



POLICY DELIVERY STATE: \_\_\_\_\_

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

A. CASE DETAILS

1. General agency contract number: \_\_\_\_\_

B. PROPOSED INSURED (POLICYOWNER UNLESS OTHERWISE NAMED)

1. Name: \_\_\_\_\_

2. Social Security Number: \_\_\_\_\_ 3. Gender:  Female  Male 4. Date of birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

5. Date policy to save age?  Yes  No

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

*If None, why not?:* \_\_\_\_\_

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

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

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

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

9. Email address (required): \_\_\_\_\_

10. Contact phone numbers: Home: \_\_\_\_\_ Business: \_\_\_\_\_ Alternate: \_\_\_\_\_

Preferred contact number: Check one:  Home  Business  Alternate

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

*If No, provide:* Country of legal residence: \_\_\_\_\_ Length of U.S. residence: \_\_\_\_\_

Type of visa: \_\_\_\_\_ Visa number: \_\_\_\_\_ Expiration date: \_\_\_\_\_

12. Earned annual income: \$ \_\_\_\_\_ Unearned annual income: \$ \_\_\_\_\_ Net worth: \$ \_\_\_\_\_

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

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

*If Yes, provide names:* \_\_\_\_\_

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

Name: \_\_\_\_\_

C. PLAN OF INSURANCE

1. Amount of insurance applied for: \$ \_\_\_\_\_

2. Product applied for:  Term Essential®:  10  15  20  30

PruLife® Founders Plus (PFP)

FlexGuard Life (IVUL)

Other: \_\_\_\_\_

PruLife® Custom Premier II (PCP II)

VUL Protector<sup>SM</sup> (VULP)

PruLife® Essential Universal Life (EUL)

PruLife® Index Advantage (IAUL)

3. For **UL and VUL products only**: Death Benefit type:

Type A (Level)  Type B  Type C (Return of Premium)—**N/A for VULP & IVUL**—Interest rate: \_\_\_\_\_%

4. For **UL and VUL products only**: Definition of life insurance:

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

5. Requested Optional Benefits (Not all benefits are available for all products.):

Waiver of Premium/Enhanced Disability Benefit

Acceleration of Death Benefit (Living Needs Benefit)

Accidental Death Benefit: Amount \$ \_\_\_\_\_

BenefitAccess Rider

*If applicable, Select Max Monthly Benefit Percentage*  2% or  4%

Other Riders/Benefits (indicate amount where applicable): \_\_\_\_\_

Overloan Protection Rider

Child Rider: Amount \$ \_\_\_\_\_

Automatic Premium Loan

Enhanced Cash Value Rider



**D. PREMIUM**

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

**E. BENEFICIARY DETAILS**

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

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

**F. INSURANCE HISTORY**

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

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

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

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

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

**OH JUVENILE (AGE 0 - 17) ONLY:**

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

**All other states:**

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

**F. INSURANCE HISTORY (CONTINUED)**

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

9. Do you have any other accident and health care insurance policy, accelerated death benefit policy or rider, long term care insurance, nursing home insurance, home care insurance or long term care insurance provided under the Partnership for Long Term Care Program as defined by New York law?  Yes  No

10. Is this rider intended to replace the coverage identified in #9 above?  Yes  No

11. List the following details for all existing coverage:

a. Company \_\_\_\_\_ Amount \$ \_\_\_\_\_ Policy/Certificate Number \_\_\_\_\_ To Be Replaced?  Yes  No

- Type of Benefit:  Long Term Care Insurance provided under the Partnership for Long Term Care Program  
 Accident and Health Care Insurance  Accelerated Death Benefit Policy or Rider  
 Long Term Care Insurance  Nursing Home Insurance  
 Home Care Insurance

b. Company \_\_\_\_\_ Amount \$ \_\_\_\_\_ Policy/Certificate Number \_\_\_\_\_ To Be Replaced?  Yes  No

- Type of Benefit:  Long Term Care Insurance provided under the Partnership for Long Term Care Program  
 Accident and Health Care Insurance  Accelerated Death Benefit Policy or Rider  
 Long Term Care Insurance  Nursing Home Insurance  
 Home Care Insurance

c. Company \_\_\_\_\_ Amount \$ \_\_\_\_\_ Policy/Certificate Number \_\_\_\_\_ To Be Replaced?  Yes  No

- Type of Benefit:  Long Term Care Insurance provided under the Partnership for Long Term Care Program  
 Accident and Health Care Insurance  Accelerated Death Benefit Policy or Rider  
 Long Term Care Insurance  Nursing Home Insurance  
 Home Care Insurance

**G. TAX CERTIFICATION**

1. Back-up withholding (select one):  
 The policyowner is subject to backup withholding under Section 3406(a)(1)(C) of the Internal Revenue Code.  
 The policyowner is **NOT** subject to backup withholding under Section 3406(a)(1)(C) of the Internal Revenue Code.
2. The policyowner is subject to FATCA reporting under Section 6038D.  Yes  No
3. The policyowner is a U.S. person (including a U.S. resident alien).  Yes  No

**H. FINANCIAL DETAILS (COMPLETE FINANCIAL SUPPLEMENT WITH TOTAL FACE AMOUNTS OF \$5,000,000 OR MORE UP TO AGE 70, \$2,500,000 OR MORE AGES 71-80, \$1,000,000 OR MORE AGES 81 AND UP. FINANCIAL INFORMATION PREPARED BY AN INDEPENDENT THIRD-PARTY IS REQUIRED FOR APPLICATIONS WITH TOTAL FACE AMOUNTS OF \$10,000,000 OR MORE UP TO AGE 70, \$2,500,000 OR MORE AGES 71-80, \$1,000,000 OR MORE AGES 81 AND UP.)**

Submit copies of material that supplements the information requested, such as loan commitments, written buy-sell agreements, audited financial statements or letters. If the *Additional Financial Information* form (ORD 86154-2013) is submitted in-lieu of independent third-party financial documentation, the form is required to be completed by the third-party financial advisor and signed by the proposed insured(s), owner(s), and producer.

**Financial Information**

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

**H. FINANCIAL DETAILS (CONTINUED)**

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

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

Additional comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**I. POLICYOWNER STATEMENT**

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

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

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

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

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

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

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

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

\_\_\_\_\_

\_\_\_\_\_

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

For multiple owners, list details in Remarks.

1. Name of policyowner: \_\_\_\_\_

2. Social Security/Tax identification Number (SSN/TIN): \_\_\_\_\_

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

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

5. Policyowner's email address: \_\_\_\_\_

6a. For trust owner: **Complete the Trustee Statement and Agreement.**

Trust date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Trustee(s) \_\_\_\_\_

Type:  Revocable  Irrevocable  Qualified Retirement Plan Trust  Welfare Benefit Trust

6b. For business owner:

Form:  Corporation  Partnership  Sole Proprietorship  Other: \_\_\_\_\_  
 S Corporation  LLC  Tax Exempt

6c. For personal owner:

Total insurance program: Currently inforce: \$ \_\_\_\_\_ Pending applications: \$ \_\_\_\_\_

Relationship to proposed insured: \_\_\_\_\_ Date of birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

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

Why will this person own the contract?

Business Insurance  Estate Tax  Support for Insured  
 Final Expenses  Other \_\_\_\_\_

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

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

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

Proposed Insured  Accountant/CPA  Banker  Attorney  Producer  Other: \_\_\_\_\_

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

Proposed Insured  Accountant/CPA  Banker  Attorney  Producer  Other: \_\_\_\_\_

3. Name of company: \_\_\_\_\_

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

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

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

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

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

a.  Buy-Sell Arrangement

- 1. Is there a written buy-sell agreement?  Yes  No
- 2. Are all other parties to agreement already covered by or applying for comparable amounts of insurance?  Yes  No

**If No, explain:** \_\_\_\_\_

b.  Key Person

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

**If No, explain:** \_\_\_\_\_

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

\_\_\_\_\_

c.  Business Loan Collateral

- 1. Is the insurance required by the creditor?  Yes  No
- 2. Is the Proposed Insured personally responsible for the loan?  Yes  No

3. Name of creditor/lending institution: \_\_\_\_\_

4. What is the purpose of the loan? \_\_\_\_\_

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

6. What is the repayment schedule? \_\_\_\_\_

7. Date loan was committed: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**If not yet committed, please explain:** \_\_\_\_\_

\_\_\_\_\_

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

9. Business values:

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

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

10. Additional comments: \_\_\_\_\_

**L. ACCOUNT SELECTION FOR PRULIFE® FOUNDERS PLUS UL OR PRULIFE® INDEX ADVANTAGE UL**

**1A. COMPLETE THIS SECTION FOR PRULIFE FOUNDERS PLUS UL (2020 OR LATER):**

The policy applied for provides for automatic transfers of premiums and other amounts paid into the policy from the Fixed Account to the Indexed Account(s). Amounts eligible for transfer are described in the policy.

**Retain in:** Fixed Account: \_\_\_\_\_ %  
**Transfer to:** S&P 500® Indexed Account \_\_\_\_\_ %  
(offers opportunity for index interest based on performance of the \*S&P 500® Index): \_\_\_\_\_ %  
Goldman Sachs Voyager Indexed Account \_\_\_\_\_ %  
(offers opportunity for index interest based on performance of the \*\*GS Voyager Index): \_\_\_\_\_ %  
**Total** 100 %

**Optional Election of Designated Transfer Amount.** The amount designated will be transferred monthly on the Transfer Date, from the Fixed Account to the Indexed Account(s). Use of this feature requires that at least a portion of your payment allocations be directed to the Fixed Account.

Dollar amount of designated transfer: \$ \_\_\_\_\_

**Transfer to:**

\*S&P 500® Indexed Account: \_\_\_\_\_ %  
\*\*Goldman Sachs Voyager Indexed Account: \_\_\_\_\_ %  
**Total** 100 %

Number of months for designated transfer: \_\_\_\_\_ or  unlimited

**2A. COMPLETE THIS SECTION FOR PRULIFE® INDEX ADVANTAGE UL (2016 OR LATER)**

The policy applied for provides for automatic transfers of premiums and other amounts paid into the policy from the Fixed Account to Indexed Accounts.

**Retain in:** Fixed Account: \_\_\_\_\_ %  
**Transfer to:** \*S&P 500® Indexed Account: \_\_\_\_\_ %  
**Transfer to:** \*S&P 500® Uncapped Indexed Account: \_\_\_\_\_ %  
**Total** 100 %

**Designated Transfers (Optional)**

The Index Advantage Universal Life Policy allows for a specific dollar amount to be transferred monthly on the Transfer Date, from the Fixed Accounts to the Indexed Accounts. Use of this feature requires that at least a portion of your payment allocations be directed to the Fixed Account.

Dollar amount of designated transfer: \$ \_\_\_\_\_

**Transfer to:**

\*S&P 500® Indexed Account: \_\_\_\_\_ %  
\*S&P 500® Uncapped Indexed Account: \_\_\_\_\_ %  
**Total** 100 %

Number of months for designated transfer: \_\_\_\_\_ or  unlimited

**M. VARIABLE CONTRACTS (COMPLETE THIS SECTION WHEN APPLICATION IS FOR A VARIABLE CONTRACT.)**

**1. Investment Options and Allocations** (Indicate investment option, code & allocation percentage for each fund chosen.)

Total allocation must equal 100%.)

- Allocations to the Fixed Rate Option (FXRT) are subject to transfer restrictions to subaccounts.
- Fixed Rate Option is required to be used for Designated Transfers (below) into Index Strategies.
- Automatic Money Market (AMKT) is required to be used for Dollar Cost Averaging (DCA, below).
- If you select the Extended Plus No-Lapse Guarantee Rider (below), your allocations are restricted to Buffered Index Strategies.

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

To enroll in Dollar Cost Averaging (DCA), the *Request for Dollar Cost Averaging-Enrollment or Change* (COMB 98815) form must be completed. **Automatic Money Market (AMKT) is required to be used for Dollar Cost Averaging (DCA).**

**2. No-Lapse Guarantee:** If applying for Flexguard Life IVUL, you may extend your policy's built-in No-Lapse Guarantee by selecting a rider below.

- Extended No-Lapse Guarantee Rider** – the No-Lapse Guarantee Rider will terminate no later than the policy anniversary immediately on or after the insured's 91st birthday.
- Extended Plus No-Lapse Guarantee Rider** – the No-Lapse Guarantee Rider will terminate no later than the policy anniversary immediately on or after the insured's 121st birthday.

**3. S&P 500® Indexed Account Rider:** If applying for PruLife Customer Premier II, election of this rider allows you to select the S&P 500® Indexed Account, now or in the future.

- Check this box to elect the S&P 500® Indexed Account Rider**

**4. Designated Transfers (optional):** You may specify a dollar amount to be transferred monthly on the transfer date to the Index Strategy(ies).

- A portion is required to be allocated to Fixed Rate Option (FXRT) in section 1 above.
- For product(s) that offer(s) S&P 500® Indexed Account as a Rider, the rider is required to be selected in section 3 above to request designated transfers.

Dollar amount of designated transfer: \$ \_\_\_\_\_

Number of months for designated transfer: \_\_\_\_\_ or  unlimited

**FLEXGUARD LIFE IVUL ONLY:**

Transfer to:

Index Strategy	Code	Allocation	Index Strategy	Code	Allocation
_____	_____	_____ %	_____	_____	_____ %
_____	_____	_____ %			

**5. Allocated Charges** (Must be in whole percentages, maximum 2):

Investment Option: \_\_\_\_\_ Percentage: \_\_\_\_\_%      Investment Option: \_\_\_\_\_ Percentage: \_\_\_\_\_%

To enroll in Automatic Rebalancing, the *Request for Auto Rebalance* (ORD 96819) form must be completed.

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

Did the policyowner authorize telephone reallocation and fund transfer?  Yes  No

He/She understands that by not taking this option any future request for this option must be submitted in writing.

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