Prudential

Application for Life Insurance
Survivorship Life

Corporate Offices, Newark, New Jersey

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

POLICY NUMBER (IF KNOWN): _____

PART 1 – A. FIRST PROPOSED INSURED (1ST PI)

1. Name: _____
2. Previous name (if changed in the last 5 yrs.): _____
3. Social Security number: _____ 4. State of birth (Country if not U.S.): _____
5. Gender: ☐ Female ☐ Male 6. Date of birth: ____/____/____ 7. Date policy to Save Age? ☐ Yes ☐ No
8. Are you a permanent, legal US resident? ☐ Yes ☐ No
   If No, provide country of legal residence, type and number of visa, expiration date and length of US residence **:**
   _____
9. Driver's license issuing state: _____ Number: _____ Expiration date: _____
   If None, why not? **:** _____
10. Residence address (No PO boxes): Street _____ Apt _____
    City _____ State _____ ZIP _____
11. e-mail address: _____
12. Home telephone number: _____ Business telephone number (ext.): _____
13. Current employer name: _____
    Business address: Street _____ Suite _____
    City _____ State _____ ZIP _____
14. Occupation: _____
    Duties: _____
15. Earned annual income $_____ Unearned annual income $_____ Net worth $_____

A-2. SECOND PROPOSED INSURED (2ND PI)

1. Name: _____
2. Previous name (if changed in the last 5 yrs.): _____
3. Social Security number: _____ 4. State of birth (Country if not U.S.): _____
5. Gender: ☐ Female ☐ Male 6. Date of birth: ____/____/____ 7. Date policy to Save Age? ☐ Yes ☐ No
8. Are you a permanent, legal US resident? ☐ Yes ☐ No
   If No, provide country of legal residence, type and number of visa, expiration date and length of US residence **:**
   _____
9. Driver's license issuing state: _____ Number: _____ Expiration date: _____
   If None, why not? **:** _____
10. Residence address (If different from 1st PI. No PO boxes.): Street _____ Apt _____
    City _____ State _____ ZIP _____
11. e-mail address: _____
12. Home telephone number: _____ Business telephone number (ext.): _____
13. Current employer name: _____
    Business address: Street _____ Suite _____
    City _____ State _____ ZIP _____
14. Occupation: _____
    Duties: _____
15. Earned annual income $_____ Unearned annual income $_____ Net worth $_____

B. PLAN OF INSURANCE

1. Amount of insurance applied for: $_____ **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.**
2. Product applied for: ☐ PruLife® SUL Protector ☐ Other: _____
3. For Death Benefit type: ☐ Type A (Level) ☐ Type B (Variable) ☐ Type C (Return of Premium)
4. Requested Optional Benefits: ☐ Estate Protection Rider: Amount $_____
   ☐ Enhanced Cash Value Rider ☐ Other Riders/Benefits *(indicate where applicable)*: _____

C. 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: ☐ Annual ☐ Semiannual ☐ Quarterly ☐ Monthly – Electronic Funds Transfer
3. Billed premium: $_____

D. OWNER (COMPLETE IF OWNER IS OTHER THAN THE PROPOSED INSUREDS)

For multiple owners, details are to be listed in Special Requests, section H.

1. Name of owner: _____
2. Social Security/Tax identification number (SSN/TIN): _____
3. Residence address (No PO boxes): Street _____ Apt _____
   City _____ State _____ ZIP _____
4. Owner's email address: _____

5a. For trust owner: **Complete the *Trustee Statement and Agreement* (COMB 86044).** Trust date: ____/____/____
   Trustee(s)_____
   Type: ☐ Revocable ☐ Irrevocable ☐ Qualified Retirement Plan Trust ☐ Welfare Benefit Trust

5b. For business owner: **Complete the *Business Supplement.***
   Form: ☐ Corporation ☐ Partnership ☐ Sole proprietorship ☐ Other: _____
   ☐ S Corporation ☐ LLC ☐ Tax exempt

5c. For personal owner:
   Total insurance program: Currently in-force: $ _____ Pending applications: $_____
   Relationship to Proposed Insured: _____ Date of birth: ____/____/____
   Earned annual income: $_____ Unearned annual income: $_____ Net worth: $_____

E. BENEFICIARY DETAILS

If insurance is for business purposes, also complete the Business Insurance Supplement. 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
					☐	☐
					☐	☐
					☐	☐
					☐	☐

F. INSURANCE HISTORY

	1st PI	2nd PI
1. Do you have any existing life insurance or annuities? Note: Existing coverage includes any life insurance policies that have been assigned, sold or transferred.	☐ Yes ☐ No	☐ Yes ☐ No
2. Will this insurance replace* any existing insurance or annuity?	☐ Yes ☐ No	☐ Yes ☐ No

1st PI

3a. List the following details for all existing coverage. (List only annuities to be replaced*, list all in force life insurance):

Insurance Company	Face Amount	Type	Product	To Be Replaced?*	1035 Exchange?
______________	$__________	☐ Group ☐ Individual	☐ Annuity ☐ Life	☐ Yes ☐ No	☐ Yes ☐ No
______________	$__________	☐ Group ☐ Individual	☐ Annuity ☐ Life	☐ Yes ☐ No	☐ Yes ☐ No
______________	$__________	☐ Group ☐ Individual	☐ Annuity ☐ Life	☐ Yes ☐ No	☐ Yes ☐ No
______________	$__________	☐ Group ☐ Individual	☐ Annuity ☐ Life	☐ Yes ☐ No	☐ Yes ☐ No
______________	$__________	☐ Group ☐ Individual	☐ Annuity ☐ Life	☐ Yes ☐ No	☐ Yes ☐ No

*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.

2nd PI

3b. List the following details for all existing coverage. (List only annuities to be replaced*, list all in force life insurance):

Insurance Company	Face Amount	Type	Product	To Be Replaced?*	1035 Exchange?
______________	$__________	☐ Group ☐ Individual	☐ Annuity ☐ Life	☐ Yes ☐ No	☐ Yes ☐ No
______________	$__________	☐ Group ☐ Individual	☐ Annuity ☐ Life	☐ Yes ☐ No	☐ Yes ☐ No
______________	$__________	☐ Group ☐ Individual	☐ Annuity ☐ Life	☐ Yes ☐ No	☐ Yes ☐ No
______________	$__________	☐ Group ☐ Individual	☐ Annuity ☐ Life	☐ Yes ☐ No	☐ Yes ☐ No
______________	$__________	☐ Group ☐ Individual	☐ Annuity ☐ Life	☐ Yes ☐ No	☐ Yes ☐ No

*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.

	1st PI	2nd PI
4. Are you applying for or reinstating life insurance with any company? ***If Yes, give name of insured, amount applied for and total amount to be placed, including this application.***	☐ Yes ☐ No	☐ Yes ☐ No
5. Have you had life or health insurance declined, postponed or issued with an increased premium? ***If Yes, give name of insured, company name, type of insurance, date, action taken and reason for action.***	☐ Yes ☐ No	☐ Yes ☐ No
6. Is either 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?	☐ Yes ☐ No	☐ Yes ☐ No

If Yes, provide details : ______________________________

G. GENERAL INFORMATION

	1ST PI	2ND PI
1. In the past five years, have you flown as a pilot, student pilot or crew member or do you intend to become a pilot?	☐ Yes ☐ No	☐ Yes ☐ No
2. In the past five years, have you participated in any activities such as motorized vehicle racing, SCUBA diving, mountain climbing, skydiving, extreme sports such as BASE jumping, bungee jumping or cave exploration, or do you intend to?	☐ Yes ☐ No	☐ Yes ☐ No

If Yes, to Question 1 or 2 above, complete the appropriate Supplement.

3. Have you ever used tobacco or any other nicotine products such as cigarettes, cigars, pipe, chewing tobacco, snuff, nicotine gum or nicotine patch? ***If Yes, provide details*** **:** ☐ Yes ☐ No ☐ Yes ☐ No

1ST PI

Product Type(s)	Date Last Used	Frequency of Use

2ND PI

Product Type(s)	Date Last Used	Frequency of Use

4. In the past five years, have you:

a. had your driver's license denied, suspended or revoked?	☐ Yes ☐ No	☐ Yes ☐ No
b. been convicted of or pled guilty to driving under the influence of alcohol and/or drugs?	☐ Yes ☐ No	☐ Yes ☐ No
c. been convicted of or pled guilty to any moving violations?	☐ Yes ☐ No	☐ Yes ☐ No

5. Within the past 10 years, have you been arrested, convicted, or imprisoned for any crime and/or are you currently awaiting trial for any crime?	☐ Yes ☐ No	☐ Yes ☐ No
6. Will you live or travel outside the United States within the next 12 months? ***Details required include location (city/country), frequency, duration and purpose of each trip.***	☐ Yes ☐ No	☐ Yes ☐ No

7. Give complete details of any "Yes" answers for questions 4 – 6, including question number, proposed insured and appropriate details:

Question #	PI	Details

H. SPECIAL REQUESTS

PART 2

A. PERSONAL PHYSICIAN INFORMATION

1ST PI

Name _____

Address: Street _____ Suite _____

City _____ State _____ ZIP _____

Telephone number (____) _____ Date last seen _____

Reason last seen: _____

2ND PI

Name _____

Address: Street _____ Suite _____

City _____ State _____ ZIP _____

Telephone number (____) _____ Date last seen _____

Reason last seen: _____

If more than one personal physician, provide details in section D, number 6.

B. PHYSICAL MEASUREMENTS

1ST PI

1. Height: _____ feet _____ inches Weight: _____ pounds
2. Within the last 12 months, have you had a change of weight (gain or loss) of more than 10 pounds? ☐ Yes ☐ No

   If Yes, provide details **:** _____

2ND PI

1. Height: _____ feet _____ inches Weight: _____ pounds
2. Within the last 12 months, have you had a change of weight (gain or loss) of more than 10 pounds? ☐ Yes ☐ No

   If Yes, provide details **:** _____

C. FAMILY HISTORY

1ST PI

1. Have any immediate family members (mother, father, brother, sister) been diagnosed with or died from coronary artery disease, cerebrovascular disease, diabetes or cancer before age 70? ☐ Yes ☐ No

   If Yes, provide details including which member and medical condition, age at diagnosis and age at death (if applicable) **:**

2. **Father:** Current age _____ or Age at death: _____ **Mother:** Current age _____ or Age at death: _____

2ND PI

1. Have any immediate family members (mother, father, brother, sister) been diagnosed with or died from coronary artery disease, cerebrovascular disease, diabetes or cancer before age 70? ☐ Yes ☐ No

   If Yes, provide details including which member and medical condition, age at diagnosis and age at death (if applicable) **:**

2. **Father:** Current age _____ or Age at death: _____ **Mother:** Current age _____ or Age at death: _____

D. MEDICAL INFORMATION

	1ST PI		2ND PI	
1. Has a member of the medical profession ever treated you for or diagnosed you with:				
a. high blood pressure, chest pain, a heart attack, coronary artery disease, a heart valve disorder, a heart murmur, an irregular heart beat, cerebrovascular disease, a stroke, circulatory disease, an aneurysm or any disease of the heart or blood vessels?	☐ Yes	☐ No	☐ Yes	☐ No
b. anemia or other abnormality of the blood (other than HIV)?	☐ Yes	☐ No	☐ Yes	☐ No
c. a polyp, cyst, tumor, cancer, leukemia, melanoma, lymphoma or Hodgkin's disease?	☐ Yes	☐ No	☐ Yes	☐ No
d. diabetes, high blood sugar, glucose intolerance or other endocrine disorder?	☐ Yes	☐ No	☐ Yes	☐ No
e. anxiety, depression, or any other mental or psychiatric illness?	☐ Yes	☐ No	☐ Yes	☐ No
f. an infection caused by the Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), or any other sexually transmitted disease?	☐ Yes	☐ No	☐ Yes	☐ No
g. asthma, emphysema, cystic fibrosis, sleep apnea, sarcoidosis, tuberculosis or any other disorder of the lungs or respiratory system?	☐ Yes	☐ No	☐ Yes	☐ No
h. a seizure, epilepsy, multiple sclerosis, Parkinson's disease, muscular dystrophy, cerebral palsy, paralysis, Alzheimer's disease or any other disorder of the brain or nervous system?	☐ Yes	☐ No	☐ Yes	☐ No
i. an ulcer, hepatitis, cirrhosis, pancreatitis, ulcerative colitis, Crohn's disease or any other disorder of the esophagus, liver, stomach or intestines?	☐ Yes	☐ No	☐ Yes	☐ No
j. nephritis, polycystic kidney disease or any other disorder of the bladder, kidney, urinary tract or prostate?	☐ Yes	☐ No	☐ Yes	☐ No
k. arthritis, gout, back trouble, or any disease or disorder of the joints, muscles or bones?	☐ Yes	☐ No	☐ Yes	☐ No
l. lupus, rheumatoid arthritis, chronic fatigue syndrome, fibromyalgia, or any other disease or disorder of the autoimmune system?	☐ Yes	☐ No	☐ Yes	☐ No
2. Have you ever used:				
a. cocaine, crack, marijuana, heroin, Ecstasy, PCP, LSD, methamphetamine, any other hallucinogenic drug or controlled substance?	☐ Yes	☐ No	☐ Yes	☐ No
b. amphetamines, barbiturates, sedatives, opiates or methadone, or controlled substance except as prescribed by a physician?	☐ Yes	☐ No	☐ Yes	☐ No
3. Have you had or been advised to have treatment or counseling for alcohol or drug use or been asked to reduce or eliminate their usage?	☐ Yes	☐ No	☐ Yes	☐ No
4. Other than what has already been disclosed, within the past 5 years, have you:				
a. requested or received disability or compensation benefits?	☐ Yes	☐ No	☐ Yes	☐ No
b. been a patient in a hospital or other medical facility, other than for normal childbirth?	☐ Yes	☐ No	☐ Yes	☐ No
c. been diagnosed or treated by a member of the medical profession for any other disease, disorder or condition?	☐ Yes	☐ No	☐ Yes	☐ No
d. been advised to have surgery, medical tests or diagnostic procedures (other than for HIV)?	☐ Yes	☐ No	☐ Yes	☐ No
5. Are you currently receiving medical treatment or taking any other medication or herbal supplement that has not already been disclosed?	☐ Yes	☐ No	☐ Yes	☐ No

(CONTINUED)

D. MEDICAL INFORMATION (CONTINUED)

6. Give complete details of any "Yes" answers for questions 1-5, including: **Question number, diagnosis, date of onset and recovery, medication/treatment prescribed and the name, address and telephone number of all attending physicians and hospitals.**

PI	Question #	Diagnosis	Date of Onset	Date of Recovery	Medication/ Treatment Prescribed	Physician/Hospital Name, Address & Phone Number

AGREEMENTS

By signing this form, I have carefully reviewed the application including all supplements attached to the policy, and I agree to the following:

- To the best of my knowledge and belief, the statements in this application are complete, true and correctly recorded.
- Except for failure to pay premium, the validity of this policy will not be contested after it has been in force during the insured's lifetime for two years from the date it takes effect.
- My original signature has been affixed to this application, the original will be retained by the Company named at the beginning of this application ("Company"). The copies attached to the policy issued to me are identical in form and substance.
- Any policy issued on this application shall not take effect until after all of the following conditions are met:
  - A payment equal to the full first required premium is received by the Company within the lifetime of the proposed insured. A payment will only be considered to be received if one of the following valid items is received by the Company: (i) a check in the amount of the full first required premium; (ii) a completed and signed payment form for the first full premium; or (iii) any other form of payment acceptable to the Company.
  - The form of payment submitted is honored. If payment is made by credit/debit card, wire transfer or automatic bank draft, no premium is considered to be honored until the Company actually receives the funds unless otherwise provided by applicable law.
  - A signed copy of this Application is received by the Company.
  - The Owner has personally received the policy during the lifetime of and while the health of the Proposed Insured is as stated in this application.
- Only an officer of the Company with the rank or title of Vice President may make or alter any contract or agree not to enforce any of the rights of the Company, and then only in writing. **No producer or medical examiner is authorized to accept risks, pass on insurability, make or alter contracts, or waive any of the other rights or requirements of the Company.** Notice to or knowledge imputed to any producer or medical examiner will not be notice of or knowledge to the Company unless it is set out in writing in this application.

FRAUD WARNING

Any person who knowingly and intentionally gives false or deceptive information when completing an application for insurance or filing a claim, for the purpose of defrauding an insurance company may have committed fraud, or may have violated state law.

SIGNATURES

Owner's Tax Certification (check boxes **ONLY** if applicable):

Under penalties of perjury, I certify that the taxpayer identification number (TIN) I have listed on this form is my correct TIN. I further certify that I am a U.S. person (including resident alien), I am not subject to backup withholding under Section 3406(a)(1)(C) of the Internal Revenue Code, and I am not subject to FATCA reporting.

☐ I have been notified by the Internal Revenue Service that I am subject to backup withholding due to the underreporting of interest or dividends

☐ I am subject to FATCA reporting

☐ I am not a U.S. person (including resident alien). You must submit the applicable Form W-8 (BEN, BEN-E, ECI, EXP or IMY). In most cases, Form W-8BEN will be the appropriate form.

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

Signed at (**STATE**) _____ on (**DATE**) _____

➔ Signature of 1st proposed insured **X** _____

➔ Signature of 2nd proposed insured **X** _____

If policyowner is different from the proposed insured:

➔ *For a personal policyowner(s)*: Signature of policyowner(s) **X** _____

For an entity policyowner(s) (i.e., trust, business): _____

➔ Signature of officer/trustee(s) **X** _____

➔ Title of officer/trustee(s) _____

Signature of producer **X** _____