
Client 1

Family Member (circle gender of siblings)	Current Age	Age at Death & Cause of Death	Family Member (circle gender of siblings)	Current Age	Age at Death & Cause of Death
Father			Sibling: Male Female		
Mother			Sibling: Male Female		
Sibling: Male Female			Sibling: Male Female		

Client 2

Family Member (circle gender of siblings)	Current Age	Age at Death & Cause of Death	Family Member (circle gender of siblings)	Current Age	Age at Death & Cause of Death
Father			Sibling: Male Female		
Mother			Sibling: Male Female		
Sibling: Male Female			Sibling: Male Female		

SECTION G - ADDITIONAL DETAILS

Provide details to any “Yes” answers from Section F, including the Client name and question number:

Client 1	Client 2	Question #	Details

SECTION H - MEDICAL INFORMATION

Please provide details about the client’s medical history, including all medical conditions, physical disorders, or diseases that the client has been diagnosed with and/or treated for:

Client 1	Client 2	Diagnosis/Medical Condition	Date of Onset/ recovery	Treatment - including medication, device (ex CPAP), surgery, etc.	Name, address and phone of attending physician or medical facility

SECTION I - ADDITIONAL REMARKS

Prudential

Authorization for the Release of Information

The Prudential Insurance Company of America
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This Authorization was intended to comply with the HIPAA Privacy Rule

Acknowledgment. I have received the **Important Notice**.

- I authorize any licensed physician, medical practitioner, hospital, clinic, other health care provider, pharmacy benefit manager, insurance company or producer, financial or legal advisor, government agency, MIB Inc, consumer reporting agency, or other organization or person to give any information about me, or my mental or physical health to the Company and/or its authorized agents to determine my eligibility for insurance and/or benefit payment, and/or to conduct legally permissible actuarial, audit and research activities. It also includes motor vehicle records.
- The information authorized for release includes:

  My entire medical record, including any information regarding medications used, drug and alcohol treatment, and communicable or venereal diseases, such as hepatitis, syphilis, gonorrhea, the human immunodeficiency virus (HIV), and Acquired Immune Deficiency Syndrome (AIDS), and the diagnosis and treatment of mental health conditions, excluding psychotherapy notes.
- For purposes of this Authorization, I hereby revoke any prior restriction on disclosure of my medical records, and authorize the release of my entire medical record to the Company, excluding psychotherapy notes.
- This Authorization may be revoked at any time by writing us at the Customer Service Office address provided in the Important Notice. The revocation will not be valid to the extent we relied on the authorization prior to the notice of revocation. Revocation or alteration of this Authorization may mean that we will not be able to complete the evaluation process.
- 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 is valid for 2 years after the date below for the purposes stated above.
- A copy of this Authorization will be provided to me or my authorized representative by my insurance representative or the Company, either at the time of execution or shortly thereafter. I understand my representative can tell me how and when I will receive a copy. A photocopy of this Authorization is as valid as the original.
- Treatment, payment, enrollment in a health plan, or eligibility for health benefits may not be conditioned on signing this authorization.

➔Signature of client **X** ____ Date: ____________________

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  My entire medical record, including any information regarding medications used, drug and alcohol treatment, and communicable or venereal diseases, such as hepatitis, syphilis, gonorrhea, the human immunodeficiency virus (HIV), and Acquired Immune Deficiency Syndrome (AIDS), and the diagnosis and treatment of mental health conditions, excluding psychotherapy notes.
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➔Signature of client **X** ______________________________ Date: ____________________

Prudential

Important Notice

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

Disclosing Information

We will treat any information we obtain or have obtained about you as confidential. We may disclose information we have collected as follows: to affiliates or third parties that perform services for us, or on our behalf, or that are providing service to you; to your doctor; to insurance regulators; to law enforcement or other governmental authorities under limited circumstances; for actuarial or research studies; or as otherwise permitted or required, with or without your authorization, by applicable law. Prudential or its reinsurers may make a brief report to the MIB, a not for profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the MIB, upon request, will supply such company with the information in its file. Information about MIB may be obtained on its website at www.mib.com. Prudential, or its reinsurers, may also release information in its file to other life insurance companies to which you may apply for life or health insurance or to which a claim for benefits may be submitted. A consumer reporting agency that prepares 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 you submit an application for a contract and we do not issue the contract you requested, we will tell you and explain the reasons for our decision in writing. However, these rights will not apply if your insurance producer submits an inquiry but no application is submitted by you. You have the right to make a written request within a reasonable period of time to receive additional, detailed information about the nature and scope of any investigative consumer report we request. You also have the right to request a written summary of your rights as a consumer from the consumer reporting agency that prepared the report. Upon your request to the address below, we will provide you with our notice of information practices. If you write to us at the address shown below, we will describe the information we have relating to this insurance transaction, describe how you may get access to it, tell you about certain disclosures that may have been made, and tell you how you may request correction, amendment or deletion of information that you dispute. If you request one, a copy of any consumer report we obtained about you will be provided to you.

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

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