

SERFF Tracking Number: PRUD-125558856 State: Arkansas
Filing Company: The Prudential Insurance Company of America State Tracking Number: 38516
Company Tracking Number: IIGH-GRP114018-RP-AR
TOI: LTC03I Individual Long Term Care Sub-TOI: LTC03I.001 Qualified
Product Name: Individual Long Term Care Insurance
Project Name/Number: ILTC-4/01768

Filing at a Glance

Company: The Prudential Insurance Company of America

Product Name: Individual Long Term Care Insurance SERFF Tr Num: PRUD-125558856 State: ArkansasLH

TOI: LTC03I Individual Long Term Care
Sub-TOI: LTC03I.001 Qualified

SERFF Status: Closed

State Tr Num: 38516

Co Tr Num: IIGH-GRP114018-RP-AR State Status: Approved-Closed

Filing Type: Form/Rate

Co Status: IIGH

Reviewer(s): Marie Bennett, Harris Shearer

Author: Raenonna Ransom

Disposition Date: 10/01/2008

Date Submitted: 03/25/2008

Disposition Status: Approved

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: ILTC-4

Project Number: 01768

Requested Filing Mode:

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 10/01/2008

State Status Changed: 10/01/2008

Corresponding Filing Tracking Number:

Filing Description:

ILTC-4

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments: Filed Concurrently

Market Type: Individual

Group Market Size:

Group Market Type:

Deemer Date:

Company and Contact

Filing Contact Information

SERFF Tracking Number: PRUD-125558856 State: Arkansas
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Product Name: Individual Long Term Care Insurance
Project Name/Number: ILTC-4/01768

Karen Smyth, Assistant Secretary karen.smyth@prudential.com
2101 Welsh Road (215) 658-6279 [Phone]
Dresher, PA 19025 (888) 294-6332[FAX]

Filing Company Information

The Prudential Insurance Company of America CoCode: 68241 State of Domicile: New Jersey
751 Broad Street Group Code: 304 Company Type: Life
Newark, NJ 07102-3777 Group Name: State ID Number:
(973) 802-6000 ext. [Phone] FEIN Number: 22-1211670

SERFF Tracking Number: PRUD-125558856 State: Arkansas
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Product Name: Individual Long Term Care Insurance
Project Name/Number: ILTC-4/01768

Filing Fees

Fee Required? Yes
Fee Amount: \$290.00
Retaliatory? No
Fee Explanation:
Per Company: No

| COMPANY | AMOUNT | DATE PROCESSED | TRANSACTION # |
|---|----------|----------------|---------------|
| The Prudential Insurance Company of America | \$290.00 | 03/25/2008 | 18941393 |

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 Project Name/Number: ILTC-4/01768

Correspondence Summary

Dispositions

| Status | Created By | Created On | Date Submitted |
|----------|---------------|------------|----------------|
| Approved | Marie Bennett | 10/01/2008 | 10/01/2008 |

Objection Letters and Response Letters

| Objection Letters | | | | Response Letters | | |
|---------------------------------|----------------|------------|----------------|--------------------|------------|----------------|
| Status | Created By | Created On | Date Submitted | Responded By | Created On | Date Submitted |
| Pending Industry Response | Harris Shearer | 08/06/2008 | 08/06/2008 | Raenonna Ransom | 09/30/2008 | 09/30/2008 |

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Disposition

Disposition Date: 10/01/2008

Implementation Date:

Status: Approved

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: PRUD-125558856 State: Arkansas
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 Product Name: Individual Long Term Care Insurance
 Project Name/Number: ILTC-4/01768

| Item Type | Item Name | Item Status | Public Access |
|---------------------|---|-------------|---------------|
| Supporting Document | Certification/Notice | | Yes |
| Supporting Document | Application | | Yes |
| Supporting Document | Health - Actuarial Justification | | Yes |
| Supporting Document | Outline of Coverage | | Yes |
| Supporting Document | Filing Letter | | Yes |
| Supporting Document | Letter of Reply | | Yes |
| Supporting Document | GRP 113124 - Agent/Producer Statement | | Yes |
| Form (revised) | Individual Long Term Care Insurance Policy - Prudential LTC Evolution | | Yes |
| Form | Individual Long Term Care Insurance Policy - Prudential LTC Evolution | Withdrawn | Yes |
| Form | Outline of Coverage | | Yes |
| Form (revised) | 3% Automatic Compound Increase option Rider | | Yes |
| Form | 3% Automatic Compound Increase option Rider | Withdrawn | Yes |
| Form | 5% Automatic Compound Increase Option Inflation Rider | | Yes |
| Form | Non-Forfeiture Benefit Rider | | Yes |
| Form | Shared Care Rider | | Yes |
| Form (revised) | ILTC-4 Application | | Yes |
| Form | ILTC-4 Application | Withdrawn | Yes |
| Form (revised) | ILTC-4 ESP Buy-Up Application | | Yes |
| Form | ILTC-4 ESP Buy-Up Application | Withdrawn | Yes |
| Form (revised) | ILTC-4 ESP Application | | Yes |
| Form | ILTC-4 ESP Application | Withdrawn | Yes |
| Form (revised) | ILTC-4 Plan Design Form | | Yes |
| Form | ILTC-4 Plan Design Form | Withdrawn | Yes |
| Form (revised) | ILTC-4 ESP Plan Design Form | | Yes |
| Form | ILTC-4 ESP Plan Design Form | Withdrawn | Yes |
| Form (revised) | ILTC-4 ESP Buy-Up Plan Design Form | | Yes |
| Form | ILTC-4 ESP Buy-Up Plan Design Form | Withdrawn | Yes |
| | Personal Worksheet | | Yes |

SERFF Tracking Number: PRUD-125558856 State: Arkansas
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Form

| | | |
|-------------|----------------------|-----|
| Rate | Actuarial Memorandum | No |
| Rate | Rate Pages | Yes |

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Product Name: Individual Long Term Care Insurance
Project Name/Number: ILTC-4/01768

Objection Letter

Objection Letter Status Pending Industry Response
Objection Letter Date 08/06/2008
Submitted Date 08/06/2008
Respond By Date 09/08/2008

Dear Karen Smyth,

This will acknowledge receipt of the captioned filing.

Objection 1

- Individual Long Term Care Insurance Policy - Prudential LTC Evolution (Form)

Comment: Page 20 - Subsections of CONTINGENT NON FORFEITURE PROVISION are not properly numbered. please correct.

Objection 2

- 3% Automatic Compound Increase option Rider (Form)

Comment: The form number on this Rider is incorrect. The number should be GRP 114020. Please correct.

Objection 3

- ILTC-4 Application (Form)
- ILTC-4 ESP Buy-Up Application (Form)
- ILTC-4 ESP Application (Form)

Comment: AR Rule 13, Section 14 requires specific questions to elicit information as to other long term care insurance as well as whether or not the agent has previously sold the applicant other health insurance. If this information is solicited on a previously approved Supplemental Application, please furnish form number and date of approval.

Please feel free to contact me if you have questions.

Sincerely,

Harris Shearer

Response Letter

Response Letter Status Submitted to State
Response Letter Date 09/30/2008
Submitted Date 09/30/2008

SERFF Tracking Number: PRUD-125558856 State: Arkansas
Filing Company: The Prudential Insurance Company of America State Tracking Number: 38516
Company Tracking Number: IIGH-GRP114018-RP-AR
TOI: LTC03I Individual Long Term Care Sub-TOI: LTC03I.001 Qualified
Product Name: Individual Long Term Care Insurance
Project Name/Number: ILTC-4/01768

Dear Harris Shearer,

Comments:

Response 1

Comments: Mr. Shearer:

Please refer to the attached letter of response and amended forms.

Should you be in need of any additional information, please do not hesitate to contact me.

Thank you.

Raenonna L. Prince, CLTC, LTCP
Lead Analyst
The Prudential Insurance Company of America
2101 Welsh Road, LTC Unit
Dresher, PA 19025
Voice: 800-732-0416 or 215-658-6281
Fax: 888-294-6332
E-Mail: raenonna.prince@prudential.com

Related Objection 1

Applies To:

- Individual Long Term Care Insurance Policy - Prudential LTC Evolution (Form)

Comment:

Page 20 - Subsections of CONTINGENT NON FORFEITURE PROVISION are not properly numbered. please correct.

Related Objection 2

Applies To:

- 3% Automatic Compound Increase option Rider (Form)

Comment:

The form number on this Rider is incorrect. The number should be GRP 114020. Please correct.

Related Objection 3

Applies To:

- ILTC-4 Application (Form)
- ILTC-4 ESP Buy-Up Application (Form)
- ILTC-4 ESP Application (Form)

SERFF Tracking Number: PRUD-125558856 State: Arkansas
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 Product Name: Individual Long Term Care Insurance
 Project Name/Number: ILTC-4/01768

Comment:

AR Rule 13, Section 14 requires specific questions to elicit information as to other long term care insurance as well as whether or not the agent has previously sold the applicant other health insurance. If this information is solicited on a previously approved Supplemental Application, please furnish form number and date of approval.

Changed Items:

Supporting Document Schedule Item Changes

Satisfied -Name: Letter of Reply

Comment:

Satisfied -Name: GRP 113124 - Agent/Producer Statement

Comment:

Form Schedule Item Changes

| Form Name | Form Number | Edition Date | Form Type | Action | Action Specific Data | Readability Score | Attach Document |
|---|-------------|--------------|---------------------------------------|---------|----------------------|-------------------|--|
| Individual Long Term Care Insurance Policy - Prudential LTC Evolution | GRP 114018 | | Policy/Contract/Fraternal Certificate | Initial | | 0 | GRP 114018 - ILTC-4 Standard Policy - 8-2008.pdf |

Previous Version

| | | | | | | | |
|---|------------|--|---|---------|--|---|--|
| Individual Long Term Care Insurance Policy - Prudential LTC Evolution | GRP 114018 | | Policy/Contract/Fraternal Certificate | Initial | | 0 | GRP 114018 - ILTC-4 Standard Policy.pdf |
| 3% Automatic Compound Increase option Rider | GRP 114020 | | Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider | Initial | | 0 | GRP 114020 - 3% Automatic Compound Increase Option |

SERFF Tracking Number: PRUD-125558856 State: Arkansas
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 TOI: LTC03I Individual Long Term Care Sub-TOI: LTC03I.001 Qualified
 Product Name: Individual Long Term Care Insurance
 Project Name/Number: ILTC-4/01768

Rider.pdf

Previous Version

3% Automatic GRP Policy/Contract/Fraternal Initial 0 GRP
 Compound Increase 114020 Certificate: Amendment, 114020 -
 option Rider Insert Page, Endorsement 3%
 or Rider or Rider Automatic
 Compound
 Increase
 Option
 Rider.pdf

ILTC-4 Application GRP Application/Enrollment Initial 0 GRP
 114024 Form 114024 -
 ILTC-4 -
 Application - 9-12-
 2008.pdf

Previous Version

ILTC-4 Application GRP Application/Enrollment Initial 0 GRP
 114024 Form 114024 -
 LTC4 IND
 Application
 n.pdf

ILTC-4 ESP Buy-Up GRP Application/Enrollment Initial 0 GRP
 Application 114029 Form 114029 -
 ILTC-4
 ESP Buy
 Up
 Application - 9-12-
 2008.pdf

Previous Version

ILTC-4 ESP Buy-Up GRP Application/Enrollment Initial 0 GRP
 Application 114029 Form 114029 -
 LTC4 ESP
 Buy Up

SERFF Tracking Number: PRUD-125558856 State: Arkansas
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 Product Name: Individual Long Term Care Insurance
 Project Name/Number: ILTC-4/01768

| Application/Enrollment Form | Initial | 0 | Application/Enrollment Form | Initial | 0 | Application/Enrollment Form | Initial | 0 | Application/Enrollment Form | Initial | 0 |
|---|---------|---|-----------------------------|---------|---|-----------------------------|---------|---|-----------------------------|---------|---|
| ILTC-4 ESP Application GRP 114027 | Initial | 0 | Application/Enrollment Form | Initial | 0 | Application/Enrollment Form | Initial | 0 | Application/Enrollment Form | Initial | 0 |
| Previous Version | | | | | | | | | | | |
| ILTC-4 ESP Application GRP 114027 | Initial | 0 | Application/Enrollment Form | Initial | 0 | Application/Enrollment Form | Initial | 0 | Application/Enrollment Form | Initial | 0 |
| ILTC-4 Plan Design GRP Form 114025 | Initial | 0 | Application/Enrollment Form | Initial | 0 | Application/Enrollment Form | Initial | 0 | Application/Enrollment Form | Initial | 0 |
| Previous Version | | | | | | | | | | | |
| ILTC-4 Plan Design GRP Form 114025 | Initial | 0 | Application/Enrollment Form | Initial | 0 | Application/Enrollment Form | Initial | 0 | Application/Enrollment Form | Initial | 0 |
| ILTC-4 ESP Plan GRP Design Form 114028 | Initial | 0 | Application/Enrollment Form | Initial | 0 | Application/Enrollment Form | Initial | 0 | Application/Enrollment Form | Initial | 0 |

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 TOI: LTC03I Individual Long Term Care Sub-TOI: LTC03I.001 Qualified
 Product Name: Individual Long Term Care Insurance
 Project Name/Number: ILTC-4/01768

Form - 9-12-2008.pdf

Previous Version

| | | | | | |
|------------------------------------|---------------|-----------------------------|---------|---|--|
| ILTC-4 ESP Plan Design Form | GRP 114028 | Application/Enrollment Form | Initial | 0 | GRP 114028 - LTC-4 ESP Plan Design - Standard. pdf |
| ILTC-4 ESP Buy-Up Plan Design Form | GRP 114030 | Application/Enrollment Form | Initial | 0 | GRP 114030 - ESP Buy- Up Plan Design Form - 9-12-2008.pdf |

Previous Version

| | | | | | |
|------------------------------------|---------------|-----------------------------|---------|---|---|
| ILTC-4 ESP Buy-Up Plan Design Form | GRP 114030 | Application/Enrollment Form | Initial | 0 | GRP 114030 - LTC4 ESP Buy Up Plan Design - Standard. pdf |
|------------------------------------|---------------|-----------------------------|---------|---|---|

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Filing Company: The Prudential Insurance Company of America *State Tracking Number:* 38516
Company Tracking Number: IIGH-GRP114018-RP-AR
TOI: LTC03I Individual Long Term Care *Sub-TOI:* LTC03I.001 Qualified
Product Name: Individual Long Term Care Insurance
Project Name/Number: ILTC-4/01768

No Rate/Rule Schedule items changed.

Sincerely,
Raenonna Ransom

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 Project Name/Number: ILTC-4/01768

Form Schedule

Lead Form Number: GRP 114018

| Review Status | Form Number | Form Type | Form Name | Action | Action Specific Data | Readability | Attachment |
|---------------|-------------|---------------------|---|---------|----------------------|-------------|--|
| | GRP 114018 | Policy/Cont | Individual Long Term Initial ract/Fratern Care Insurance al Policy - Prudential Certificate LTC Evolution | Initial | | 0 | GRP 114018 - ILTC-4 Standard Policy - 8- 2008.pdf |
| | GRP 114019 | Outline of Coverage | Outline of Coverage | Initial | | 0 | GRP 114019 - ILTC-4 Outline of Coverage.pdf |
| | GRP 114020 | Policy/Cont | 3% Automatic ract/Fratern Compound Increase al option Rider Certificate: Amendmen t, Insert Page, Endorseme nt or Rider | Initial | | 0 | GRP 114020 - 3% Automatic Compound Increase Option Rider.pdf |
| | GRP 114021 | Policy/Cont | 5% Automatic ract/Fratern Compound Increase al Option Inflation Rider Certificate: Amendmen t, Insert Page, Endorseme nt or Rider | Initial | | 0 | GRP 114021 - 5% Automatic Compound Increase Option Rider.pdf |
| | GRP 114022 | Policy/Cont | Non-Forfeiture ract/Fratern Benefit Rider al Certificate: Amendmen | Initial | | 0 | GRP 114022 - Nonforfeiture Benefit Rider.pdf |

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 Product Name: Individual Long Term Care Insurance
 Project Name/Number: ILTC-4/01768

| GRP | Policy/Cont | Initial | 0 | GRP |
|--------|--|---------|---|--|
| 114023 | Shared Care Rider t, Insert Page, Endorseme nt or Rider | Initial | 0 | GRP 114023 - Shared Care Rider.pdf |
| 114024 | Application/ILTC-4 Application Enrollment Form | Initial | 0 | GRP 114024 - ILTC-4 - Application - 9-12-2008.pdf |
| 114029 | Application/ILTC-4 ESP Buy-Up Enrollment Application Form | Initial | 0 | GRP 114029 - ILTC-4 ESP Buy Up Application - 9-12-2008.pdf |
| 114027 | Application/ILTC-4 ESP Enrollment Application Form | Initial | 0 | GRP 114027 - ILTC-4 ESP Application - 9-12-2008.pdf |
| 114025 | Application/ILTC-4 Plan Design Enrollment Form Form | Initial | 0 | GRP 114025 - ILTC-4 Plan Design Form - 9-12-2008.pdf |
| 114028 | Application/ILTC-4 ESP Plan Enrollment Design Form Form | Initial | 0 | GRP 114028 - ESP Plan Design Form - 9-12-2008.pdf |
| 114030 | Application/ILTC-4 ESP Buy-Up Enrollment Plan Design Form Form | Initial | 0 | GRP 114030 - ESP Buy-Up Plan Design Form - 9-12- |

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Project Name/Number: ILTC-4/01768

GRP
114031

Other

Personal Worksheet Initial

0

2008.pdf
GRP 114031
ILTC-4
Personal
Worksheet.pdf

The Prudential Insurance Company of America

751 Broad Street, Newark, New Jersey 07102

Individual Long Term Care Insurance Policy

Prudential LTC EvolutionSM

READ YOUR POLICY CAREFULLY. Prudential will provide the coverage described in this Policy, subject to all stated terms, conditions, limitations and exclusions. Your coverage consists of this Policy, any optional Benefit Riders and any Amendatory Riders attached to it. Please refer to your Policy's Glossary for definitions.

THIS IS NOT A MEDICARE SUPPLEMENT POLICY. If you are eligible for Medicare, review the *Guide to Health Insurance for People with Medicare* that you received at the time of application.

THIS POLICY DOES NOT CONTAIN A PRE-EXISTING CONDITIONS LIMITATION.





CORPORATE ADDRESS: The Prudential Insurance Company of America
751 Broad Street, Newark NJ 07102

CONTACT ADDRESS: The Prudential Long Term Care Customer Service Center
P. O. Box 8519, Philadelphia, PA 19176-8519

In your Policy, The Prudential Insurance Company of America is referred to as Prudential, we, our, or us. The insured is referred to as you, your, or yours.

Thank you for choosing a Prudential Long Term Care Insurance Policy. Your Policy is a contract between you and Prudential. The coverage begins as stated herein at 12:01 A. M., Standard Time, if the first full modal premium is paid.

TAX STATUS: Your Policy is intended to be a federally tax-qualified long-term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986, as amended.

RENEWABILITY: Your Policy is guaranteed renewable. It begins on the Original Effective Date shown in the **Schedule of Policy Benefits**. You can continue your Policy as long as the full modal premium is paid on time and the Policy Lifetime Maximum has not been exhausted. Prudential cannot change the terms of your Policy on its own, except it may change the premiums. (See "Premiums" provisions.) Certain provisions of your Policy may be changed to conform with changes in state or federal law or regulation that apply to your Policy.

IMPORTANT 30-DAY REVIEW: You have 30 days from receipt of your Policy to review it. If you decide you do not want the Policy, you may return it, during these 30 days, to your Producer or to Prudential at the Contact Address shown above. Your Policy will be deemed void from its Original Effective Date and any premium paid will be returned to you.

CAUTION: The issuance of this long-term care insurance Policy is based upon your responses to the questions on your Application. A copy of your Application is enclosed. If your answers are incorrect or untrue, Prudential has the right to deny benefits or rescind your Policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact Prudential at the Contact Address shown above.

NOTICE TO BUYER: This Policy may not cover all of the costs associated with Long-Term Care incurred by you during the period of coverage. You are advised to carefully review all Policy limitations.

Handwritten signature of Kathleen M. Gibson in black ink.

Secretary

Handwritten signature of the Chairman of the Board in black ink.

Chairman of the Board

For Residents of the State of Arkansas

You may reach the Arkansas Insurance Department at this address: Arkansas Insurance Department, Consumer Services Division, 1200 West Third Street, Little Rock, AR 72201-1904 or call 1-501-371-2640 or 1-800-852-5494.

For Residents of the State of Wisconsin

THE WISCONSIN INSURANCE COMMISSIONER HAS ESTABLISHED MINIMUM STANDARDS FOR LONG-TERM CARE INSURANCE. THIS POLICY MEETS THOSE STANDARDS.

THIS POLICY COVERS CERTAIN TYPES OF NURSING HOME AND HOME HEALTH CARE SERVICES. THERE MAY BE LIMITATIONS ON THE SERVICES COVERED. READ THIS POLICY CAREFULLY.

FOR MORE INFORMATION ON LONG-TERM CARE SEE THE *GUIDE TO LONG-TERM CARE* GIVEN TO YOU WHEN YOU APPLIED FOR THIS POLICY. THIS POLICY'S BENEFITS ARE NOT RELATED TO MEDICARE.

PROBLEMS WITH YOUR INSURANCE? – If you are having problems with your insurance company or Producer, do not hesitate to contact the insurance company or Producer to resolve your problem.

**The Prudential Insurance Company of America
Long Term Care Customer Service Center
P.O. Box 8519
Philadelphia, PA 19176-8519
800-732-0416**

You can also contact the **OFFICE OF THE COMMISSIONER OF INSURANCE**, a state agency that enforces Wisconsin's insurance laws, and file a complaint. You can contact the Office of the Commissioner of Insurance by contacting:

OFFICE OF THE COMMISSIONER OF INSURANCE
Complaints Department
P.O. Box 7873
Madison, WI 53707-7873
800-236-8517
608-266-0103

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YOUR LONG-TERM CARE INSURANCE BENEFITS

This Policy provides benefits for Qualified Long-Term Care Services. Benefit descriptions are stated below. Not all charges are covered. Please refer to the **Policy Exclusions** section.

The benefit payment for covered services and the Policy Lifetime Maximum are shown in the **Schedule of Policy Benefits**. These benefits are subject to change if you have elected additional optional inflation protection or exercise an option under the Guaranteed Increase Feature. Prudential will pay benefits for Eligible Charges up to the benefit limit that applies for the charges incurred, after all terms and conditions of coverage have been met. No dollar limit will be applied to any particular day you receive Qualified Long Term Care Services; however, there are limits on certain benefits. Limits on specific benefits are stated in the **Benefit Descriptions** section.

Please refer to **The Claims Process** provisions. Prudential will pay benefits if the conditions described in these provisions are met. Only charges related to services included in the Plan of Care will be considered Eligible Charges. Benefits for Eligible Charges are provided if the Calendar Day Elimination Period, if applicable, has been satisfied. All benefits are subject to the Calendar Day Elimination Period except the Hospice Care Benefit, the Starter Benefit and the Home Support Services Benefit. All benefits paid reduce your Policy Lifetime Maximum.

Your Policy gives you access to information on long-term care resources and care providers in your community. Prudential's Long Term Care Resource Center can help provide this information or you may access this information from Prudential's website at www.prudential.com. You do not need to meet the Benefit Eligibility Criteria in order to use this service. Call the Prudential Long Term Care Customer Service Center at 1-800-732-0416 for assistance.

BENEFIT DESCRIPTIONS

FACILITY CARE

NURSING HOME, ADULT FOSTER HOME OR BOARD AND CARE FACILITY, ASSISTED LIVING FACILITY, OR RESIDENTIAL HEALTH CARE FACILITY BENEFIT

Your Policy provides benefits for Eligible Charges for covered services you receive as a resident of a Nursing Home, an Adult Foster Home or Board and Care Facility, Assisted Living Facility or Residential Health Care Facility. This includes covered services you receive as Respite Care.

80% of the Eligible Charges will be paid for each day you are a resident in one of the above listed facilities.

Benefits will not be paid for Facility Care or Home Care and the Starter Benefit on the same day.

**BED
RESERVATION
BENEFIT**

Your Policy provides benefits to retain your bed at a facility if you are a resident in such a facility and you are absent for any reason for 24 hours or more.

Charges for Bed Reservation are Eligible Charges if they satisfy the following requirements.

- 1) The charge is a separate, customary facility charge to reserve the bed during a temporary absence from the facility.
- 2) You would be required to pay the charge in the absence of insurance.
- 3) The charge is incurred while you are receiving benefits for care in a facility.
- 4) Benefits were payable immediately prior to your absence due to your need to receive Qualified Long-Term Care Services on a 24-hour per day basis.

80% of the Eligible Charges to reserve your bed will be paid. Benefits will not be paid for other Facility Care or Home Care for the same day on which a Bed Reservation benefit is paid.

**HOSPICE CARE
BENEFIT**

Your Policy provides benefits for Eligible Charges for Hospice Care when you are Terminally Ill. 80% of the Eligible Charges will be paid for each day you receive Hospice Care as a resident in a facility or in your Home.

HOME CARE

**ADULT DAY CARE,
HOME HEALTH
CARE,
HOMEMAKER
SERVICES, AND
PERSONAL CARE
SERVICES
BENEFIT**

Your Policy provides benefits for Eligible Charges you receive as Home Health Care, Homemaker Services or Personal Care Services. Such services must be received from a Caregiver. This Policy also provides coverage when you receive Adult Day Care.

80% of the Eligible Charges will be paid for each day you receive Adult Day Care, Home Health Care, Homemaker Services or Personal Care Services from a Caregiver.

Benefits will not be paid for Facility Care or Home Care and the Starter Benefit on the same day.

ADDITIONAL POLICY BENEFITS

STARTER BENEFIT

At your option, your Policy will pay a Starter Benefit to you in cash in lieu of reimbursement for Eligible Charges for Facility Care or Home Care. The Starter Benefit is a fixed monthly amount shown in your **Schedule of Policy Benefits**.

The Starter Benefit is subject to the following criteria.

- 1) You can only elect this benefit on a monthly basis. This election is made on the claim form.
- 2) Benefits are paid in lieu of Facility Care or Home Care benefits.
- 3) The Starter Benefit Policy Maximum is 12 months.

The Starter Benefit is only available during the first 12 cumulative months that you have a Chronic Illness or Disability. The Starter Benefit is not subject to the Calendar Day Elimination Period. The months in your Calendar Day Elimination Period during which you receive the Starter Benefit count towards the Starter Benefit Policy Maximum.

If your Policy Lifetime Maximum is exhausted in less than 12 months, you may continue to receive the Starter Benefit as long as you satisfy the Benefit Eligibility Criteria until the 12-month Starter Benefit Policy Maximum has been reached.

Under the Starter Benefit, charges for Qualified Long Term Care services do NOT need to be incurred and any **Policy Exclusions** related to covered charges shall not apply.

HOME SUPPORT SERVICES BENEFIT

Your Policy provides benefits for goods or services that help you remain independent in your Home and relate to your Qualified Long-Term Care Service needs. These goods or services must be recommended in writing by a Licensed Health Care Practitioner and be part of your Plan of Care. 100% of the Eligible Charges will be paid for Home Support Services. Benefits for Home Support Services are subject to the Home Support Services Policy Maximum. Eligible Charges are listed below.

Assistive Devices or Technology means adaptive tools, devices or technology that helps you function independently in your Home. Examples of such items include but are not limited to, specially adaptive eating and dressing utensils, a "Health Buddy" prompting device, "smart shoes" with GPS (global positioning system), or "Wander Mats."

Caregiver Training means a training program provided by a Home Health Care Agency, Nursing Home, hospital or other similarly licensed medical facility acceptable to Prudential which provides instruction to Primary Informal Caregivers in basic care giving techniques which will allow you to remain in your Home. Such training is to help your Primary Informal Caregiver tend to your specific long-term care needs. The Primary Informal Caregiver may be a relative or someone chosen by you, but in no event will we pay for training provided to someone who will be

paid to care for you.

Durable Medical Equipment means equipment you rent or purchase that is designed to be used more than once in your Home to assist you in performing Activities of Daily Living. Examples include walkers, hospital-style beds, crutches and wheelchairs and those items routinely considered Durable Medical Equipment under the Medicare Program. Durable Medical Equipment does not include prescription drugs, athletic equipment, equipment placed in your body or items commonly found in a household.

Emergency Medical Response System means a communication system that is installed in your Home and used to call for assistance in the event of a medical emergency. It does not include a home security system or normal telephonic equipment or service.

Home Modifications means modifications to your Home that are primarily being made to improve your ability to perform Activities of Daily Living and to allow you to live safely and independently in your Home. Examples of Home Modifications include the following items.

- 1) Installation of ramps for wheelchair access.
- 2) Installation of grab bars.
- 3) Widening doorways.
- 4) Other similar accessibility modifications.

Home Modifications do not include hot tubs, swimming pools, home repair or maintenance or other similar modifications. This benefit will not cover normal home modification that would only provide an incidental benefit to your Chronic Illness or Disability.

Private Care Manager means charges by a Private Care Manager or Geriatric Care Manager for the following types of services.

- 1) Advocacy for your care with respect to appropriate use of your own as well as community resources.
- 2) Development of or revisions to your Plan of Care.
- 3) Arrangement for delivery of Qualified Long-Term Care Services appropriate to your needs.
- 4) Counseling, support and education with respect to your long-term care needs and resources.

Transportation Services means transportation provided by a licensed transportation carrier, which carries passengers for a fare, to and from your Home directly from and to a Provider solely

for the purpose of receiving medically necessary health care, if the care is included in your Plan of Care.

**ALTERNATE PLAN
OF CARE BENEFIT**

Your Policy provides coverage for a broad range of services including Facility and Home Care. Prudential will consider a claim for services designed to help you function independently in your home or for stays in facilities not otherwise covered by your Policy. 80% of such Eligible Charges will be paid.

Eligible Charges must be for a service that meets the following requirements.

- 1) It must be considered a Qualified Long-Term Care Service within the terms of Internal Revenue Code Section 7702B.
- 2) It must be clearly specified in your Plan of Care.
- 3) It must be agreed to by you, your Licensed Health Care Practitioner and Prudential as an appropriate alternative to services covered by your Policy. However, you may choose to stop the covered alternative services at any time and use other services covered by your Policy.

**WAIVER OF
PREMIUMS
BENEFIT**

After you meet the Benefit Eligibility Criteria and satisfy any applicable Calendar Day Elimination Period, the premiums for your Policy will be waived.

Waiver of premiums is subject to these rules.

- 1) Waiver begins on the day following the date you satisfy your Calendar Day Elimination Period.
- 2) Waiver ends on the date your Chronic Illness or Disability ends.

If premiums for your Policy are paid in advance at the time of waiver, Prudential will refund the pro-rated portion of the advanced premium. Premiums will again become due as of the first day after the date your Chronic Illness or Disability ends.

**GUARANTEED
INCREASE
FEATURE**

Every five years on your Policy Anniversary Date, Prudential will increase your Policy Lifetime Maximum with an associated increase in premium. You will be notified of this benefit increase at least 60 days prior to your Policy Anniversary Date. You will not have to provide proof of good health to receive this benefit increase.

All benefit increases will occur even if you are receiving benefits or have met the Benefit Eligibility Criteria at the time of the increase takes effect. No further benefit increases will be put into effect on or after the date of your 76th birthday.

The additional premium for the increase in coverage will be based

on your attained age. These increases will occur without your taking any action. If you want to decline any increase, you must notify Prudential in writing, within 30 days of receipt of the notification. You may decline any number of these increases without affecting the availability of or your acceptance of future increases.

With each benefit increase, your Policy Lifetime Maximum will be increased by 25% of the Policy Lifetime Maximum then in effect on that Policy Anniversary (not including any prior benefit increases applied under this Guaranteed Issue Feature, and excluding any amounts paid in claims).

The value of your remaining Policy Lifetime Maximum will be determined as follows. Your Policy Lifetime Maximum in effect on your Policy Anniversary plus all benefit increases applied under this Guaranteed Issue Feature, less the total of all benefits paid under your Policy.

With each benefit increase, your Starter Benefit will increase by \$375. The Home Support Services Policy Maximum will increase by \$2,500. However, if you have exhausted the Starter Benefit Policy Maximum or the Home Support Services Policy Maximum before accepting a benefit increase, these benefits will not increase.

You will receive a new **Schedule of Policy Benefits** following each benefit increase.

THE CLAIMS PROCESS

In accordance with the provisions below, this section describes what Prudential needs to determine if benefits are payable under your Policy. You must have a Chronic Illness or Disability while Your Policy is in force. You must undergo an Assessment and be certified by a Licensed Health Care Practitioner as having a Chronic Illness or Disability. A Licensed Health Care Practitioner must then develop a Plan of Care, consistent with the certification. Prudential must be provided with satisfactory proof of loss, including a completed claim form and other documentation. Once these requirements are met, Prudential will review your claim and determine whether benefits are payable.

LIMITATIONS OR CONDITIONS ON ELIGIBILITY FOR PAYMENT OF BENEFITS

BENEFIT ELIGIBILITY CRITERIA

Before incurring Eligible Charges and submitting a claim, you must undergo an Assessment and be certified by a Licensed Health Care Practitioner as having a Chronic Illness or Disability. A Chronic Illness or Disability is one that meets either definition below.

- 1) A loss of the ability to perform, without Substantial Assistance, at least two Activities of Daily Living due to a loss of functional capacity. This inability must be expected to continue for at least 90 consecutive days. This expectation is not a waiting or elimination period. Activities of Daily Living are Bathing, Continence, Dressing, Eating, Toileting and Transferring.
- 2) A severe Cognitive Impairment that requires Substantial Supervision to protect you from threats to health and safety.

A Licensed Health Care Practitioner must then develop a Plan of Care. All benefits are paid pursuant to the Plan of Care.

NOTICE OF CLAIM

If you think you have a Chronic Illness or Disability that is expected to last at least 90 days, you should call the Prudential Long Term Care Customer Service Center at 1-800-732-0416. Either you or your representative may call. This notice should be given to Prudential within 20 days of the onset of a potential Chronic Illness or Disability, or as soon as reasonably possible. Notice may be given to The Prudential Insurance Company of America at its Long Term Care Customer Service Center. The notice should include your name and Policy Number. The address for the Customer Service Center appears on the first page of your Policy.

CERTIFICATION PROCESS

Prudential will arrange for an Assessment to determine if you have a Chronic Illness or Disability. As part of the Assessment process, you will be interviewed. The Assessment will be based

on objective standards of measurement. The Assessment must be made at a time when the chronic nature of the condition can be determined. The Assessment should take place in your home or in the setting in which care is to be rendered.

Your Chronic Illness or Disability must be certified by a Licensed Health Care Practitioner. After your Chronic Illness or Disability is certified, a Plan of Care must be developed consistent with your needs. Prudential reserves the right to verify that all of the Benefit Eligibility Criteria have been satisfied and determine if you are eligible for benefits. You will be sent a written notice to confirm the date you become eligible. If you are not eligible, you will be sent a written notice explaining the reasons you are not eligible.

You can select your own Licensed Health Care Practitioner to certify your Chronic Illness or Disability. If you wish to do so, you should notify us when you call our Long Term Care Customer Service Center. Prudential will send you an Assessment Form that your Licensed Health Care Practitioner must complete and return together with the Plan of Care to us prior to submitting proof of loss. Prudential must receive proof that a Licensed Health Care Practitioner has certified, in writing, that you have a Chronic Illness or Disability. Prudential must receive such proof within 12 months of the certification date. The certification must occur on or after your Effective Date. Prudential reserves the right to verify that all of the Benefit Eligibility Criteria have been satisfied and determine if you are eligible for benefits.

CLAIM FORMS

When Prudential is notified, you will be sent a claim form. It will be sent no later than 10 working days following the date of your notice. If you do not receive the claim form within this time, you may send us the documentation identified in the Proof of Loss section of your Policy.

PROOF OF LOSS

For reimbursement of Eligible Charges, your Proof of Loss must include the Provider's bill, together with the completed claim form. Any bill must include all of the following items.

- 1) The name of the person who received the service.
- 2) The name and address of the Provider who rendered the service.
- 3) The date(s) of service.
- 4) Each type of service rendered.
- 5) The charge for that service.

At your own expense, you must obtain and submit all required documentation to us in English.

If you are submitting Proof of Loss for charges for Qualified Long-Term Care Services rendered by a Nursing Home, Assisted Living Facility, Residential Health Care Facility, Adult Foster Home or Board and Care Facility, or by a vendor providing such services on behalf of the facility, you must submit a written bill that itemizes and separately details each service, cost and expense that you sustained. This bill must include an itemized listing of all services, costs and expenses. Prudential reserves the right to require that facility bills be sufficiently itemized to allow us to determine which charges, if any, from a facility may be Eligible Charges under your Coverage. You are responsible for obtaining a sufficiently itemized bill from the facility you use.

A provider's bill does not need to be submitted for a claim under the Starter Benefit. Only a completed Claim Forms needs to be submitted.

This proof of loss should be sent within 90 days of the date loss begins. Failure to furnish such proof within the time required will not invalidate or reduce any claim if both of the following apply.

- 1) It was not reasonably possible to furnish the proof within that time.
- 2) Proof is furnished as soon as reasonably possible.

Except in the absence of legal capacity, the required proof must be given no later than one year (Fifteen months for residents of Hawaii) from the time specified.

PHYSICAL EXAMINATION

You may be required to have a physical examination to be eligible for benefits. Prudential may do this when and as often as is reasonable, while your claim is pending, at its own expense.

TIME OF CLAIM PAYMENT

Benefits are payable where Prudential receives satisfactory proof of loss. An explanation of benefits notice that explains the resolution of your claim will be sent to you within 30 days from the date Prudential receives satisfactory proof of loss.

At your request, you may assign all or a portion of any benefits payable under your Policy directly to the eligible Provider. Benefits not assigned will be paid directly to you.

Benefits will be calculated and paid in United States currency.

FACILITY OF PAYMENT

Benefits due and unpaid at your death will be paid to your estate.

Prudential may pay benefits to a person whom we deem entitled to the benefits if they would otherwise be paid to your estate, or to a person who is a minor or to a person otherwise not competent to give a valid release.

We may pay up to \$1,000 under this provision. Any payment

made by us, in good faith pursuant to this provision, shall fully discharge Prudential to the extent of such payment.

At your written request, all or a portion of any benefits payable under your Policy may be paid directly to the eligible Provider.

LATE PAYMENTS

If benefits are not paid in a timely fashion, Prudential will pay interest on any such late claim payments in accordance with the laws then in effect.

REASSESSMENT

You will be reassessed periodically to determine if you are still eligible for benefits. To comply with federal income tax requirements, you must be assessed at least once in a 12-month period. Prudential reserves the right to verify at any time that all of the Benefit Eligibility Criteria have been satisfied and determine if you continue to be eligible for benefits.

APPEALS

You have the right to appeal decisions made about your eligibility for benefits or a claim.

If your claim or benefit is denied, Prudential will explain the procedure you must follow if you choose to appeal a claim decision.

Prudential will send you a written acknowledgement of your appeal within 10 days of receipt. If no additional information is required and the appeal is denied, the acknowledgment will include an explanation of the reasons for the denial. If additional information is required, we will explain what information is needed. If we do not receive the requested data within 21 days, we will notify you in writing. Within 30 days of the receipt of the required information, Prudential will notify you in writing of the decision concerning your claim.

The Appeals process does not in any way negate or reduce your rights under the Legal Actions provision.

LEGAL ACTIONS

No action at law or in equity can be brought against Prudential to recover benefits from this Policy until 60 days after the required proof of loss is furnished to Prudential. No such action shall be brought more than three years (five years in Kansas; six years in South Carolina) after you incur Eligible Charges.

For Florida residents, no such action shall be brought after the end of the applicable Florida statute of limitations from the time within which proof of loss is required.

For Missouri and Texas residents, no such action shall be brought more than three years after the expiration of the period within which proof of loss must be furnished.

**CALENDAR DAY
ELIMINATION
PERIOD**

The Calendar Day Elimination Period must be satisfied once during your lifetime before benefits are paid. The number of calendar days is stated in the **Schedule of Policy Benefits**.

Prudential will begin to count days to satisfy your Calendar Day Elimination Period with the date you are certified by a Licensed Health Care Practitioner as having a Chronic Illness or Disability. Each day your Chronic Illness or Disability continues counts in satisfaction of this Calendar Day Elimination Period.

Once a day of the Calendar Day Elimination Period is satisfied, it is satisfied for the life of your Policy.

POLICY EXCLUSIONS

Your Policy is designed to provide benefits to pay for your Qualified Long-Term Care Services. Your Policy does not provide benefits for any of the following.

- 1) Illness, treatment or medical conditions arising out of
 - a) War or an act of war, whether declared or undeclared, while you are insured; or
 - b) Your participation in a felony, riot or insurrection; or
 - c) Alcoholism and drug addiction.
- 2) Treatment provided in a government facility, unless payment of the charge is required by law or services provided by any law or governmental plan under which you are covered. This does not apply to a state plan under Medicaid or to any law or plan when, by law, its benefits are excess to those of any private insurance program or other non-governmental program.
- 3) Charges for services or supplies in excess of those normally charged by the Provider in the absence of insurance.
- 4) Charges for care or treatment received outside the United States of America, its territories or possessions.
- 5) Charges for care or treatment rendered by a member of your Immediate Family, unless he or she is a Caregiver (other than an Independent Health Care Professional or Independent Caregiver), and he or she receives no compensation other than the normal compensation for employees in his or her job category.
- 6) Charges for any care received while in a hospital, except in a unit specifically designated and licensed as a Nursing Home or Hospice facility.

NON-DUPLICATION OF MEDICARE BENEFITS

Benefits under your Policy are not payable for expenses for Qualified Long-Term Care Services to the extent that either of the following applies.

- 1) Such expenses are reimbursable under Medicare.
- 2) Such expenses would be reimbursable under Medicare but for the application of a deductible or coinsurance amount.

This provision does not apply if such expenses are reimbursable by Medicare as a secondary payer or to claims for the Starter Benefit.

COORDINATION WITH OTHER PRUDENTIAL INDIVIDUAL LONG TERM CARE INSURANCE POLICIES

Benefits under your Policy may be reduced if we also pay benefits for Eligible Charges under any other Prudential Individual Long Term Care Insurance Policy. Benefits will be reduced under this Policy only when payment under this Policy and all other Prudential Individual Long Term Care Insurance Policies combined would exceed the actual amount you incur for Eligible Charges. In no event will we pay more under this Policy than the difference between

your actual expenses and the amount payable by your other Prudential policies.

If you are insured under more than one Prudential Individual Long Term Care Insurance Policy with a similar Coordination provision, the policy with the earliest effective date will be deemed primary and will pay its benefits first. Thereafter, payment will be made under any additional policy (secondary coverage) in order of effective date, from the earliest to the latest. A Prudential policy without a similar Coordination provision will pay first, without any reduction in its benefits.

This provision does not apply to claims for the Starter Benefit.

PREMIUMS

AMOUNT OF PREMIUM

Your age at the time you purchase a benefit is used to rate that benefit. The amount of your premium is calculated using this rate for the benefits you have chosen. Premiums for the base Policy and any options will not automatically increase solely due to your becoming older. Premiums will not automatically increase because benefits are paid.

CHANGES IN PREMIUMS

Premiums for your Policy are shown in the **Schedule of Policy Benefits**. Your initial premium is based on the rates in effect on the Effective Date of your insurance. Prudential has the right to change rates only if both items 1) and 2) occur.

- 1) The change occurs after the first Policy Anniversary Date.
- 2) The change applies to all insureds in your premium class. "Class" means a group of insured risks that exhibit a trait requiring a separate premium rate due to risk characteristics.

Any change in rates is subject to review by the appropriate state regulatory agency. We will not change premium rates more frequently than once a year. We will notify you at least 60 days before a change in the premium rates.

The premium for your Policy can also change under the following circumstances.

- 1) You change your benefit amounts or plan options.
- 2) A benefit increase is automatically applied to your Policy under the Guaranteed Increase Feature, if available under your Policy.

MISSTATEMENT OF AGE

The age shown on your Application is used to determine your eligibility for coverage and to calculate your premium. If that age is in error, we may either reduce your Policy benefits or rescind your Policy.

If we need to reduce your benefits, your benefits will be reduced to those that the premium paid would have purchased at your correct age.

If we need to rescind your Policy, Prudential's liability will be limited to a refund of the premiums paid for this Policy.

MISSTATEMENT OF INFORMATION

Since Prudential relied on information provided by you to calculate your premium, if it is later discovered that you were not rated properly, the premium rate will be adjusted prospectively with the next premium due.

GRACE PERIOD

Your first full modal premium must be paid for your Policy to take effect. A grace period does not apply to the first premium. Your renewal premium is due on or before the premium due date.

Your Policy provides a 31-day grace period for your renewal premiums. This means that if a renewal premium is not paid on or before the due date, it may be paid during the following grace period. During the grace period, your Policy will stay in effect. If the full modal premium is not received within the grace period, Prudential will mail a late payment notice to request payment within 31 days to you and your designee (if applicable). The notice will be deemed to have been given 5 days after the date mailed.

If we do not receive payment within 31 days of the date the late payment notice is given, your Policy will lapse (end) as of the premium due date.

PROTECTION AGAINST UNINTENTIONAL LAPSE

You have the right to name a person, in addition to yourself, to receive notice that your Policy will lapse because your full modal premium was not received. You may exercise or waive this right at the time you apply for your Policy or any time thereafter. At least every two years, Prudential will notify you of your right to name a person for this purpose or to change the person currently named.

REINSTATEMENT

If your full modal premium is not paid within the time required, your Policy will lapse. To reinstate your Policy, all of the following must occur.

- 1) You must request reinstatement within 90 days from the date the last notice of unpaid premium is given by Prudential.
- 2) You must complete a reinstatement application.
- 3) Prudential must approve the reinstatement application.
- 4) You must pay all past due premium as of the date of reinstatement.

If Prudential or its Producer accepts payment for the past due and unpaid premiums without requesting a reinstatement application, your Policy will be reinstated.

You will be given a conditional receipt for any premium paid with your request for reinstatement. If Prudential approves the reinstatement, your Policy will be reinstated as of the approval date.

If approval of a reinstatement application is required, your Policy will be reinstated on the 45th day after the date of the conditional receipt unless we previously wrote you of its disapproval. If a reinstatement application is required and approved, the reinstated policy will cover only a Chronic Illness or Disability that starts after

the date of reinstatement.

If your Policy lapsed due to your Chronic Illness or Disability, you or your representative may request reinstatement, without a reinstatement application, if both of the following items apply.

- 1) The request is made within five months of the premium due date.
- 2) Your Chronic Illness or Disability is certified by a Licensed Health Care Practitioner and existed on the premium due date.

Your Policy will be reinstated as of the premium due date provided all past due premium has been received.

In all other respects, your rights and Prudential's rights will remain the same. You will have the same level of coverage you had before your Policy lapsed. All benefits paid before the reinstatement count towards your Policy Lifetime Maximum under the reinstated policy.

Call the Prudential Long Term Care Customer Service Center at 1-800-732-0416 to determine if your Policy can be reinstated.

**REFUND OF
UNEARNED
PREMIUM**

Unless satisfactory proof is provided to Prudential to indicate a third party has the legal right to a refund of premiums made in connection with this Policy, all premium refunds shall be made to the insured or the insured's estate.

Upon proper notice of the cancellation of your Policy after the 30-day period described on page one, Prudential will refund on a pro-rata basis any part of the premium paid in advance that applies to the period after cancellation.

Upon receipt of proper notice of your death, Prudential will refund to your estate on a pro-rata basis any part of the premium paid in advance that applies to the period of time after death.

**CONTINGENT NON
FORFEITURE
PROVISION**

If the Non-Forfeiture Benefit Rider is not a part of your Policy, these Contingent Non-Forfeiture provisions apply. These provisions change your Long-Term Care insurance to provide options to you in the event your Policy ends due to non-payment of premium after a Substantial Premium Increase.

A Substantial Premium Increase is one that results in a cumulative increase to your Annual Premium that is equal to or exceeds a certain percentage of that premium. It does not include premium increases that result from a voluntary purchase of additional coverage including benefit increases under the Guaranteed Increase Feature. The limits of cumulative increase as a percentage of your Annual Premium are based on your age as of the Policy's Original Effective Date shown in your **Schedule of**

Policy Benefits.

You will be notified of any Substantial Premium Increase at least 60 days prior to the change to your premium. The notice will include the amount of the premium and its due date, and the following contingency options in the event of lapse.

1. Reduced benefits at the premium in effect prior to the increase, without undergoing medical underwriting.
2. A lesser Policy Lifetime Maximum, with no further premium payment required. You will have 120 days following the premium due date to elect this option. Under this option, the same benefit amounts in effect at the time of lapse will be payable, but the Policy Lifetime Maximum will be equal to the greater of the following items.
3. The total amount of premiums paid for your Policy.
4. 3% of your initial Policy Lifetime Maximum as of your Original Effective Date.

The total of all benefits paid under your Policy will not exceed the Policy Lifetime Maximum that would have been payable if your Policy did not lapse.

Option 2 will automatically take effect if both of the following apply.

1. Your Policy lapses within 120 days of the premium due date for the Substantially Increased Premium.
2. You have not made an election.

The table below shows the cumulative increase that will trigger the Contingent Non-Forfeiture Provision.

| SUBSTANTIAL PREMIUM INCREASE TABLE | | | |
|---|----------------------------|--------------------|----------------------------|
| PREMIUM AGE | PERCENT OF INCREASE | PREMIUM AGE | PERCENT OF INCREASE |
| Less than 30 | 200% | 72 | 36% |
| 30 - 34 | 190% | 73 | 34% |
| 35 - 39 | 170% | 74 | 32% |
| 40 - 44 | 150% | 75 | 30% |
| 45 - 49 | 130% | 76 | 28% |
| 50 - 54 | 110% | 77 | 26% |
| 55 - 59 | 90% | 78 | 24% |
| 60 | 70% | 79 | 22% |
| 61 | 66% | 80 | 20% |
| 62 | 62% | 81 | 19% |
| 63 | 58% | 82 | 18% |
| 64 | 54% | 83 | 17% |
| 65 | 50% | 84 | 16% |
| 66 | 48% | 85 | 15% |
| 67 | 46% | 86 | 14% |
| 68 | 44% | 87 | 13% |
| 69 | 42% | 88 | 12% |
| 70 | 40% | 89 | 11% |
| 71 | 38% | 90 and over | 10% |

GENERAL INFORMATION

TAX STATUS OF PREMIUMS AND BENEFITS

Your Policy is intended to be a **Qualified Long-Term Care Insurance Contract as defined by the Internal Revenue Code Section 7702B(b)**. The benefits you may receive under your Policy should not be considered taxable income. In addition, some or all of the premiums you pay for your Policy may be tax deductible as a medical expense subject to certain limitations. Consult a tax advisor for more information concerning this deduction.

Public guidance issued by the Internal Revenue Service or Treasury Department may provide that a provision of your Policy does not comply with the requirements of Code Section 7702B. In this event, this provision will be automatically nullified without any further action by Prudential.

ENTIRE CONTRACT

The entire contract between you and Prudential consists of your Policy, all attached pages, any optional Riders and your Application. A change in this contract will be valid only when approved by a Prudential officer and made a part of the contract. A Producer may not change the contract or waive any part of it.

DIVIDENDS

Your Policy is non-participating. It will not share in Prudential's profits or surplus earnings. Prudential will pay no dividends on it.

COMMUNICATION THROUGH ELECTRONIC MEANS

Prudential reserves the right to designate the form and means for all communications or notices required by your Policy.

With our prior consent, communications made by you or your representative pursuant to or in connection with your Policy, using electronic means or technologies, may be made to us.

With your prior consent, communications made by Prudential pursuant to or in connection with your Policy, using electronic means or technologies, may be made to you.

The transmittal of information, that is authorized or not otherwise prohibited by state or federal law, by electronic means or technology, is intended to have the same legal effect, validity, and enforceability as it would if the information were provided in other than an electronic form.

OTHER GOODS AND SERVICES

From time to time, Prudential may offer or provide certain goods and services to you in addition to the insurance coverage. Prudential also may arrange for third party vendors to provide goods and services at a discount (including without limitation beneficiary financial counseling services, estate guidance and employee assistance programs) to you. Though Prudential may

make the arrangements, the third party vendors are solely liable for providing the goods and services. Prudential shall not be responsible for providing or failing to provide the goods and services to you. Further, Prudential shall not be liable to you for the negligent provision of the goods and services by third party vendors.

OWNERSHIP

You are the owner of your Policy.

**REDUCING
COVERAGE**

You may make a request to reduce your Policy Lifetime Maximum to lower your premium while your Policy is in force.

Prudential may limit any reduction in coverage to options available for this Policy and to those for which benefits will be available after consideration of claims paid or payable. The age to determine the premium for reduced coverage shall be based on the age used to determine the premiums for the coverage currently in force. We will not require any additional proof of good health to reduce benefits.

To make a request, you can choose one of the following options.

- 1) You may contact your Producer to initiate a request to reduce your coverage.
- 2) You may write to us at the Contact Address in your Policy.
- 3) You may call the Prudential Long Term Care Customer Service Center at 1-800-732-0416 for assistance.

WHEN YOUR POLICY ENDS

TERMINATION OF YOUR POLICY

Your Policy and any applicable Riders will end at 12:01 A. M., Standard Time on the earliest of the following dates.

- 1) The premium due date if you fail to pay the full modal premium required for your Policy when due or in accordance with the Grace Period provision. This will not apply if the premium is being waived under the Waiver of Premiums provision.
- 2) The later of the date you have exhausted your Policy Lifetime Maximum or the date you have exhausted your Starter Benefit.
- 3) The date of your death.
- 4) The date we receive written notice requesting cancellation of your Policy or the date requested in such notice, if later.

Termination of your Policy will be without prejudice to benefits payable for your care in a Nursing Home, an Adult Foster Home, an Assisted Living Facility, or a Residential Health Care Facility if such care began while your Policy was in force and continues without interruption after your Policy ends. Benefits will be extended until the earlier of the following dates.

- 1) The date on which you no longer incur Eligible Charges for such care.
- 2) The date your Policy Lifetime Maximum has been exhausted.

If you are receiving benefits when the Policy terminated, you will be considered covered under your Policy for purposes of the Waiver of Premiums provision.

INCONTESTABILITY PROVISIONS

Your Policy was issued based on information given in your Application. All statements made in your Application are considered to be to the best of your knowledge and belief. Such statements will be deemed representations and not warranties. A statement will not be used in a contest to avoid this insurance or reduce benefits unless both of the following apply.

- 1) It is a written statement signed by you.
- 2) A copy of that statement is or has been furnished to you or your representative.

During the first six months your Policy is in force, if:

- 1) Information on your Application misrepresented any information about you or your health or medical history; and

- 2) As a result, we offered you insurance that you otherwise would not have been offered,

Prudential can rescind your Policy or deny an otherwise valid claim.

After your Policy has been in effect for six months, but less than two years, if:

- 1) Information on your Application misrepresented any information about you or your health or medical history; and
- 2) As a result, we offered you insurance that you otherwise would not have been offered; and
- 3) The misrepresentation pertains to the condition for which benefits are claimed,

Prudential can rescind your Policy or deny an otherwise valid claim.

After your Policy has been in effect for two years, if:

- 1) Relevant facts relating to your health were knowingly and intentionally misrepresented on your Application; and
- 2) As a result, we offered you insurance that you otherwise would not have been offered,

Prudential can rescind your Policy or deny an otherwise valid claim.

These provisions also apply if you provide additional evidence of insurability to purchase additional coverage after your Policy Effective Date.

GLOSSARY

This section defines certain of the terms used in your Policy. These definitions apply to the terms used in your Policy and any other attached forms.

ACTIVITIES OF DAILY LIVING (ADLs)

Bathing - Washing oneself by sponge bath, or in either a tub or shower, including the task of getting into or out of the tub or shower.

Continence - The ability to maintain control of bowel and bladder function, or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).

Dressing - Putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.

Eating - Feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by feeding tube or intravenously.

Toileting - Getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.

Transferring - Moving into or out of a bed, chair or wheelchair.

ADULT DAY CARE

A formal community based program for six (6) or more individuals, providing social and health related services during the day, to functionally and/or cognitively impaired adults. It must be licensed and/or certified as Adult Day Care according to the laws of the jurisdiction in which it is located. If licensure and/or certification is not required, then the Adult Day Care must satisfy all of the following requirements.

- 1) It must have a structured program that includes a variety of health, social and other related support services in a protective setting during daytime hours, but less than 24-hour care.
- 2) It must have established procedures for obtaining emergency medical services for clients.
- 3) It must maintain a written record of services provided to each client.
- 4) It must provide personal assistance with meals, toileting, continence and transferring.

ADULT FOSTER HOME OR BOARD AND CARE FACILITY

A family home or other facility in which residential care is provided to five or fewer adults in a home-like environment for compensation. Residents must be unrelated to the Provider by blood or marriage and be elderly or physically disabled. It must be licensed and/or certified as an Adult Foster Home or Board and Care Facility according to the laws of the jurisdiction in which it is located. For facilities located in a jurisdiction that does not license or certify Adult Foster Homes or Board and Care Facilities, it is a facility that provides ongoing services to a maximum of five residents in one location and is determined by Prudential to meet the following requirements.

- 1) It is a group residence that maintains records for services to each resident.
- 2) It provides services and oversight on a 24 hour a day basis.
- 3) It provides a combination of housing, supportive services, and personal assistance designed to respond to the resident's need for help with Activities of Daily Living and instrumental activities of daily living.
- 4) It provides, at a minimum, assistance with Bathing, Dressing and help with medications.
- 5) It is not licensed as a Nursing Home.

Adult Foster Home does not include any house, institution, hotel or other similar living arrangement that supplies room or board only, if you do not receive any Qualified Long-Term Care Services as a resident of the facility.

ASSESSMENT

An evaluation performed by a Licensed Health Care Practitioner to determine or verify that you have a Chronic Illness or Disability. The Assessment will be based on objective standards of measurement using generally accepted tests to produce verifiable results. The Assessment must be made at a time when the chronic nature of the condition can be determined. The Assessment should take place in your home or in the setting in which care is to be rendered.

ASSISTED LIVING FACILITY OR RESIDENTIAL HEALTH CARE FACILITY

It must be licensed and/or certified as an Assisted Living Facility or Residential Health Care Facility according to the laws of the jurisdiction in which it is located. For facilities located in a jurisdiction that does not license or certify Assisted Living Facilities or Residential Health Care Facilities, it is a facility that provides ongoing services to a minimum of three residents in one location and is determined by Prudential to meet the following requirements.

- 1) It is a group residence that maintains records for services to each resident.
- 2) It provides services and oversight on a 24 hour a day basis.
- 3) It provides a combination of housing, supportive services, and personal assistance designed to respond to the resident's need for help with Activities of Daily Living and instrumental activities of daily living.
- 4) It provides, at a minimum, assistance with Bathing, Dressing and help with medications.
- 5) It is not licensed as a Nursing Home.

**CALENDAR DAY
ELIMINATION
PERIOD**

The number of calendar days that you have a Chronic Illness or Disability that must elapse before certain Policy benefits may be payable. The Calendar Day Elimination Period applies to all benefits except the Hospice Care Benefit, the Starter Benefit and the Home Support Services Benefit. The Calendar Day Elimination Period is shown in the **Schedule of Policy Benefits**.

CAREGIVER

Caregiver means any provider of Home Health Care, Homemaker Services or Personal Care Services who is licensed, certified or otherwise authorized by the state where the services are performed to perform Home Health Care, Homemaker Services or Personal Care Services.

Caregiver includes a Home Health Care Agency, Home Health Aide, Referral Agency, Nurse Registry, Independent Health Care Professional and Personal Care Agency, Assisted Living Facility or Residential Health Care Facility.

Prudential recognizes that licensure, certification, and the names of eligible care providers vary from state-to-state. Therefore, we have developed alternative criteria to credential eligible care providers.

Care providers who meet the alternative criteria below when licensure, certification or other authorization to perform Home Health Care, Homemaker Services or Personal Care Services is not required by the state shall be considered eligible care providers.

Caregiver also includes an entity that satisfies the Agencies as Caregivers requirements below, or an individual that satisfies the Independent Caregiver requirements below.

- 1) **Agencies as Caregivers.** If the Home Health Care, Homemaker Services or Personal Care Services are furnished through an agency but the state in which the services are provided does not require the agency to be licensed, certified or otherwise authorized by the state to

provide Home Health Care, Homemaker Services or Personal Care Services, then the agency must satisfy all of the following requirements, to be a Caregiver.

- a) The agency must employ a full-time agency administrator responsible for the following activities.
 - i) Developing and maintaining care standards for Home Health Care, Homemaker Services or Personal Care Services provided to individuals.
 - ii) Ensuring that care providers receive adequate training in medical and non-medical home care protocols, as appropriate, to effectively perform Home Health Care, Homemaker Services or Personal Care Services.
 - b) The agency must employ or contract with a Registered Nurse to direct and supervise care providers who provide Home Health Care, Homemaker Services or Personal Care Services.
 - c) The agency must create a customized care plan to meet the needs of each individual to whom it provides Home Health Care, Homemaker Services or Personal Care Services.
 - d) The agency must maintain written records of services provided during each home care visit.
 - e) The agency must employ or contract with care providers who are appropriately licensed, certified or otherwise authorized by the state to provide medical and/or non-medical Home Health Care, Homemaker Services or Personal Care Services, if the state in which services are provided requires care providers to be licensed, certified or otherwise authorized to provide such services. If the state does not require care providers to be licensed, certified or otherwise authorized to provide such services, then the agency must employ or contract with care providers who satisfy the Independent Caregivers requirements below, or are otherwise adequately and appropriately trained to provide medical and/or non-medical Home Health Care, Homemaker Services or Personal Care Services.
 - f) The agency must hold a current business license from the state in which Home Health Care, Homemaker Services or Personal Care Services are provided.
- 2) **Independent Caregivers.** If a care provider works independently and is not an agency or affiliated with an agency, and the state in which Home Health Care,

Homemaker Services or Personal Care Services are provided does not require the independent Home Health Care provider to be certified, licensed or otherwise authorized to provide such services, then the independent Home Health Care provider must satisfy all of the following requirements to be a Caregiver.

- a) The independent care provider must submit documentation to Prudential confirming that he or she successfully completed a formal training program providing instruction and/or classroom training in topics relating to the provision of assistance with Activities of Daily Living or the provision of other Qualified Long-Term Care Services, such as body mechanics, nutrition, infection control, and safe transfer techniques. The training must be obtained from one of the following places.
 - i) community college.
 - ii) similar accredited educational institution or vocational school.
 - iii) an agency that meets the Agencies as Caregiver definition above.
 - iv) a state-approved training program for home care workers.
 - v) another school, organization or individual that is authorized to provide such training by the state in which Home Health Care, Homemaker Services or Personal Care Services are provided.
- b) The independent care provider must submit to Prudential proof of identity, such as a valid state issued driver's license.
- c) Upon request, the independent care provider must submit to Prudential written records documenting the Home Health Care, Homemaker Services or Personal Care Services provided during each home care visit.
- d) An Independent Caregiver cannot be a member of your immediate family.

**CHRONIC ILLNESS
OR DISABILITY**

An illness or disability certified by a Licensed Health Care Practitioner in which there is at least one of the following.

- 1) The loss of the ability to perform, without Substantial Assistance, at least two Activities of Daily Living due to a loss of functional capacity. This inability must be expected to continue for at least 90 consecutive days. This expectation is not a waiting period. The Activities of Daily Living are defined

and listed above.

- 2) A Severe Cognitive Impairment that requires Substantial Supervision to protect you from threats to health or safety.

**DOMESTIC
PARTNER**

Each of two people who have registered or filed as domestic partners or members of a civil union with a government agency or office where such registration or filing is available. Or

Each of two people who meet all the criteria listed below.

- 1) Are 18 years of age or older.
- 2) Are living together.
- 3) Have a serious and committed relationship.
- 4) Are not legally married nor a Domestic Partner to anyone else.
- 5) Are financially interdependent, meaning both are jointly responsible for the cost of food and housing.

**ELIGIBLE
CHARGES**

The charges for your Qualified Long-Term Care Services that are used as the basis for a claim determination by Prudential. Such Qualified Long-Term Care Services must be included in your Plan of Care in order for the charges to be considered Eligible Charges. These charges must be incurred

- 1) while your Coverage is in force.
- 2) after the Calendar Day Elimination Period, if any, is satisfied.
- 3) after the date you are certified as having a Chronic Illness or Disability.

Eligible Charges must be incurred for services and supplies described in **Your Long-Term Care Insurance Benefit Descriptions** section. Eligible Charges must be incurred from Providers who meet the criteria defined by your Coverage. A charge is considered incurred on the date you receive the service or supply.

Room and board charges and comparable expenses for residence in a facility shall not be Eligible Charges unless a Licensed Health Care Practitioner certifies in a Plan of Care both of the following requirements.

- 1) The primary reason for your residence in a Nursing Home, Assisted Living Facility, Residential Health Care Facility, Adult Foster Home or Board and Care Facility is your need to receive Qualified Long-Term Care Services in connection with your Chronic Illness or Disability on a 24-hour per day basis.
- 2) Such services are available at that Nursing Home, Assisted

Living Facility, Residential Health Care Facility, Adult Foster Home or Board and Care Facility.

A charge is not an Eligible Charge if it is described in the Coverage Exclusions section. Eligible Charges do not include charges incurred during the Calendar Day Elimination Period.

Eligible Charges also do not include charges for ancillary or miscellaneous items or services, provided in or by a facility or as part of Home Health Care provided to you which are not directly related to providing Qualified Long-Term Care Services in connection with your Chronic Illness or Disability. Examples include, but are not limited to, charges for utilities, newspapers, routine over-the-counter medical supplies, guest charges and convenience items.

Starter Benefits are paid without regard to Eligible Charges.

HOME

The house, apartment or room that is the primary place where you live. You are not required to own your home. For example, if you live in an adult child's primary residence, that would be considered your Home.

HOME HEALTH AIDE

A person whose function is to provide Personal Care Services or Homemaker Services. A Home Health Aide must be licensed or certified according to the laws of the jurisdiction in which care is rendered.

When licensing or certification is not required, a person will be deemed a Home Health Aide if he or she meets the following requirements.

- 1) He or she meets the minimum training qualifications recognized by the Foundation for Hospice & Home Care, National League of Nursing or Health Care Financing Administration.
- 2) He or she is employed through an eligible Home Health Care Agency, or is an Independent Health Care Professional.

HOME HEALTH CARE AGENCY

An organization that meets at least one of these three criteria.

- 1) It is an agency licensed as a home health care agency in the jurisdiction in which the Home Health Care is delivered.
- 2) It is a home health care agency as defined by Medicare.
- 3) It is an agency or organization that provides a program of Home Health Care that meets all these tests.
 - a) It is licensed to provide the services for Home Health Care in the Plan of Care.

- b) It maintains written records of services provided to patients.
- c) Its staff includes at least one Registered Nurse or nursing care by a Registered Nurse is available to it.

HOME HEALTH CARE

Medical and non-medical services, provided to ill, disabled or infirm persons in their Home.

HOMEMAKER SERVICES

Services that are designed to maintain your ability to function independently in your Home. Homemaker Services include but are not limited to the following activities.

- 1) Shopping.
- 2) Planning menus, preparing meals, and delivering meals to your Home.
- 3) Laundry and light house cleaning and maintenance. Light house cleaning includes vacuuming, dusting, dry mopping, dishwashing, cleaning the kitchen and bathroom and changing beds.

HOSPICE

A public agency or private organization providing palliative medical care (care which seeks to reduce pain and provide comfort, rather than provide a cure) to a Terminally Ill individuals. The agency or organization must meet federal certification requirements as a Hospice, or be licensed according to the laws of the jurisdiction in which it is located.

HOSPICE CARE

Services and supplies provided through a Hospice to meet the special physical, psychological, spiritual and social needs for a Terminally Ill person and his or her Immediate Family. Hospice Care provides palliative and supportive medical, nursing and other health services through home and inpatient care during the illness to one or both of the following persons.

- 1) A Terminally Ill person who has no reasonable prospect of cure as estimated by a Physician.
- 2) The Immediate Family or Primary Informal Caregiver of the person described in 1) above.

Hospice Care includes, but is not limited to the following care and services.

- 1) Part-time nursing care by or supervised by a Registered Nurse.
- 2) Counseling, including dietary counseling, for the Terminally Ill person.
- 3) Family counseling for the Immediate Family and the Primary

Informal Caregiver before the death of the Terminally Ill person.

- 4) Medical supplies, equipment, and medication required to maintain the comfort and manage the pain of the Terminally Ill person.

IMMEDIATE FAMILY

Your spouse, Domestic Partner or anyone who is related to you or your spouse or Domestic Partner (including adopted, in-law and step-relatives) as a parent, child, grandchild, or sibling.

INDEPENDENT HEALTH CARE PROFESSIONAL

A Home Health Aide, Registered Nurse, Licensed Practical Nurse or Therapist not affiliated with an agency independently providing Home Health Care services within the scope of his or her license. An Independent Health Care Professional cannot be a member of your immediate family.

LICENSED HEALTH CARE PRACTITIONER

A Physician, a Registered Nurse, a licensed or certified social worker, or another professional individual who meets the requirements prescribed by the United States Secretary of the Treasury.

LICENSED PRACTICAL NURSE

A professional nurse legally designated "LPN" who, where licensing is required, holds a valid license according to the laws of the jurisdiction in which the nursing service is performed. The term licensed practical nurse (LPN) shall include a licensed vocational nurse (LVN) and any other similarly designated nurse in those jurisdictions in which a professional nurse is designated as other than an LPN and for whom licensing is required.

LICENSED SOCIAL WORKER

A person who has a Baccalaureate, Master's or Doctoral degree in Social Work from a program accredited by the Council on Social Work Education and is appropriately licensed or certified, if licensing and certification is required, in the United States' jurisdiction where the social work is performed.

MEDICAID

Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time.

MEDICARE

The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as then constituted or later amended.

NURSE REGISTRY

An organization that meets the following requirements.

- 1) Its main function is to provide a referral service for Registered Nurses or Licensed Practical Nurses specialized in providing Home Health Care services.

- 2) It is appropriately licensed according to the laws of the jurisdiction in which the services are provided, if the jurisdiction in which the Nurse Registry is located requires licensure.

NURSING HOME

A facility whose primary purpose is to provide skilled, intermediate or custodial nursing care and meets one of the following requirements.

- 1) It is Medicare-approved as a Provider of skilled nursing care services.
- 2) It is licensed and operated according to the laws of the jurisdiction in which it is located as a skilled nursing home, an intermediate care facility or a custodial care facility.
- 3) It meets all the following requirements.
 - a) Its main function is to provide skilled, intermediate or custodial nursing care.
 - b) It is engaged in providing continuous room and board accommodations for three or more persons.
 - c) It has a Physician on staff or available to it under contract.
 - d) It is under the supervision of a Registered Nurse or Licensed Practical Nurse.
 - e) It maintains medical records for each patient.
 - f) It maintains control of and records of all medications dispensed.

A nursing home shall not include a facility that is primarily a facility for the treatment of alcoholism or chemical dependency.

PERSONAL CARE SERVICES

The provision of hands-on services to assist an individual with Activities of Daily Living.

PHYSICIAN

Any person licensed by a United States jurisdiction as a Medical Doctor (M.D.) or Doctor of Osteopathy (D.O.) practicing within the scope of his or her license.

PLAN OF CARE

A written, individualized plan that has been developed to meet your long-term care needs. The Plan of Care must meet the following requirements.

- 1) It is developed based on the results of an assessment by a Licensed Health Care Practitioner, a review of your health status, medical records and other available information.
- 2) It is prescribed by a Licensed Health Care Practitioner.

- 3) It names the type, frequency and duration of services you need and the appropriate Providers to furnish such services.
- 4) It fairly, accurately and appropriately addresses your needs in accordance with accepted medical and nursing standards of practice for a person with a similar Chronic Illness or Disability.

Prudential reserves the right to review or discuss your Plan of Care with the Licensed Health Care Practitioner who prescribed it. We may also verify that the Plan of Care is consistent with accepted medical and nursing standards of practice for a person with a similar Chronic Illness or Disability. Your Plan of Care must be updated as your condition and care needs change. We must be provided with a revised Plan of Care each time it is updated. We may request periodic updates not more frequently than once every 30 days.

**POLICY LIFETIME
MAXIMUM**

The maximum lifetime benefit payable for Eligible Charges according to the benefits you have chosen. Your initial Policy Lifetime Maximum is the amount available for all benefits payable under your Policy as of the Policy's Original Effective Date. The Policy Lifetime Maximum is shown on your **Schedule of Policy Benefits**. Benefits paid are deducted from the Policy Lifetime Maximum.

**PRIMARY
INFORMAL
CAREGIVER**

An unpaid person who regularly provides one of the following types of care.

- 1) Substantial Assistance when you are unable to perform at least two of the Activities of Daily Living.
- 2) Substantial Supervision when you have a Severe Cognitive Impairment.

The Primary Informal Caregiver may be a relative or someone chosen by you, but in no event will we pay for training provided to someone who will be paid to care for you.

**PRIVATE CARE
MANAGER**

A Licensed Health Care Practitioner, not associated with Prudential, who is qualified to coordinate your necessary medical care, long-term care, Personal Care and social services. Qualifications are based on training and experience and can include health care industry, state or national standards.

PROVIDER

A licensed or certified professional or entity that provides Qualified Long-Term Care Services.

QUALIFIED LONG-TERM CARE SERVICES

Necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, and rehabilitative services, and maintenance or Personal Care services, provided in a setting other than an acute care unit at a hospital which began while your Policy is in-force.

REFERRAL AGENCY

An agency that meets the following requirements.

- 1) Its main function is to provide a referral service for Registered Nurses, Licensed Practical Nurses, Therapists or licensed Home Health Aides providing Home Health Care.
- 2) It is licensed according to the laws of the jurisdiction in which it is located to provide such services. If licensing is not required, the agency must be accredited by the Joint Commission on Accreditation of Healthcare Organizations or other association that has substantially the same accreditation standards.

REGISTERED NURSE

A professional nurse legally designated "RN" who, where licensing is required, holds a valid license according to the laws of the United States jurisdiction in which the nursing service is performed.

RESPITE CARE

Short-term care provided by a third party to relieve your Primary Informal Caregiver from care giving responsibilities.

SEVERE COGNITIVE IMPAIRMENT

A loss or deterioration in intellectual capacity that is:

- 1) Comparable to (and includes) Alzheimer's Disease and similar forms of irreversible dementia, and
- 2) Measured by clinical evidence and standardized tests that reliably measure impairment in the individual's
 - a) Short-term or long-term memory,
 - b) Orientation as to people, places, or time and
 - c) Deductive or abstract reasoning.

SUBSTANTIAL ASSISTANCE

Hands-on assistance or stand-by assistance.

- 1) Hands-on assistance is the physical assistance (minimal, moderate or maximal) of another person without which an individual would be unable to perform an Activity of Daily Living.
- 2) Stand-by assistance is the presence of another person within arm's reach that is necessary to prevent, by physical intervention, injury to an individual while the individual is performing an Activity of Daily Living.

**SUBSTANTIAL
SUPERVISION**

Continual oversight that may include cueing by verbal prompting, gestures or other demonstrations by another person, and that is necessary to protect you from threats to your health or safety.

TERMINALLY ILL

A medical prognosis given by a Physician that your life expectancy is six months or less.

THERAPIST

A physical therapist, occupational therapist, respiratory therapist, speech pathologist or audiologist who is licensed according to the laws of the jurisdiction in where the services are performed.

SCHEDULE OF POLICY BENEFITS

Prudential LTC EvolutionSM

POLICY NUMBER: 1234567890

ORIGINAL EFFECTIVE DATE: 01/01/2009

CHANGE EFFECTIVE DATE: Not Applicable

PREMIUM AGE: 50

INSURED: John Doe

RATE CLASS: Standard 1

123 Main Street

POLICY ANNIVERSARY DATE: 01/01/2010

Dresher, PA 19025

and each 01/01 thereafter

PLAN INFORMATION

| | |
|---|-------------------------|
| CALENDAR DAY ELIMINATION PERIOD | 90 days |
| BENEFIT PAYMENT FOR COVERED SERVICES | 80% of Eligible Charges |
| CO-PAYMENT FOR COVERED SERVICES | 20% of Eligible Charges |
| STARTER BENEFIT | \$1,500 per month |
| STARTER BENEFIT POLICY MAXIMUM | 12 months |
| HOME SUPPORT SERVICES POLICY MAXIMUM | \$10,000 |
| POLICY LIFETIME MAXIMUM (does not reflect claims paid or payable) | \$ 500,000 |

THIS POLICY INCLUDES THE FOLLOWING OPTIONAL BENEFIT RIDERS

| OPTIONAL RIDER | EFFECTIVE DATE OF RIDER |
|--|-------------------------|
| INFLATION RIDER: 5% AUTOMATIC COMPOUND INCREASE OPTION RIDER | 01/01/2009 |
| NON-FORFEITURE BENEFIT RIDER | 01/01/2009 |
| SHARED CARE BENEFIT RIDER | 01/01/2009 |
| SHARED CARE PARTNER | Mary Doe |
| See next page for Premium Information. | |

SCHEDULE OF POLICY BENEFITS (Continued)

Prudential LTC EvolutionSM

POLICY NUMBER: 1234567890

INSURED: John Doe

PREMIUM INFORMATION

| | | |
|---|-----------|--------------------|
| Annual Premium For Base Policy | | \$ 2,000.00 |
| Optional Benefit Riders Premium | | \$ 1,500.00 |
| Optional Inflation Rider | \$ 500.00 | |
| Non-Forfeiture Benefit Rider | \$ 500.00 | |
| Shared Care Benefit Rider | \$ 500.00 | |
| Annual Premium Including All Optional Riders | | \$ 3,500.00 |
| Partner Discount* | 30% | |
| *Discounts are multiplicative. | | |
| Total Annual Premium Including Optional Riders and Less Discounts | | \$ 2,450.00 |
| Modal Premiums | | |
| Annual | | \$2,450.00 |
| Semi-Annual* | | \$1,261.75 |
| Quarterly | | \$649.25 |
| Monthly – EFT | | \$208.25 |
| *This is the modal premium you have elected. The total annual cost of your coverage will vary both by the frequency of premium payment (mode) as well as the method of payment chosen. The more frequent the premium payment mode the higher the annual cost. | | |

ALTERNATE BILLING ADDRESS
(if other than the insured)

ABC Company, Inc.
Attention: Jane Smith
456 Main Street
Dresher, PA 19025

Producer: Sam Jones
789 Main Street
Dresher, PA 19025

Telephone Number:

215-555-1212

Telephone Number:

215-555-2121

THE PRUDENTIAL INSURANCE COMPANY OF AMERICA

751 BROAD STREET

NEWARK, NEW JERSEY 07102

(800) 732-0416

LONG-TERM CARE INSURANCE

OUTLINE OF COVERAGE

Policy Number GRP 114018

The following applies to applicants who must answer medical questions in order to qualify for the Long Term Care Insurance.

Caution: *The issuance of this long-term care insurance Policy is based upon your responses to the questions on your Application. A copy of your Application will be included with your Policy when issued. If your answers are incorrect or untrue, or you fail to include all material medical information requested, Prudential may have the right to deny benefits or rescind your Policy, subject to the Incontestability provision. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the company at this address: Prudential Long Term Care Customer Service Center, P. O. Box 8519, Philadelphia, PA 19176-8519.*

Notice to buyer: This Policy may not cover all of the costs associated with long-term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations.

1. This policy is an individual policy of insurance.
2. **PURPOSE OF OUTLINE OF COVERAGE.** This outline of coverage provides a very brief description of the important features of the policy. You should compare this outline of coverage to outlines of coverage for other policies available to you. This is not an insurance contract, but only a summary of coverage. Only the individual policy contains governing contractual provisions. This means that the policy sets forth in detail the rights and obligations of both you and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you **READ YOUR POLICY CAREFULLY!**
3. **FEDERAL TAX CONSEQUENCES. This POLICY is intended to be a federally tax-qualified long-term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986, as amended.**
4. **TERMS UNDER WHICH THE POLICY MAY BE CONTINUED IN FORCE OR DISCONTINUED.**

RENEWABILITY: THIS POLICY IS GUARANTEED RENEWABLE. This means you have the right, subject to the terms of your policy, to continue this policy as long as you pay your premiums on time. Prudential cannot change any of the terms of your policy on its own, except that, in the future, **IT MAY INCREASE THE PREMIUM YOU PAY.**

This Policy contains a Waiver of Premium provision. After you meet the Benefit Eligibility Criteria and satisfy the required Calendar Day Elimination Period, the premiums for your Policy will be waived, subject to the terms and conditions of Your Policy. These features are described in full detail in the Policy.

5. TERMS UNDER WHICH THE COMPANY MAY CHANGE PREMIUMS.

PRUDENTIAL MAY CHANGE THE PREMIUM YOU PAY, BUT ONLY IF THE CHANGE APPLIES TO ALL INSUREDS WITHIN YOUR CLASS.

6. TERMS UNDER WHICH THE POLICY MAY BE RETURNED AND PREMIUM REFUNDED.

30-Day Right to Review Policy: If you decide you do not want this Long Term Care Policy, you may return it within 30 days of receipt. Your Policy will be canceled as of the Effective Date and any premium paid will be returned to you.

Pro-Rata Refund of Unearned Premium: Upon proper notification of your death or cancellation of this Policy, Prudential will refund on a pro-rata basis any part of the premium for you which applies to the period after death or cancellation.

7. THIS IS NOT MEDICARE SUPPLEMENT COVERAGE. If you are eligible for Medicare, review the *Guide to Health Insurance for People with Medicare* available from Prudential. Neither Prudential nor its agents represent Medicare, the federal government or any state government.

8. LONG-TERM CARE COVERAGE. Policies of this category are designed to provide coverage for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital, such as in a nursing home, in the community or in the home.

This Policy provides coverage in the form of reimbursement benefits based on a specified percentage of the actual Eligible Charges incurred for covered long term care expenses up to the Policy Lifetime Maximum. Benefits are subject to subject to Policy Exclusions, benefit limitations, the Calendar Day Elimination Period and coinsurance requirements. In some cases, if you choose the Starter benefit, benefits will be payable on an indemnity basis, subject to applicable terms and conditions of coverage.

9. BENEFITS PROVIDED BY THIS POLICY. After you have been certified as having a Chronic Illness or Disability and have satisfied your Calendar Day Elimination Period, this Policy pays benefits for Eligible Charges incurred by you. Benefits paid for Eligible Charges count towards fulfillment of your Policy Lifetime Maximum.

80% of Eligible Charges will be reimbursed for the following care.

- Nursing Home Care
- Adult Foster Home Care

- Care in an Assisted Living Facility
- Care in a Residential Health Care Facility
- Care in an Adult Foster Home or Board and Care Facility
- Bed Reservation
- Hospice Care (not subject to Calendar Day Elimination Period)
- Respite Care
- Home Health Care
- Adult Day Care
- Homemaker Services
- Personal Care
- Alternate Plan of Care

100% of actual Eligible Charges will be reimbursed, up to the Home Support Services Policy Maximum of \$10,000, for the following items. Benefits for Home Support Services are not subject to Calendar Day Elimination Period.

- Assistive Devices or Technology
- Caregiver Training
- Durable Medical Equipment
- Emergency Medical Response System
- Home Modifications
- Private Care Manager
- Transportation Services

A cash Starter Benefit is available during the Calendar Day Elimination Period. Consult the policy for details.

Calendar Day Elimination Period. The Calendar Day Elimination Period must be satisfied once during your lifetime before benefits are paid. Prudential will begin to count days to satisfy your Calendar Day Elimination Period with the date you are certified by a Licensed Health Care Practitioner as having a Chronic Illness or Disability. Each day your Chronic Illness or Disability continues counts in satisfaction of this Calendar Day Elimination Period. Once a day of the Calendar Day Elimination Period is satisfied, it is satisfied for the life of your Policy.

Eligibility for Payment of Benefits. Before incurring Eligible Charges and submitting a claim, you must undergo an Assessment and be certified by a Licensed Health Care Practitioner as having a Chronic Illness or Disability. A Chronic Illness or Disability is one that meets either definition below.

- 1) A loss of the ability to perform, without Substantial Assistance, at least two Activities of Daily Living due to a loss of functional capacity. This inability must be expected to continue for at least 90 consecutive days. This expectation is not a waiting or elimination period. Activities of Daily Living are Bathing, Continence, Dressing, Eating, Toileting and Transferring.
- 2) A severe Cognitive Impairment that requires Substantial Supervision to protect you from threats to health and safety.

Prudential will arrange for a Licensed Health Care Practitioner to assess you or you may select your own Licensed Health Care Practitioner. The assessment will be based on objective standards of measurement. After your Chronic Illness or Disability is certified, Prudential will determine if you are eligible for benefits. If you are eligible, you will need a Plan of Care developed by a Licensed Health Care Practitioner. All benefits are paid pursuant to the Plan of Care.

Activities of Daily Living:

Bathing - Washing oneself by sponge bath, or in either a tub or shower, including the task of getting into or out of the tub or shower.

Continence - The ability to maintain control of bowel and bladder function, or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).

Dressing - Putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.

Eating - Feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by feeding tube or intravenously.

Toileting - Getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.

Transferring - Moving into or out of a bed, chair or wheelchair.

Severe Cognitive Impairment: A loss or deterioration in intellectual capacity that is comparable to (and includes) Alzheimer's Disease and similar forms of irreversible dementia, and measured by clinical evidence and standardized tests that reliably measure impairment in the individual's short-term or long-term memory, orientation as to people, places, or time and deductive or abstract reasoning.

10. LIMITATIONS AND EXCLUSIONS.

There is no pre-existing conditions limitation.

The Policy does not provide benefits for any of the following.

- a) Illness, treatment or medical conditions arising out of
 - i) War or an act of war, whether declared or undeclared, while you are insured; or
 - ii) Your participation in a felony, riot or insurrection; or

- iii) Alcoholism and drug addiction.
- b) Treatment provided in a government facility, unless payment of the charge is required by law or services provided by any law or governmental plan under which you are covered. This does not apply to a state plan under Medicaid or to any law or plan when, by law, its benefits are excess to those of any private insurance program or other non-governmental program.
- c) Charges for services or supplies in excess of those normally charged by the Provider in the absence of insurance.
- d) Charges for care or treatment received outside the United States of America, its territories or possessions.
- e) Charges for care or treatment rendered by a member of your Immediate Family, unless he or she is a Caregiver (other than an Independent Health Care Practitioner), and he or she receives no compensation other than the normal compensation for employees in his or her job category.
- f) Charges for any care received while in a hospital, except in a unit specifically designated and licensed as a Nursing Home or Hospice facility.

Benefits under your Policy are not payable for expenses for Qualified Long Term Care Services to the extent that such expenses are reimbursable under Medicare; or such expenses would be reimbursable under Medicare but for the application of a deductible or coinsurance amount.

Benefits under your Policy may be reduced if we also pay benefits for Qualified Long Term Care Services under any other Prudential Individual Long Term Care Insurance Policy.

THIS POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LONG-TERM CARE NEEDS.

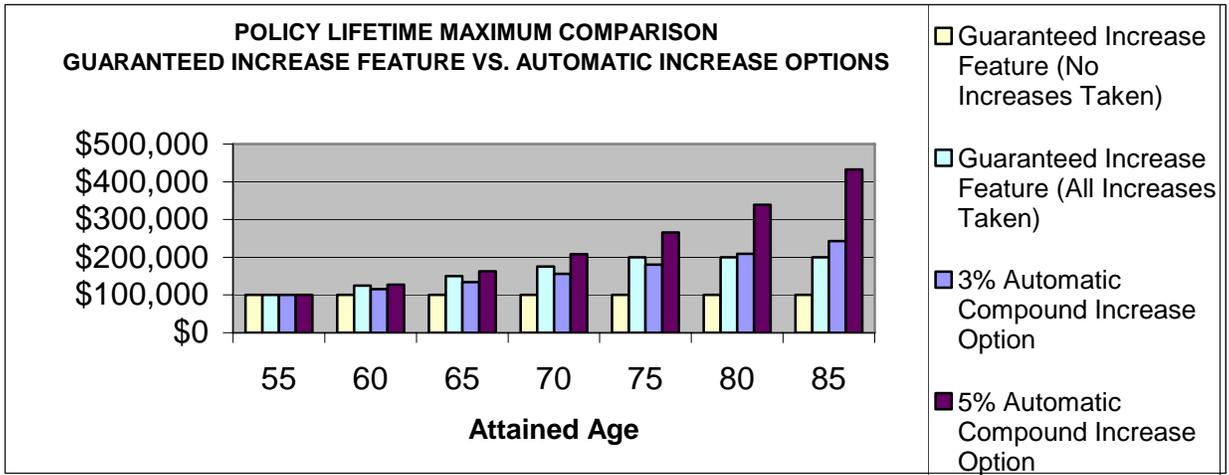
11. **RELATIONSHIP OF COST OF CARE AND BENEFITS.** Because the costs of long-term care services will likely increase over time, you should consider whether and how the benefits of this plan may be adjusted. Since there is no maximum daily benefit in your Policy, you will be reimbursed for either 80% or 100% of the actual Eligible Charges, depending on the service or care received. However, you will have a choice of three options to increase your Policy Lifetime Maximum. Your base policy contains a Guaranteed Increase Feature.

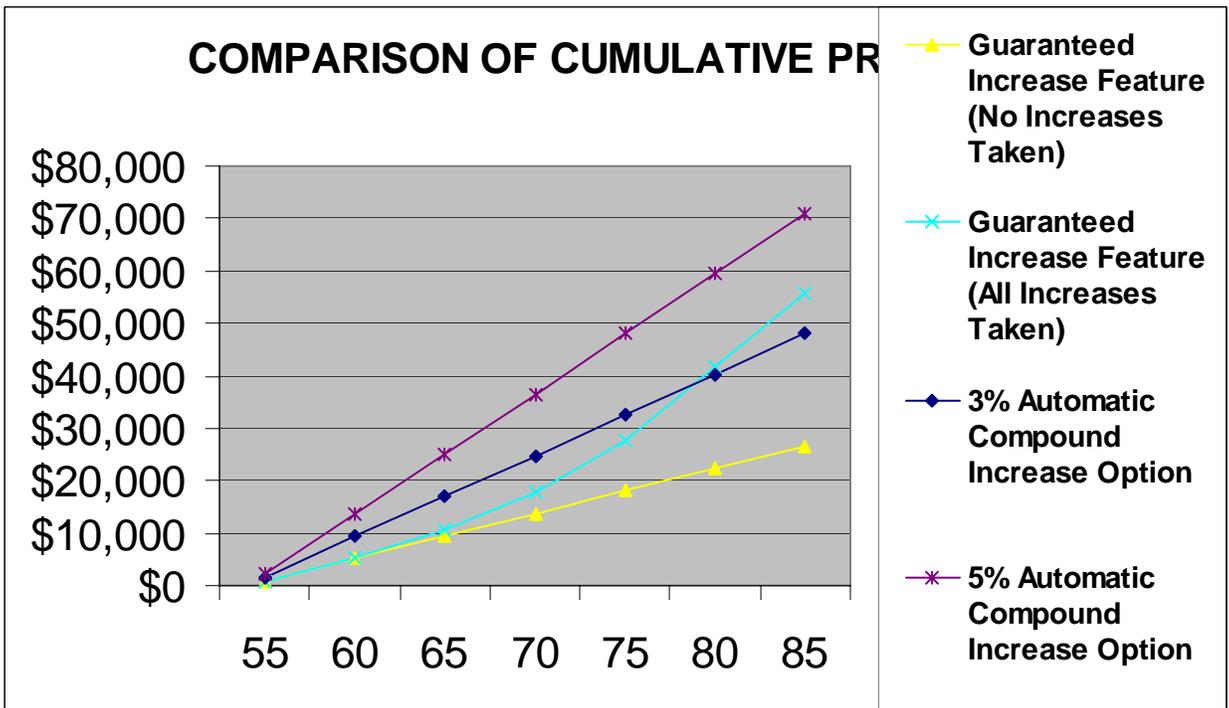
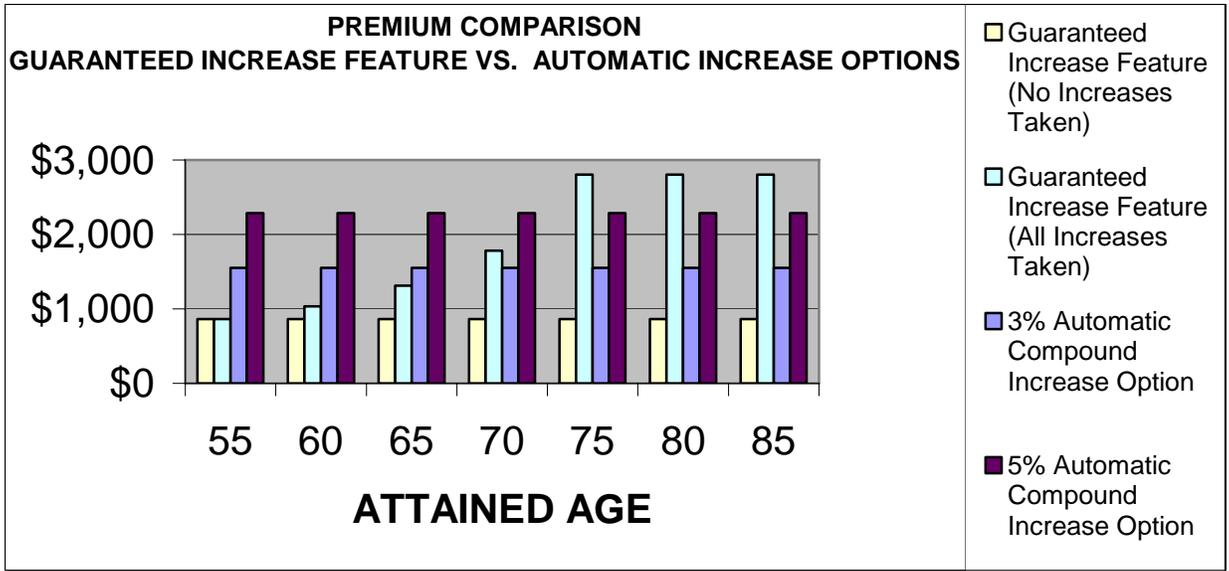
Guaranteed Increase Feature. Every five years on the Policy's Anniversary Date, Prudential will increase the Policy Lifetime Maximum with an associated increase in premium. With each benefit increase, your Policy Lifetime Maximum will be increased by 25% of the Policy Lifetime Maximum then in effect on that Policy Anniversary (not including any prior benefit increases applied under this Guaranteed Issue Feature, and excluding any amounts paid in claims). You will be notified of this benefit increase at least 60 days prior to the Policy Anniversary Date. You will not have to provide proof of good health to receive this benefit increase. The additional premium for the increase in coverage will be based on your attained age. All benefit increases will occur

even if you are receiving benefits or have met the Benefit Eligibility Criteria at the time of the increase takes effect. No further benefit increases will be put into effect on or after the date of your 76th birthday.

For additional premium at the time you purchase coverage, you may elect one of two optional riders that will automatically increase your benefits annually without an annual increase in your premium. The 5% Automatic Compound Increase Rider increases your Policy Lifetime Maximum each year at an annual compounded rate of 5%. The 3% Automatic Compound Increase Rider increases your Policy Lifetime Maximum each year at an annual compounded rate of 3%.

The following is a hypothetical graphic comparison of the benefit and premium levels of a Policy that increases lifetime benefits over the period of coverage with a Policy that does not increase lifetime benefits. The graphic comparison shows benefit and premium levels over a thirty-year period. The example is based upon a \$100,000 Policy Lifetime Maximum purchased by a 55 year old.





12. ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS.

The policy provides coverage for insureds clinically diagnosed as having Alzheimer's disease or related degenerative and dementing illnesses.

13. PREMIUM. The total annual premium for the Policy and options you have selected will be \$_____. Please see the last page of this Outline of Coverage for a complete listing of the features and premium for the options you have selected.

14. ADDITIONAL FEATURES.

Medical Underwriting. Medical underwriting is used to determine your eligibility for the Policy. To apply for coverage under the Policy, you must complete an Application. Satisfactory evidence of good health is required for all applicants in order to be eligible for this Policy. Individuals over the age of 79 are not eligible.

Protection Against Unintentional Lapse. You have the right to designate a person to receive notice that your Policy is about to lapse or terminate for nonpayment of premium. Unless you have chosen not to do so, your Application shows the name and address of the person you have designated to receive this notice. You may change this written designation at any time.

Reinstatement. If you fail to pay your premium and your Policy lapses for this reason, you may be eligible to reinstate your Policy. You may make a request for reinstatement within 90 days from the date the last notice of unpaid premium is given. If, due to your Chronic Illness or Disability, you fail to pay your premium and your Policy lapses for this reason, you may be eligible to reinstate your Policy. You or your representative may request reinstatement within five months of the date premiums were due.

Non-Forfeiture Benefit. For additional premium, you may purchase an Optional Rider to add a provision to your Policy that extends coverage for a shortened benefit period if your Policy ends due to non-payment of premium. Benefits will be payable based on a reduced Policy Lifetime Maximum. The reduced Policy Lifetime Maximum will be equal to the greater of 1) 3% of your initial Policy Lifetime Maximum as of your Original Effective Date, up to the Policy Lifetime Maximum in effect on the date your Policy would otherwise have ended, or 2) The total amount of premiums paid for your Policy, and any optional Riders, less the sum of all benefits paid on your behalf, while your Policy is in effect.

15. CONTACT THE STATE SENIOR HEALTH INSURANCE ASSISTANCE PROGRAM IF YOU HAVE GENERAL QUESTIONS REGARDING LONG-TERM CARE INSURANCE. CONTACT THE INSURANCE COMPANY IF YOU HAVE SPECIFIC QUESTIONS REGARDING YOUR LONG-TERM CARE INSURANCE POLICY OR CERTIFICATE.

16. **SENIOR COUNSELING PROGRAMS.** Please refer to *A Shopper's Guide To Long Term Care Insurance* given to you by your Producer for the telephone number of the Senior Counseling Program in your state.



The Prudential Insurance Company of America
751 Broad Street, Newark, New Jersey 07102-3777

Long Term Care Insurance Optional Inflation Rider 3% AUTOMATIC COMPOUND INCREASE OPTION

This Rider is issued in consideration of your Application and payment of the full modal premium. It becomes a part of your Policy. It takes effect on the Effective Date stated for this Rider in the **Schedule of Policy Benefits**. Please refer to the **Glossary** in your Policy for definitions.

This Rider amends your Policy to increase the benefit limits as described below, by 3% compounded annually.

The following provision replaces the section entitled **GUARANTEED INCREASE OPTION**.

3% AUTOMATIC COMPOUND INCREASES

Your benefits will automatically increase on each Policy Anniversary. The first increase will take effect on the Policy Anniversary that follows the Effective Date of this Rider. The increase will occur even if you are receiving benefits.

If you have purchased additional benefits after the Effective Date of this Rider, increases will also occur for those benefits, in accordance with the terms and conditions described herein.

Your premium will not increase solely due to increases under this Rider.

INCREASES TO YOUR POLICY LIFETIME MAXIMUM

Your increased Policy Lifetime Maximum will be determined as follows.

- 1) The Policy Lifetime Maximum remaining as of the Prior Policy Anniversary will be increased by 3%.
- 2) Amounts are rounded to the nearest dollar.
- 3) Benefits paid under your Policy, if any, during the Prior Policy Year will be deducted from this amount.

INCREASES TO YOUR HOME SUPPORT SERVICES POLICY MAXIMUM

Your increased Home Support Services Policy Maximum will be determined as follows.

- 1) The Home Support Services Policy Maximum in effect on the Prior Policy Anniversary will be increased by 3%.
- 2) Amounts are rounded to the nearest dollar.
- 3) Home Support Services Benefits paid under your Policy, if any, during the Prior Policy Year will be deducted from this amount.

INCREASES TO YOUR

Your increased monthly Starter Benefit will be determined as follows.

- 1) The monthly Starter Benefit in effect on the Prior Policy

**STARTER
BENEFIT**

Anniversary will be increased by 3%.

- 2) Amounts are rounded to the nearest dollar.

If you have exhausted the Starter Benefit Policy Maximum before a Policy Anniversary Date, this benefit will not increase.

The following provisions are added to the section of your Policy entitled **WHEN YOUR POLICY ENDS.**

**TERMINATION
OF RIDER**

This Rider will terminate if any of the following events occur.

- 1) Your Policy lapses because you fail to pay the full modal premium when due or in accordance with the Grace Period provision. This Rider will end as of the due date of the unpaid premium.
- 2) You send a written request to terminate this Rider. This Rider will end as of the date the request is received, unless a later date is specified.

**EFFECT OF
LAPSE AND
TERMINATION
OF RIDER**

If your Policy ends and is later reinstated, automatic benefit increases will be made as if your Policy had remained in effect.

If your Policy lapses for non-payment of premium and coverage continues under the Non-Forfeiture Benefit Rider, no automatic benefit increases will be made after the due date of the unpaid premium.

If you elect a lesser Policy Lifetime Maximum under the Contingent Non-Forfeiture provision, no additional automatic benefit increases will be made.

Except as modified above, all other terms and conditions of your Policy remain the same.

THE PRUDENTIAL INSURANCE COMPANY OF AMERICA


Secretary



The Prudential Insurance Company of America
751 Broad Street, Newark, New Jersey 07102-3777

Long Term Care Insurance Optional Inflation Rider 5% AUTOMATIC COMPOUND INCREASE OPTION

This Rider is issued in consideration of your Application and payment of the full modal premium. It becomes a part of your Policy. It takes effect on the Effective Date stated for this Rider in the **Schedule of Policy Benefits**. Please refer to the **Glossary** in your Policy for definitions.

This Rider amends your Policy to increase the benefit limits as described below, by 5% compounded annually.

The following provision replaces the section entitled **GUARANTEED INCREASE OPTION**.

5% AUTOMATIC COMPOUND INCREASES

Your benefits will automatically increase on each Policy Anniversary. The first increase will take effect on the Policy Anniversary that follows the Effective Date of this Rider. The increase will occur even if you are receiving benefits.

If you have purchased additional benefits after the Effective Date of this Rider, increases will also occur for those benefits, in accordance with the terms and conditions described herein.

Your premium will not increase solely due to increases under this Rider.

INCREASES TO YOUR POLICY LIFETIME MAXIMUM

Your increased Policy Lifetime Maximum will be determined as follows.

- 1) The Policy Lifetime Maximum remaining as of the Prior Policy Anniversary will be increased by 5%.
- 2) Amounts are rounded to the nearest dollar.
- 3) Benefits paid under your Policy, if any, during the Prior Policy Year will be deducted from this amount.

INCREASES TO YOUR HOME SUPPORT SERVICES POLICY MAXIMUM

Your increased Home Support Services Policy Maximum will be determined as follows.

- 1) The Home Support Services Policy Maximum in effect on the Prior Policy Anniversary will be increased by 5%.
- 2) Amounts are rounded to the nearest dollar.
- 3) Home Support Services Benefits paid under your Policy, if any, during the Prior Policy Year will be deducted from this amount.

INCREASES TO YOUR

Your increased monthly Starter Benefit will be determined as follows.

- 1) The monthly Starter Benefit in effect on the Prior Policy

**STARTER
BENEFIT**

Anniversary will be increased by 5%.

- 2) Amounts are rounded to the nearest dollar.

If you have exhausted the Starter Benefit Policy Maximum before a Policy Anniversary Date, this benefit will not increase.

The following provisions are added to the section of your Policy entitled **WHEN YOUR POLICY ENDS.**

**TERMINATION
OF RIDER**

This Rider will terminate if any of the following events occur.

- 1) Your Policy lapses because you fail to pay the full modal premium when due or in accordance with the Grace Period provision. This Rider will end as of the due date of the unpaid premium.
- 2) You send a written request to terminate this Rider. This Rider will end as of the date the request is received, unless a later date is specified.

**EFFECT OF
LAPSE AND
TERMINATION
OF RIDER**

If your Policy ends and is later reinstated, automatic benefit increases will be made as if your Policy had remained in effect.

If your Policy lapses for non-payment of premium and coverage continues under the Non-Forfeiture Benefit Rider, no automatic benefit increases will be made after the due date of the unpaid premium.

If you elect a lesser Policy Lifetime Maximum under the Contingent Non-Forfeiture provision, no additional automatic benefit increases will be made.

Except as modified above, all other terms and conditions of your Policy remain the same.

THE PRUDENTIAL INSURANCE COMPANY OF AMERICA


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751 Broad Street, Newark, New Jersey 07102-3777

Long Term Care Insurance Optional Rider NON-FORFEITURE BENEFIT

This Rider is issued in consideration of your Application and payment of the full modal premium. It becomes a part of your Policy. It takes effect on the Effective Date stated for this Rider in the **Schedule of Policy Benefits**. Please refer to the **Glossary** in your Policy for the definitions.

This Rider adds a provision to your Policy that extends coverage as described below, for a shortened benefit period if your Policy ends due to non-payment of premium. Your Policy and this Rider must have the same effective date.

The **Contingent Non-Forfeiture Provisions** in the **PREMIUMS** section of your Policy is replaced by the following.

NON-FORFEITURE BENEFIT

If your Policy ends due to non-payment of premium, your coverage will be extended as a Non-Forfeiture Benefit unless either of the following occurs.

- 1) Your Policy ends before its third anniversary.
- 2) You have already received benefits that equal or exceed the total amount of premiums paid for your Policy.

SHORTENED BENEFIT PERIOD

Under the Non-Forfeiture Benefit, benefits will be payable based on the benefits in effect on the date your coverage would otherwise have ended. However, there will be a reduced Policy Lifetime Maximum. A reduced Policy Lifetime Maximum means that your benefits will be payable for a shorter length of time. The reduced Policy Lifetime Maximum will be equal to the greater of items 1) or 2).

- 1) 3% of your initial Policy Lifetime Maximum as of your Original Effective Date, up to the Policy Lifetime Maximum in effect on the date your Policy would otherwise have ended.
- 2) The total amount of premiums paid for your Policy, and any optional Riders, less the sum of all benefits paid on your behalf, while your Policy is in effect.

Effect on Optional Riders

If your Policy includes an Optional Inflation Rider, Inflation increases will not occur for coverage under this Non-Forfeiture Benefit.

The following provisions are added to the section of your Policy entitled **WHEN YOUR POLICY ENDS**.

**NON-FORFEITURE
BENEFIT**

If your Policy would have ended due to non-payment of premium because you fail to pay the full modal premium required for your Policy when due or in accordance with the Grace Period provision, your coverage shall be extended in accordance with the provisions of the **Non-Forfeiture Benefit Rider**.

**TERMINATION OF
NON-FORFEITURE
BENEFIT RIDER**

This Rider will terminate if any of the following events occur.

- 1) Before your third Policy Anniversary, your Policy lapses because you fail to pay the full modal premium when due or in accordance with the Grace Period provision. This Rider will end as of the due date of the unpaid premium.
- 2) You send a written request to terminate this Rider. This Rider will end as of the date the request is received, unless a later date is specified in the written request.

Except as modified above, all other terms and conditions of your Policy remain the same.

THE PRUDENTIAL INSURANCE COMPANY OF AMERICA


Secretary



The Prudential Insurance Company of America
751 Broad Street, Newark, New Jersey 07102-3777

Long Term Care Insurance Optional Rider SHARED CARE RIDER

This Rider is issued in consideration of your Application and payment of the full modal premium. It becomes a part of your Policy. It takes effect on the Effective Date stated for this Rider in the **Schedule of Policy Benefits**. Please refer to the **Glossary** in your Policy for definitions.

This Rider allows your Shared Care Partner (Partner) to access the benefits available under your Policy once your Partner's Policy Lifetime Maximum is exhausted. Furthermore, if your Partner dies, we will increase your Policy Lifetime Maximum by the amount of the deceased Partner's remaining Policy Lifetime Maximum, if any.

The following provision is added to the section **ADDITIONAL POLICY FEATURES**.

SHARED CARE BENEFIT

At the time of purchase, you designated a Shared Care Partner (Partner), who is the person able to access the benefits of your Policy. Your Partner may access any available benefits under your Policy if the following conditions are met.

- 1) You keep this Rider in force.
- 2) Your Partner also has the Shared Care Rider in effect and you are the designated Shared Care Partner on his or her Policy.
- 3) You and your Partner must have and maintain identical Policy Benefits, including Optional Benefit Riders.

You and your Partner must identically accept or decline benefit increases under the Guaranteed Increase Feature, if applicable.

If your Partner exhausts his or her Policy Lifetime Maximum, we will provide benefits for his or her Eligible Charges under your Policy. Benefits will be paid for your Partner in accordance with applicable monthly and lifetime limits of his or her Policy.

You and your Partner may receive benefits under your Policy at the same time. In no event will we pay benefits that exceed the Policy Lifetime Maximum of both Policies.

Shared Care Partner Death

If your Partner dies while this Policy is in force, we will increase your Policy Lifetime Maximum by the amount of your Partner's remaining Policy Lifetime Maximum, if any, as of the date of your Partner's death. We will also reduce your premium by the increment for the Shared Care Rider.

The amount that is added to your Policy Lifetime Maximum is not subject to any inflation increases.

Benefits will be available in accordance with all Policy maximums, including monthly and lifetime benefits.

If your Partner dies after your Policy's Lifetime Maximum is exhausted, your coverage will be extended by the amount of your Partner's remaining Policy Lifetime Maximum, if any. This amount is not subject to any inflation increases. Benefits will be available in accordance with all Policy maximums, including monthly and lifetime benefits that existed on the date your Policy's Lifetime Maximum was exhausted. There is no additional premium due once your coverage has been extended.

Exhaustion of Benefits

If your Partner exhausts your Policy's Lifetime Maximum, you may purchase a new policy from Prudential on a guaranteed issue basis. Your Partner will not have access to the benefits of this new policy.

You may only purchase a policy with a Policy Lifetime Maximum equal to 50% of your initial Policy Lifetime Maximum (minimum \$100,000, maximum \$300,000). Your new policy can include any Optional Riders that were in force on the date your Policy's Lifetime Maximum was exhausted, with the exception of the Shared Care Rider. Your age at the time you purchase this new policy is used to rate that policy and any Optional Riders. The amount of your premium is calculated using the rates then in effect for the benefits you chose.

You may not elect to purchase this new policy if the following conditions apply.

- 1) You met the Benefit Eligibility Criteria during the two-year period prior to the day your Policy's Lifetime Maximum was exhausted.
- 2) You are age 91 or older on the day your Policy's Lifetime Maximum was exhausted.

We will notify you of your right to purchase a new policy. We must receive written application for this new policy from you within 45 days of the date of our notice.

Waiver of Premium

The premiums for your Policy will be waived only after you meet the Benefit Eligibility Criteria and satisfy any applicable Calendar Day Elimination Period. Your Partner cannot activate the Waiver of Premium provision of your Policy.

The following provision is added to the section of your Policy entitled **WHEN YOUR POLICY ENDS**.

Termination of Shared Care Rider

This Rider will terminate if any of the following events occur.

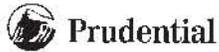
- 1) The relationship with your Partner ends. This Rider will end as of the date we receive notice that the relationship ended.
- 2) Your Policy lapses for non-payment of premium. This Rider will end as of the due date of the unpaid premium.
- 3) The Policy in effect for your Partner lapses for non-payment of premium. This Rider will end as of his or her Policy due date of the unpaid premium and your premium will be adjusted

- accordingly.
- 4) Your Partner dies. This Rider will end as of the date of your Partner's death.
 - 5) You send a written request to terminate this Rider. This Rider will end as the date the request is received, unless a later date is specified.
 - 6) The Policy Lifetime Maximum under both your Policy and your Partner's Policy has been exhausted.
 - 7) Your Policy lapses for non-payment of premium and coverage continues under the Non-Forfeiture Benefit Rider.
 - 8) You elect a lesser Policy Lifetime Maximum under the Contingent Non-forfeiture provision.

Except as mentioned above, all other terms and conditions of your Policy remain the same.

THE PRUDENTIAL INSURANCE COMPANY OF AMERICA


Secretary



THE PRUDENTIAL
INSURANCE COMPANY
OF AMERICA

LONG TERM CARE
CUSTOMER
SERVICE CENTER

PO BOX 8519
PHILADELPHIA PA 19176-8519
1.800.732.0416

LONG TERM CARE INSURANCE APPLICATION FOR

New Policy **Reinstatement**

Coverage Change

(Indicate Current Policy Number if Coverage Change or Reinstatement request)

TO: THE PRUDENTIAL INSURANCE COMPANY OF AMERICA

Please print all information except where signatures are required. Use black ink. Read all questions carefully.

APPLICANT INFORMATION

Mr. Ms. Mrs. _____ --

Applicant's Social Security #

Male Female

First Name M.I. Last Name

(As it should appear on your Policy)

Street Address (No PO Boxes) Apt. No.

 -

City State Zip Code

-- -- --

Date of Birth Age Daytime Phone Evening Phone

IF THE MAILING ADDRESS IS OTHER THAN THE ADDRESS GIVEN ABOVE, PLEASE COMPLETE THE FOLLOWING:

Address Apt. No.

 -

City State Zip Code

Best Time to Call AM PM Marital Status Yes, married No, not married

Is your Spouse/Partner applying for this insurance? Yes No

If No, does he/she currently have Prudential Long Term Care insurance? Yes No

If Yes, give Policy/Certificate Number

Spouse/Partner First Name M.I. Last Name

-- Spouse Partner

Spouse/Partner Social Security #

INSURANCE HISTORY

Indicate yes or no

If coverage is being replaced, please submit a completed Replacement Notice.

- 1 Are you covered by Medicaid or Medi-Cal (not Medicare)? Yes No
- 2 Do you have other long term care or accident and sickness insurance in force (including policies, certificates, health care service contracts, or health maintenance organization contracts)? Yes No
- 3 Did you have other long term care insurance in force during **the last 12 months**? Yes No
- 4 Do you intend to replace any of your medical health insurance with this insurance? Yes No

IF YOU ANSWERED YES TO QUESTIONS 2, 3, OR 4 OF THIS SECTION, PLEASE PROVIDE THE FOLLOWING INFORMATION

| | | | | | |
|--------------------------------|-------------------------------------|--|--|--|--|
| <input type="checkbox"/> Group | <input type="checkbox"/> Individual | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Type of Coverage | | Policy # | | If yes give date | |
| <input type="checkbox"/> Group | <input type="checkbox"/> Individual | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Type of Coverage | | Policy # | | If yes give date | |

Full name and address of insurance company

MEDICAL HISTORY – PART 1 INSURABILITY PROFILE

Indicate yes or no

- 1 Have you had, do you currently have, or have you ever been diagnosed as having any of the following medical conditions:
 - a Acquired Immune Deficiency Syndrome (AIDS), or a Human Immunodeficiency Virus (HIV) infection? Yes No
 - b Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig's Disease)? Yes No
 - c Alzheimer's Disease, Chronic Memory Loss, frequent or persistent forgetfulness, senility, dementia, or Organic Brain Syndrome? Yes No
 - d Chronic Obstructive Pulmonary Disease (COPD) or Emphysema **in combination with:** Current Smoking; Congestive Heart Failure (CHF); Asthma; or Chronic Bronchitis? Yes No
 - e Congestive Heart Failure **in combination with:** Current Smoking, Angina or Heart Surgery; Asthma or Chronic Bronchitis; Diabetes; or Tuberculosis? Yes No
 - f Congestive Heart Failure, diagnosed or symptomatic, within **the past 12 months**? Yes No
 - g Immune System Disorder? Yes No
 - h Metastatic Cancer (Cancer that has spread from the original site or location)? Yes No
 - i Stroke or Cerebrovascular Accident (CVA)? Yes No
 - j Cystic Fibrosis? Yes No
 - k Liver Cirrhosis? Yes No
 - l Multiple Sclerosis (MS), Muscular Dystrophy, Parkinson's Disease, Huntington's Disease? Yes No
 - m Transient Ischemic Attack (TIA) within **the past 5 years**; multiple TIAs; or TIA in combination with Diabetes or any Heart Surgery? Yes No
 - n Within **the past 6 months**, have you had open heart surgery, spine surgery, back surgery? Yes No
- 2 Within **the past 48 months** have you had cancer of the: Yes No
 - Bone Brain Esophagus Liver Lung Ovary Pancreas Stomach
- 3 Do you use a four pronged cane, kidney dialysis, motorized scooter, oxygen, respirator, walker, wheelchair? Yes No
- 4 Within **the past 12 months** have you: Yes No
 - Used adult day care Needed home health care
 - Been medically advised to enter or been confined to: A nursing home An assisted living facility Other long term care facility
- 5 Do you currently need assistance or supervision by another person in performing any of the following activities: Yes No
 - Bathing Eating Toileting Dressing Bowel or Bladder Control Moving in and out of bed or chair
 - Taking your medication

If you answered "Yes" to any question in this insurability profile, we recommend that you do not submit this Application.

Please provide the requested information about yourself.

1a

| | |
|-------------------|----------------|
| | |
| Height Ft./In. | Weight Lbs. |

 1b Have you had any change in weight in the last 12 months?
 Gain _____ lbs. Loss _____ lbs. N/A

2a Are you retired? Yes No 2b If yes, what was your occupation? _____

3a Are you currently employed? Yes No 3b If yes, what occupation? _____

3c Is the work Full-time or Part-time? Inside the home or Outside the home?

4 Please list any activities in which you regularly participate outside your home. (For example, vigorous exercise, walking, gardening.) _____

5a Have you smoked or used tobacco products within the past three years? Yes No

5b Do you use more than 1 (one) pack of tobacco products per day? Yes No

6a Do you drive an automobile? Yes No 6b If yes, approximate number of miles driven each year? _____

7 With whom do you live? No one Spouse/Partner Other _____

8 Are you pregnant? Yes No

9a Are you living in a retirement community? Yes No

9b If yes, please list any services you currently receive (For example, housecleaning, laundry, meals, medications.) _____

10 Are you currently receiving any Disability benefits or have you during the past 1 year? Yes No

- Please check all that apply: Disability Income Insurance State or Federal Workers Compensation
 State Insurance Program Social Security
 Occupational Disease Law Employer's Liability Insurance

11 Have two or more years passed since you received any treatment or examination by **any** health care professional? Yes No

12 Who is your Primary Care Doctor with most of your medical records?

| | | | | | |
|--|--|--|--|--|--|
| | | | | | |
|--|--|--|--|--|--|

Name

Phone

| |
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|--|

Street Address

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Apt. No.

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City

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State

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Zip Code

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Date last seen

Reason(s) last seen _____

MEDICAL HISTORY – PART 3 HEALTH PROFILE

Please answer every question in this section by indicating “Yes” or “No”

- 1 In the **past 12 months**, have you had an application rejected for long term care, nursing home care, or other health insurance? Yes No
- 2 Within the **past 5 years, (10 years for cancer)**, have you received any medical advice, examination, or treatment from a health care professional; taken any medications; or been medically diagnosed for:

| Yes | No | Condition | Yes | No | Condition | Yes | No | Condition | | | |
|-----|--------------------------|--------------------------|---|----|--------------------------|--------------------------|---|-----------|--------------------------|--------------------------|---|
| a | <input type="checkbox"/> | <input type="checkbox"/> | Cardiovascular or circulatory disorder including congestive heart failure (CHF), peripheral vascular disease, heart attack, chest pain, angina, high blood pressure or irregular heart beat | h | <input type="checkbox"/> | <input type="checkbox"/> | Asthma, chronic bronchitis, chronic obstructive pulmonary disease (COPD), emphysema, shortness of breath | o | <input type="checkbox"/> | <input type="checkbox"/> | Fracture |
| b | <input type="checkbox"/> | <input type="checkbox"/> | Cancer or non-cancerous tumors | i | <input type="checkbox"/> | <input type="checkbox"/> | Brain disorder, convulsions, epilepsy or seizures, dizziness or balance problems, fainting spells or black outs | p | <input type="checkbox"/> | <input type="checkbox"/> | Osteoarthritis |
| c | <input type="checkbox"/> | <input type="checkbox"/> | Hodgkin's Disease, Lymphoma, Leukemia, other blood disorder | j | <input type="checkbox"/> | <input type="checkbox"/> | Depression, anxiety, mental, emotional or nervous disorder, or confusion, or memory loss | q | <input type="checkbox"/> | <input type="checkbox"/> | Osteoporosis |
| d | <input type="checkbox"/> | <input type="checkbox"/> | Skin ulcers | k | <input type="checkbox"/> | <input type="checkbox"/> | Tremors | r | <input type="checkbox"/> | <input type="checkbox"/> | Myasthenia Gravis, Paralysis, weakness or numbness of the extremities |
| e | <input type="checkbox"/> | <input type="checkbox"/> | Non-insulin dependent diabetes | l | <input type="checkbox"/> | <input type="checkbox"/> | Visual disturbances | s | <input type="checkbox"/> | <input type="checkbox"/> | Replacement of the hip, knee or other joint |
| f | <input type="checkbox"/> | <input type="checkbox"/> | Insulin dependent diabetes # of units per day _____ | m | <input type="checkbox"/> | <input type="checkbox"/> | Amputation | t | <input type="checkbox"/> | <input type="checkbox"/> | Rheumatoid arthritis, Lupus, Scleroderma or other connective tissue disease |
| g | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis | n | <input type="checkbox"/> | <input type="checkbox"/> | Disabling back or spine injury | u | <input type="checkbox"/> | <input type="checkbox"/> | Other conditions causing crippling or limited motion or requiring use of an adaptive device, chronic pain or fatigue, or Fibromyalgia |
| | | | | | | | | v | <input type="checkbox"/> | <input type="checkbox"/> | Renal insufficiency or Kidney disorder |
| | | | | | | | | w | <input type="checkbox"/> | <input type="checkbox"/> | Sarcoidosis |

- 3 Within the **past three years**, have you been medically advised to enter or been confined to a hospital or other health care facility? Yes No
- 4 Within the **past three years**, have you: been confined to a nursing home, assisted living facility, or long term care facility? been medically advised to have surgery which has not been performed? received home health care? used adult day care? None
- 5 Within the **past five years**, have you been advised to limit, reduce, discontinue or seek counseling for the use of alcohol or drugs? Yes No
- 6 Within the **past five years**, have you received any medical advice, examination or treatment from a health care professional for any reason not previously stated? Yes No

In the space below you MUST provide details for any “Yes” answers to questions 1 through 6.

If needed, complete the additional medical information page that is provided.

Refers to number/letter above _____ Diagnosis date _____ Treatment date last seen _____

Reason Consulted/treated _____

Check here if treated by primary care physician (PCP). If not treated by PCP, give name, address, and phone for other treating professional

Refers to number/letter above _____ Diagnosis date _____ Treatment date last seen _____

Reason Consulted/treated _____

Check here if treated by primary care physician (PCP). If not treated by PCP, give name, address, and phone for other treating professional

Refers to number/letter above _____ Diagnosis date _____ Treatment date last seen _____

Reason Consulted/treated _____

Check here if treated by primary care physician (PCP). If not treated by PCP, give name, address, and phone for other treating professional

MEDICAL HISTORY – PART 4 MEDICATIONS

1 Please provide the requested information. Within the past 12 months have you taken any drugs or medications? Yes No
If yes, provide the information requested in the space below. If needed, complete the Additional Medical Information Page that is provided.

a Drug or Medication _____ Dosage _____ How long been taking? _____
Reason for taking _____
 Check here if prescribed by Primary Care Physician (PCP) only. If not prescribed by PCP, give name, address and phone number of treating professional:

b Drug or Medication _____ Dosage _____ How long been taking? _____
Reason for taking _____
 Check here if prescribed by Primary Care Physician (PCP) only. If not prescribed by PCP, give name, address and phone number of treating professional:

c Drug or Medication _____ Dosage _____ How long been taking? _____
Reason for taking _____
 Check here if prescribed by Primary Care Physician (PCP) only. If not prescribed by PCP, give name, address and phone number of treating professional:

d Drug or Medication _____ Dosage _____ How long been taking? _____
Reason for taking _____
 Check here if prescribed by Primary Care Physician (PCP) only. If not prescribed by PCP, give name, address and phone number of treating professional:

e Drug or Medication _____ Dosage _____ How long been taking? _____
Reason for taking _____
 Check here if prescribed by Primary Care Physician (PCP) only. If not prescribed by PCP, give name, address and phone number of treating professional:

f Drug or Medication _____ Dosage _____ How long been taking? _____
Reason for taking _____
 Check here if prescribed by Primary Care Physician (PCP) only. If not prescribed by PCP, give name, address and phone number of treating professional:

g Drug or Medication _____ Dosage _____ How long been taking? _____
Reason for taking _____
 Check here if prescribed by Primary Care Physician (PCP) only. If not prescribed by PCP, give name, address and phone number of treating professional:

If you are taking more than 7 medications, please list them on the "Additional Medical Information Page."

NOTIFICATION OF UNINTENTIONAL LAPSE

You can provide Prudential with the name of a friend or relative to notify if your Policy should lapse because the premium is not paid when due. This designation does not constitute an acceptance of liability by the person named. Prudential will notify you each year of your right to designate or change the existing designation for this purpose.

ONLY COMPLETE THE APPROPRIATE SECTION: NAME A DESIGNEE OR WAIVER OF NOTIFICATION.

Check here ONLY to name a designee, and provide the requested information about that person:

| | | | |
|----------------|-------|-----------|----------|
| | | | |
| First Name | M.I. | Last Name | |
| | | | |
| Street Address | | | Apt. No. |
| | | | |
| City | State | Zip Code | |

Check here only if you do not wish to name a person for this purpose and sign below.

WAIVER OF NOTIFICATION OPTION:

I understand that I have the right to name at least one person other than myself to receive notice of lapse of termination of my long term care insurance policy for non-payment of premium. I understand that notice will not be given until thirty-one days after the premium is due and not paid. **By my signature, I elect NOT to name any person to receive such notice.**

X _____ Applicant Signature

TO RESIDENTS OF ILLINOIS

The policy is not approved for Medicaid Asset Protection under the Illinois Long Term Care Partnership Program. However, the policy is an approved long term care policy under state insurance regulations. For information about policies approved under the Illinois Long Term Care Partnership Program, call the Senior Help-Line at the Illinois Department on Aging at 1.800.252.8966.

TO RESIDENTS OF IOWA

The policy does not qualify for Medicaid Asset Protection under the Iowa Long Term Care Asset Preservation Program. However, the policy is an approved long term care policy under state insurance regulations. For information about policies and certificates qualifying under the Iowa Long Term Care Asset Preservation Program, call the Senior Health Insurance Information Program of the Iowa Division of Insurance at 1.800.281.5705.

The following does not apply to KS, NJ, OR or VA Residents. Caution: Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, may commit a fraudulent insurance act, which is a crime that may subject such person to criminal and/or civil penalties. With respect to New York Residents, civil penalties not to exceed \$5,000, plus the stated value of the claim for each violation, can apply.

Note to residents of New Jersey: Caution: Any person who includes any false or misleading information on an application for coverage under a group policy is subject to criminal and civil penalties.

Note to residents of Virginia: Caution: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.

APPLICANT AGREEMENTS

Caution: If your answers on this Application are incorrect or untrue, or fail to include all material medical information requested, Prudential may have the right to deny benefits or rescind your Policy. I understand and agree that:

- 1 To the best of my knowledge and belief, the answers on this Application are complete and true.
- 2 This Application will be part of the Policy for which I am applying to **The Prudential Insurance Company of America** (Prudential).
- 3 A Policy will **not** take effect unless: Prudential has approved this Application; the first full modal premium has been paid prior to the Effective Date; and only if the statements and answers given in applying for this Policy are without material change until the date this Application is approved.
- 4 If issued, my Long Term Care Insurance Policy will take effect on the Effective Date assigned by Prudential.
- 5 Prudential has the right to change premium rates in the future but only on a class basis.
- 6 I have received the Outline of Coverage and *A Shopper's Guide to Long Term Care Insurance* from the Agent.
- 7 If I am eligible for Medicare, I have received the *Guide to Health Insurance for People with Medicare* from the Agent.
- 8 I have read, or have had read to me, the completed Application, and where applicable, Potential Rate Increase Disclosure Form, and I understand that any false statement or misrepresentation in my Application may result in loss of coverage under the Policy.
- 9 **INFLATION:** I have reviewed the Outline of Coverage and the graphs that compare benefits and premiums of this Policy with and without inflation protection. Specifically, I have reviewed the Automatic Compound Inflation Rider-No Maximum.
 Check this box if you REJECT the Automatic Compound Inflation Rider-No Maximum.
- 10 **NON FORFEITURE:** I have reviewed the Outline of Coverage and the Nonforfeiture benefit described therein. Specifically, I have reviewed this optional benefit available to me.
 Check this box if you REJECT the Shortened Benefit Period Rider Nonforfeiture Benefit.

11 Electronic Funds Transfer Authorization (EFT) if applicable:

Enclose a check for two month's premium.

I authorize Prudential to make deductions from my bank account for payment of premiums. I understand that: 1) Prudential shall not incur any liability on a draft returned by the bank; 2) amounts not clearing after their initial deposit shall constitute non-payment of premium and coverage under the Policy shall lapse subject to its provisions; and 3) authorization shall remain in force until I revoke by signed writing to Prudential or Prudential revokes in accordance with Policy.

BANK (Credit Union) NAME: _____

BANK ACCOUNT #: _____

BANK ROUTING #: _____

TYPE ACCOUNT: Checking Savings

BILL DATE*: 1st 8th 15th 22nd *If no choice is indicated, bill date will default to the 1st of the month.

| | |
|--|-------------------------|
| X Applicant Signature | Date |
| X Witness (licensed and appointed agent) | |
| Agent (print name) | Agent's Contract Number |
| Signed at: City | State |

INSURANCE HISTORY

Indicate yes or no

If coverage is being replaced, please submit a completed Replacement Notice.

- 1 Are you covered by Medicaid or Medi-Cal (not Medicare)? Yes No
- 2 Do you have other long term care or accident and sickness insurance in force (including policies, certificates, health care service contracts, or health maintenance organization contracts)? Yes No
- 3 Did you have other long term care insurance in force during **the last 12 months**? Yes No
- 4 Do you intend to replace any of your medical health insurance with this insurance? Yes No

IF YOU ANSWERED YES TO QUESTIONS 2, 3, OR 4 OF THIS SECTION, PLEASE PROVIDE THE FOLLOWING INFORMATION

| | | | | | | |
|--------------------------------|-------------------------------------|--------------------------------|-------------------------------------|--|--|--|
| <input type="checkbox"/> Group | <input type="checkbox"/> Individual | <input type="checkbox"/> Group | <input type="checkbox"/> Individual | Intend to replace? | Did insurance lapse? | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Type of Coverage | | Policy # | | If yes give date | | |

| | | | | | | |
|--------------------------------|-------------------------------------|--------------------------------|-------------------------------------|--|--|--|
| <input type="checkbox"/> Group | <input type="checkbox"/> Individual | <input type="checkbox"/> Group | <input type="checkbox"/> Individual | Intend to replace? | Did insurance lapse? | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Type of Coverage | | Policy # | | If yes give date | | |

Full name and address of insurance company

MEDICAL HISTORY – PART 1 INSURABILITY PROFILE

Indicate yes or no

- 1 Have you had, do you currently have, or have you ever been diagnosed as having any of the following medical conditions:
 - a Acquired Immune Deficiency Syndrome (AIDS), or a Human Immunodeficiency Virus (HIV) infection? Yes No
 - b Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig's Disease)? Yes No
 - c Alzheimer's Disease, Chronic Memory Loss, frequent or persistent forgetfulness, senility, dementia, or Organic Brain Syndrome? Yes No
 - d Chronic Obstructive Pulmonary Disease (COPD) or Emphysema **in combination with:** Current Smoking; Congestive Heart Failure (CHF); Asthma; or Chronic Bronchitis? Yes No
 - e Congestive Heart Failure **in combination with:** Current Smoking, Angina or Heart Surgery; Asthma or Chronic Bronchitis; Diabetes; or Tuberculosis? Yes No
 - f Congestive Heart Failure, diagnosed or symptomatic, within **the past 12 months**? Yes No
 - g Immune System Disorder? Yes No
 - h Metastatic Cancer (Cancer that has spread from the original site or location)? Yes No
 - i Stroke or Cerebrovascular Accident (CVA)? Yes No
 - j Cystic Fibrosis? Yes No
 - k Liver Cirrhosis? Yes No
 - l Multiple Sclerosis (MS), Muscular Dystrophy, Parkinson's Disease, Huntington's Disease? Yes No
 - m Transient Ischemic Attack (TIA) within **the past 5 years**; multiple TIAs; or TIA in combination with Diabetes or any Heart Surgery? Yes No
 - n Within **the past 6 months**, have you had open heart surgery, spine surgery, back surgery? Yes No
- 2 Within **the past 48 months** have you had cancer of the: Yes No
 - Bone Brain Esophagus Liver Lung Ovary Pancreas Stomach
- 3 Do you use a four pronged cane, kidney dialysis, motorized scooter, oxygen, respirator, walker, wheelchair? Yes No
- 4 Within **the past 12 months** have you: Yes No
 - Used adult day care Needed home health care
 - Been medically advised to enter or been confined to: A nursing home An assisted living facility Other long term care facility
- 5 Do you currently need assistance or supervision by another person in performing any of the following activities: Yes No
 - Bathing Eating Toileting Dressing Bowel or Bladder Control Moving in and out of bed or chair
 - Taking your medication

If you answered "Yes" to any question in this insurability profile, we recommend that you do not submit this Application.

MEDICAL HISTORY – PART 3 HEALTH PROFILE

Please answer every question in this section by indicating “Yes” or “No”

- 1 In the **past 12 months**, have you had an application rejected for long term care, nursing home care, or other health insurance? Yes No
- 2 Within the past **5 years**, (**10 years** for cancer), have you received any medical advice, examination, or treatment from a health care professional; taken any medications; or been medically diagnosed for:

| Yes | No | Condition | Yes | No | Condition | Yes | No | Condition |
|-----|--------------------------|--|-----|--------------------------|--|-----|--------------------------|--|
| a | <input type="checkbox"/> | <input type="checkbox"/> Cardiovascular or circulatory disorder including congestive heart failure (CHF), peripheral vascular disease, heart attack, chest pain, angina, high blood pressure or irregular heart beat | h | <input type="checkbox"/> | <input type="checkbox"/> Asthma, chronic bronchitis, chronic obstructive pulmonary disease (COPD), emphysema, shortness of breath | o | <input type="checkbox"/> | <input type="checkbox"/> Fracture |
| b | <input type="checkbox"/> | <input type="checkbox"/> Cancer or non-cancerous tumors | i | <input type="checkbox"/> | <input type="checkbox"/> Brain disorder, convulsions, epilepsy or seizures, dizziness or balance problems, fainting spells or black outs | p | <input type="checkbox"/> | <input type="checkbox"/> Osteoarthritis |
| c | <input type="checkbox"/> | <input type="checkbox"/> Hodgkin's Disease, Lymphoma, Leukemia, other blood disorder | j | <input type="checkbox"/> | <input type="checkbox"/> Depression, anxiety, mental, emotional or nervous disorder, or confusion, or memory loss | q | <input type="checkbox"/> | <input type="checkbox"/> Osteoporosis |
| d | <input type="checkbox"/> | <input type="checkbox"/> Skin ulcers | k | <input type="checkbox"/> | <input type="checkbox"/> Tremors | r | <input type="checkbox"/> | <input type="checkbox"/> Myasthenia Gravis, Paralysis, weakness or numbness of the extremities |
| e | <input type="checkbox"/> | <input type="checkbox"/> Non-insulin dependent diabetes | l | <input type="checkbox"/> | <input type="checkbox"/> Visual disturbances | s | <input type="checkbox"/> | <input type="checkbox"/> Replacement of the hip, knee or other joint |
| f | <input type="checkbox"/> | <input type="checkbox"/> Insulin dependent diabetes # of units per day _____ | m | <input type="checkbox"/> | <input type="checkbox"/> Amputation | t | <input type="checkbox"/> | <input type="checkbox"/> Rheumatoid arthritis, Lupus, Scleroderma or other connective tissue disease |
| g | <input type="checkbox"/> | <input type="checkbox"/> Hepatitis | n | <input type="checkbox"/> | <input type="checkbox"/> Disabling back or spine injury | u | <input type="checkbox"/> | <input type="checkbox"/> Other conditions causing crippling or limited motion or requiring use of an adaptive device, chronic pain or fatigue, or Fibromyalgia |
| | | | | | | v | <input type="checkbox"/> | <input type="checkbox"/> Renal insufficiency or Kidney disorder |
| | | | | | | w | <input type="checkbox"/> | <input type="checkbox"/> Sarcoidosis |

- 3 Within the **past three years**, have you been medically advised to enter or been confined to a hospital or other health care facility? Yes No
- 4 Within the **past three years**, have you: been confined to a nursing home, assisted living facility, or long term care facility?
 been medically advised to have surgery which has not been performed?
 received home health care? used adult day care? None
- 5 Within the **past five years**, have you been advised to limit, reduce, discontinue or seek counseling for the use of alcohol or drugs? Yes No
- 6 Within the **past five years**, have you received any medical advice, examination or treatment from a health care professional for any reason not previously stated? Yes No

In the space below you **MUST** provide details for any “Yes” answers to questions 1 through 6.

If needed, complete the additional medical information page that is provided.

Refers to number/letter above _____ Diagnosis date _____ Treatment date last seen _____

Reason Consulted/treated _____

Check here if treated by primary care physician (PCP). If not treated by PCP, give name, address, and phone for other treating professional

Refers to number/letter above _____ Diagnosis date _____ Treatment date last seen _____

Reason Consulted/treated _____

Check here if treated by primary care physician (PCP). If not treated by PCP, give name, address, and phone for other treating professional

Refers to number/letter above _____ Diagnosis date _____ Treatment date last seen _____

Reason Consulted/treated _____

Check here if treated by primary care physician (PCP). If not treated by PCP, give name, address, and phone for other treating professional

MEDICAL HISTORY – PART 4 MEDICATIONS

1 Please provide the requested information. Within the past 12 months have you taken any drugs or medications? Yes No
If yes, provide the information requested in the space below. If needed, complete the Additional Medical Information Page that is provided.

a Drug or Medication _____ Dosage _____ How long been taking? _____
Reason for taking _____
 Check here if prescribed by Primary Care Physician (PCP) only. If not prescribed by PCP, give name, address and phone number of treating professional:

b Drug or Medication _____ Dosage _____ How long been taking? _____
Reason for taking _____
 Check here if prescribed by Primary Care Physician (PCP) only. If not prescribed by PCP, give name, address and phone number of treating professional:

c Drug or Medication _____ Dosage _____ How long been taking? _____
Reason for taking _____
 Check here if prescribed by Primary Care Physician (PCP) only. If not prescribed by PCP, give name, address and phone number of treating professional:

d Drug or Medication _____ Dosage _____ How long been taking? _____
Reason for taking _____
 Check here if prescribed by Primary Care Physician (PCP) only. If not prescribed by PCP, give name, address and phone number of treating professional:

e Drug or Medication _____ Dosage _____ How long been taking? _____
Reason for taking _____
 Check here if prescribed by Primary Care Physician (PCP) only. If not prescribed by PCP, give name, address and phone number of treating professional:

f Drug or Medication _____ Dosage _____ How long been taking? _____
Reason for taking _____
 Check here if prescribed by Primary Care Physician (PCP) only. If not prescribed by PCP, give name, address and phone number of treating professional:

g Drug or Medication _____ Dosage _____ How long been taking? _____
Reason for taking _____
 Check here if prescribed by Primary Care Physician (PCP) only. If not prescribed by PCP, give name, address and phone number of treating professional:

If you are taking more than 7 medications, please list them on the “Additional Medical Information Page.”

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ONLY COMPLETE THE APPROPRIATE SECTION: NAME A DESIGNEE OR WAIVER OF NOTIFICATION.

Check here ONLY to name a designee, and provide the requested information about that person:

| | | |
|----------------|-------|-----------|
| | | |
| First Name | M.I. | Last Name |
| | | |
| Street Address | | Apt. No. |
| | | |
| City | State | Zip Code |

Check here only if you do not wish to name a person for this purpose and sign below.

WAIVER OF NOTIFICATION OPTION:

I understand that I have the right to name at least one person other than myself to receive notice of lapse or termination of my long term care insurance policy for non-payment of premium. I understand that notice will not be given until thirty-one days after the premium is due and not paid. **By my signature, I elect NOT to name any person to receive such notice.**

X _____ Applicant Signature

TO RESIDENTS OF ILLINOIS

The policy is not approved for Medicaid Asset Protection under the Illinois Long Term Care Partnership Program. However, the policy is an approved long term care policy under state insurance regulations. For information about policies approved under the Illinois Long Term Care Partnership Program, call the Senior Help-Line at the Illinois Department on Aging at 1.800.252.8966.

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THE PRUDENTIAL
INSURANCE COMPANY
OF AMERICA

LONG TERM CARE
CUSTOMER
SERVICE CENTER

PO BOX 8519
PHILADELPHIA PA 19176-8519
1.800.732.0416

LONG TERM CARE INSURANCE APPLICATION FOR EMPLOYER SPONSORED PROGRAM (ESP)

- New Policy**
- Coverage Change**
- Reinstatement** (Indicate Current Policy Number if Coverage Change or Reinstatement request)

Type of Coverage:

- Employee**
- Spouse** (Employer-paid plans only. Other limitations may apply.)
- Partner** (Employer-paid plans only. Other limitations may apply.)

TO: THE PRUDENTIAL INSURANCE COMPANY OF AMERICA

Please print all information except where signatures are required. Use black ink. Read all questions carefully.

APPLICANT INFORMATION

Mr. Ms. Mrs. _____ Applicant's Social Security # Male Female

First Name M.I. Last Name
(As it should appear on your Policy)

Street Address (No PO Boxes) Apt. No.

City State Zip Code

Date of Birth Age Daytime Phone Evening Phone

IF THE MAILING ADDRESS IS OTHER THAN THE ADDRESS GIVEN ABOVE, PLEASE COMPLETE THE FOLLOWING:

Address Apt. No.

City State Zip Code

Best Time to Call AM PM Marital Status Yes, married No, not married

Is your Spouse/Partner applying for this insurance? Yes No

If No, does he/she currently have Prudential Long Term Care insurance? Yes No

If Yes, give Policy/Certificate Number _____

Spouse/Partner First Name M.I. Last Name

Spouse/Partner Social Security # Spouse Partner

INSURANCE HISTORY

Indicate yes or no

If coverage is being replaced, please submit a completed Replacement Notice.

- 1 Are you covered by Medicaid or Medi-Cal (not Medicare)? Yes No
- 2 Do you have other long term care or accident and sickness insurance in force (including policies, certificates, health care service contracts, or health maintenance organization contracts)? Yes No
- 3 Did you have other long term care insurance in force during **the last 12 months**? Yes No
- 4 Do you intend to replace any of your medical health insurance with this insurance? Yes No

IF YOU ANSWERED YES TO QUESTIONS 2, 3, OR 4 OF THIS SECTION, PLEASE PROVIDE THE FOLLOWING INFORMATION

| | | | | | | |
|--------------------------------|-------------------------------------|--------------------------------|-------------------------------------|--|--|------------------|
| <input type="checkbox"/> Group | <input type="checkbox"/> Individual | <input type="checkbox"/> Group | <input type="checkbox"/> Individual | Intend to replace? | Did insurance lapse? | |
| | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | Type of Coverage | | Policy # | | | If yes give date |

| | | | | | | |
|--------------------------------|-------------------------------------|--------------------------------|-------------------------------------|--|--|------------------|
| <input type="checkbox"/> Group | <input type="checkbox"/> Individual | <input type="checkbox"/> Group | <input type="checkbox"/> Individual | Intend to replace? | Did insurance lapse? | |
| | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | Type of Coverage | | Policy # | | | If yes give date |

Full name and address of insurance company

MEDICAL HISTORY – PART 1 INSURABILITY PROFILE

Indicate yes or no

- Yes No 1 Within the past 12 months have you used any of the following:
 Wheelchair Motorized Scooter Walker Crutches Quad Cane
 Oxygen Respirator Kidney Dialysis
- Yes No 2 Within **the past 12 months** have you utilized, or been advised to utilize any of the following:
 Adult Day Care Assisted Living Facility Other long term care facility
 Home Health Care Nursing Home
- Yes No 3 Do you currently need or receive human assistance or supervision with any of the following:
 Bathing Eating Toileting Bowel or Bladder Control
 Dressing Taking Medication Walking
 Moving in or out of bed or chair
- Yes No 4 Have you ever been diagnosed with or have you consulted a health care professional or received medical advice for:
 - a Organic Brain Syndrome, Dementia, Senility, Confusion, Memory Loss, Alzheimer's Disease, Schizophrenia, or Mental Retardation?
 - b Metastatic cancer (cancer which has spread from original site)?
 - c Multiple Sclerosis (M.S.), Muscular Dystrophy, Parkinson's Disease, Huntington's Disease, Post Polio Syndrome, Lou Gehrig's Disease, (ALS) or other chronic neurological Disease/Disorder, Stroke, (CVA), more than one Transient Ischemic Attack (TIA), or Kidney Failure?
 - d Diabetes with any complications of the heart, kidney, nerves or eyes?
- Yes No 5 Have you ever had or ever been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS), or a Human Immunodeficiency Virus (HIV) Infection

Attention Agent: The above conditions are uninsurable.

- Yes No 6 Within the last 12 months have you been hospitalized or within the last 24 months have you applied for or received any form of Disability or Workman's Compensation or been declined for Long Term Care insurance?

Attention Agent: If only question #6 is answered yes, the applicant may be eligible for coverage but must submit long application and is subject to full Underwriting



THE PRUDENTIAL
INSURANCE COMPANY
OF AMERICA

LONG TERM CARE
CUSTOMER
SERVICE CENTER

PO BOX 8519
PHILADELPHIA PA 19176-8519
1.800.732.0416

Prudential LTC EvolutionSM PLAN DESIGN SELECTION A selection must be made for every option listed below.

Lifetime Maximum \$100,000 \$200,000 \$300,000 \$400,000 \$500,000
(Choose one option only.) \$600,000 \$700,000 \$800,000 \$900,000 \$1,000,000

Inflation Riders Built-in Guaranteed Increase Feature (GIF). (No additional premium.)
(Choose only one option where available.) 3% Automatic Compound Inflation Rider
 5% Automatic Compound Inflation Rider

Shared Care Options None Shared Care Rider Shared Care Partner Name _____
(Choose one option only.) (If elected, both partners must elect identical Plan Designs.)

Shortened Benefit Period Rider Yes No

Nonforfeiture Benefit

Premium Payment Mode Annual Semi-annual Quarterly Monthly EFT
(Choose one option only.)

Full Modal Premium \$ _____ . _____

Cash Submitted with Application \$ _____ . _____

Spouse/Partner Discount Yes No

Loyalty Discount Yes No
(If yes indicate - Applicant has Prudential Policy)
 Life Individual Policy Number _____
 Annuity Individual Contract Number _____,
*Not available with any other Affiliation discount or ESP discount.

Affiliation Discount Yes No
(Only where available.) (If yes, please complete the affiliation code and affiliation name fields below.)

_____ Affiliation Code _____ Affiliation Name

_____ Applicant's First Name _____ M.I. _____ Applicant's Last Name

_____ Applicant's Social Security #

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Prudential LTC EvolutionSM EMPLOYER SPONSORED PROGRAM (ESP) PLAN DESIGN SELECTION* A selection must be made for every option listed below.

Lifetime Maximum \$ 100,000 \$ 300,000 \$ 500,000 \$ 700,000 \$ 900,000
(Choose one option only.) \$ 200,000 \$ 400,000 \$ 600,000 \$ 800,000 \$ 1,000,000

Inflation Riders Built-in Guaranteed Increase Feature (GIF). (No additional premium.)
(Choose only one option where available.) 3% Automatic Compound Inflation Rider 5% Automatic Compound Inflation Rider

Shared Care Options None Shared Care Rider Shared Care Partner Name _____
(Choose one option only.) (If elected, both partners must elect identical Plan Designs.)

Shortened Benefit Period Rider
Nonforfeiture Benefit Yes No

Premium Payment Mode Annual Semi-annual Quarterly Monthly EFT
(Choose one option only.)

Full Modal Premium \$ _____ . _____

Cash Submitted with Application \$ _____ . _____

Spouse/Partner Discount Yes No

ESP Information _____ Voluntary _____ Employer-Paid
(Only where available.) (Please complete the ESP code and ESP name fields below.)

_____ ESP Code _____ Employer Name

_____ Applicant's First Name _____ M.I. _____ Applicant's Last Name

_____ Applicant's Social Security #

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Long Term Care Insurance Personal Worksheet

People buy long-term care insurance for many reasons. Some don't want to use their own assets to pay for long-term care. Some buy insurance to make sure they can choose the type of care they get. Others don't want their family to have to pay for care or don't want to go on Medicaid. But long-term care insurance may be expensive, and may not be right for everyone.

By state law, The Prudential Insurance Company of America (Prudential) must fill out part of the information on this worksheet and **ask** you to fill out the rest to help you and Prudential decide if you should buy this Policy.

Premium Information

Policy Form Number GRP 114018

The premium for the coverage you are considering will be \$_____ per

Month/EFT Quarterly Semi-Annual Annual

Type of Policy Guaranteed Renewable

Prudential's Right to Increase Premiums

Prudential has a right to increase premiums on this Policy form in the future, provided it raises rates for all policies in the same class in this state. Your premium rate may increase if you make policy changes after the Effective Date. Your premium rate may increase if you accept a benefit increase under the Guaranteed Increase Feature.

Rate Increase History

Prudential has sold long-term care insurance since 1986 and has sold this policy form since 2008. Prudential has never raised its rates for any long term care policy it has sold in this state or any other state.

Questions Related to Your Income

How will you pay each year's premium?

From My Income From My Savings/Investments My Family Will Pay

Have you considered whether you could afford to keep this Policy if the premiums went up, for example, by 20%?

YES NO

What is your annual income? (Check one)

Under \$10,000 \$10,000-\$19,999 \$20,000-\$29,999

\$30,000-\$49,999 Over \$50,000

How do you expect your income to change over the next 10 years? (Check one)

No change Increase Decrease

If you will be paying premiums with money received only from your own income, a rule of thumb is that you may not be able to afford this Policy if the premiums will be more than 7% of your income.

Will you buy additional optional inflation protection? (check one) Yes No

If not, have you considered how you will pay for the difference between future costs and your daily benefit amount?

From My Income From My Savings/Investments My Family Will Pay

The national average annual cost of care in 2006 was \$74,806 for a private room in a Nursing Home, but this figure varies across the country. In ten years, the national average annual cost would be about \$121,934 if costs increase 5% annually.

What elimination period are you considering?

Number of days 90 Approximate cost \$ _____ for that period of care.

How are you planning to pay for your care during the elimination period? (check one)

From My Income From My Savings/Investments My Family Will Pay

Questions Related to Your Savings and Investments

Not counting your home, about how much are all of your assets (your savings and investments) worth? (Check one)

Under \$20,000 \$20,000-\$29,999 \$30,000-\$49,999 Over \$50,000

How do you expect your assets to change over the next ten years? (check one)

Stay about the same Increase Decrease

If you are buying this Policy to protect your assets and your assets are less than \$30,000, you may wish to consider other options for financing your long-term care.

Disclosure Statement

Please check one

- The answers to the questions above describe my financial situation.
- OR
- I choose not to complete this information
- I acknowledge that the producer (below) has reviewed this form with me, including the premium, premium rate increase history and potential for premium increases in the future. I understand the above disclosures. **I understand that the rates for this Policy may increase in the future.** (This box must be checked).

Signed: _____
(Applicant) (Date)

- I explained to the applicant the importance of completing this information.

Signed: _____
(Producer) (Date)

Producer's Printed Name: _____

- My producer has advised me that the Policy does not seem to be suitable for me. However, I still want Prudential to consider my Application.

Signed: _____
(Applicant) (Date)

Based on your answers, Prudential may contact you to verify your desire to purchase this coverage.

SERFF Tracking Number: PRUD-125558856 State: Arkansas
Filing Company: The Prudential Insurance Company of America State Tracking Number: 38516
Company Tracking Number: IIGH-GRP114018-RP-AR
TOI: LTC03I Individual Long Term Care Sub-TOI: LTC03I.001 Qualified
Product Name: Individual Long Term Care Insurance
Project Name/Number: ILTC-4/01768

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number: PRUD-125558856 State: Arkansas
 Filing Company: The Prudential Insurance Company of America State Tracking Number: 38516
 Company Tracking Number: IIGH-GRP114018-RP-AR
 TOI: LTC03I Individual Long Term Care Sub-TOI: LTC03I.001 Qualified
 Product Name: Individual Long Term Care Insurance
 Project Name/Number: ILTC-4/01768

Rate/Rule Schedule

| Review Status: | Document Name: | Affected Form Numbers: (Separated with commas) | Rate Action: | Rate Action Information: | Attachments |
|----------------|----------------|---|--------------|--------------------------|-------------------------------------|
| | Rate Pages | GRP 114018, et al | New | | ILTC-4 Rate Pages 2008-03-04, 2.xls |

SERFF Tracking Number: PRUD-125558856 State: Arkansas
 Filing Company: The Prudential Insurance Company of America State Tracking Number: 38516
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 TOI: LTC03I Individual Long Term Care Sub-TOI: LTC03I.001 Qualified
 Product Name: Individual Long Term Care Insurance
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Supporting Document Schedules

Review Status:
Bypassed -Name: Certification/Notice 03/19/2008
Bypass Reason: N/A
Comments:

Review Status:
Bypassed -Name: Application 03/19/2008
Bypass Reason: Please refer to the Form Schedule Tab of this filing.
Comments:

Review Status:
Bypassed -Name: Health - Actuarial Justification 03/19/2008
Bypass Reason: Please refer to the Rate Schedule Tab of this filing.
Comments:

Review Status:
Bypassed -Name: Outline of Coverage 03/19/2008
Bypass Reason: Please refer to the Forms Schedule Tab of this filing.
Comments:

Review Status:
Satisfied -Name: Filing Letter 03/24/2008
Comments:
Attachment:
 AR -Filing Letter.pdf

Review Status:
Satisfied -Name: Letter of Reply 09/30/2008
Comments:
Attachment:
 AR - Letter of Reply - 9-30-2008.pdf

SERFF Tracking Number: PRUD-125558856 State: Arkansas
Filing Company: The Prudential Insurance Company of America State Tracking Number: 38516
Company Tracking Number: IIGH-GRP114018-RP-AR
TOI: LTC03I Individual Long Term Care Sub-TOI: LTC03I.001 Qualified
Product Name: Individual Long Term Care Insurance
Project Name/Number: ILTC-4/01768

Review Status:

Satisfied -Name: GRP 113124 - Agent/Producer
Statement

09/30/2008

Comments:

Attachment:

GRP 113124 - Agent-Producer Statement.pdf



Karen L. Smyth, FLMI, ACS, AIAA, AIRC, CLTC, LTCP
Assistant Secretary
Group Insurance

The Prudential Insurance Company of America
Long Term Care Unit
2101 Welsh Road
Dresher, Pennsylvania 19025
Tel 215 658-6279 Fax 888 294-6332

March 24, 2008

The Honorable Julie Benafield Bowman
Commissioner of Insurance
Department of Insurance
1200 West Third Street
Little Rock, AR 72201-1904

Re.: The Prudential Insurance Company of America
NAIC #304-68241
Individual Long Term Care Insurance
Form Numbers: GRP 114018, et al

Dear Commissioner Bowman:

We enclose for filing purposes the individual long term care insurance forms listed on the attachment. These forms are new and not intended to replace any previously filed forms.

This policy is intended to be a guaranteed renewable, federally tax qualified long-term care insurance contract in accordance with the Internal Revenue Code Section 7702B(b).

These forms represent Prudential's new individual long term care insurance product line and will be marketed through licensed agents or other state licensed insurance producers to residents of your state. This Policy provides coverage in the form of reimbursement benefits based on a specified percentage of the actual Eligible Charges incurred for covered long term care expenses up to the Policy Lifetime Maximum. Amounts are available in \$100,000 increments from \$100,000 to \$2,000,000. Benefits are subject to subject to Policy Exclusions, benefit limitations, the Calendar Day Elimination Period and coinsurance requirements. The policy also include a cash, Starter Benefit which will be payable on an indemnity basis, subject to applicable terms and conditions of coverage. This benefit is available before the Calendar Day Elimination Period is satisfied, provides consumer choice, and is intended to satisfy any applicable minimum benefit duration in your state for long term care insurance policies.

Benefits. The base policy provides reimbursement benefits for 80% of the actual Eligible Charges incurred for care in a nursing home, adult foster home/board and care facility, assisted living facility/residential health care facility, bed reservation, hospice care, respite care, and home health care, adult day care, homemaker services, personal care and alternate plan of care. The policy also provides a reimbursement benefit for 100% of the actual Eligible Charges incurred for home support services including assistive devices or technology, caregiver training, durable medical equipment, emergency medical response systems, home modifications, private care management and transportation services.

The base policy also contains a cash Starter benefit mentioned above, a waiver of premium benefit, a contingent non-forfeiture benefit if the insured does not elect a traditional non-forfeiture benefit and a guaranteed increase feature.

Elimination Period. The Elimination Period is counted in calendar days. Satisfaction of the Elimination Period begins to be counted with the date the insured is certified by a Licensed Health Care Practitioner as having a Chronic Illness or Disability. The Elimination Period needs to be satisfied once per lifetime. Available Elimination Periods are 30, 60 and 90 days.

Inflation Protection. Because the policy pays either 80 or 100% of actual, Eligible Charges, this policy's design results in expense reimbursements increasing at the actual rate of inflation. In addition to this built-in inflation component, we have included a Guaranteed Increase Feature, whereby an insured can voluntarily increase the Policy Lifetime Maximum benefit every five years based on a simple inflation calculation.

There are two optional automatic annual inflation riders available at an additional premium. An insured may only elect one form of inflation protection coverage. Election of an optional inflation protection rider will replace the Guaranteed Increase Feature in the base policy. Prospective applicants will always be offered the 5% Automatic Compound Increase Option Rider described below, in order to meet both regulatory standards and those for a federally tax-qualified long-term care insurance contract.

- 1) 3% Automatic Compound Increase Option Rider: Each year, benefits automatically increase by 3% compounded annually.
- 2) 5% Automatic Compound Increase Option Rider: Each year, benefits automatically increase by 5% compounded annually

Non-Forfeiture Benefit. A non-forfeiture benefit in the form of a shortened benefit period will be made available by Rider for additional premium. Prospective applicants will always be offered this Rider in order to meet both regulatory standards and those for a federally tax-qualified long-term care insurance contract. Since this policy does not have a daily nursing home benefit, the minimum non-forfeiture value had to be altered. In its place, we have substituted 3% of the original Policy Lifetime Maximum. For a policy with a minimum \$100,000 Policy Lifetime Maximum, the minimum non-forfeiture credit would equate to \$3,000.

Shared Care Rider. For an additional premium, a Shared Care Benefit Rider is available to two married people or partners. This rider will allow two people to access benefits under the other's policy if benefit are first exhausted under their own policy. At death, benefits unused may be transferred to the survivor.

Employer Sponsored Program. Prudential also intends to use this policy in the employer marketplace, through our "Employer Sponsored Program" (ESP). This program will make individual long term care insurance available to employees of small employer groups and their qualified family members, using modified-underwriting (short-form) for actively-at-work employees for a base level of coverage. Employees who wish to purchase additional coverage are subject to full underwriting as are qualified family members. Minimum participation requirements will apply and the program will be offered on a fully voluntary basis, partial contribution (base plan/buy up) or full contribution basis by the employer.

The Honorable Julie Benafield Bowman
March 24, 2008
PAGE THREE

Applications. Included in this filing is our base application for this product and Plan Design election form.

In support of our Employer Sponsored Program, enclosed are a modified guaranteed issue form (short form) to be used with employees when we offer this product to an employer group and an associated Plan Design election form, which contains the parameters of the options available under the ESP Program. There is also a corresponding Plan Design election form for our Employer Sponsored Program, for "Employee Buy-Ups" and for the spouse or qualified family member of the employee to complete for medical underwriting purposes.

Replacement Notice. Replacement Notice, form number (GRP 98186), was previously filed with the Department.

Suitability. Enclosed is the Personal Worksheet which is modeled after that found in the NAIC Long-Term Care Insurance Model Regulation, 2006 version. The Potential Rate Increase Disclosure Form is also enclosed. The consumer disclosure piece, "Things You Should Know Before You Buy Long Term Care Insurance," was previously filed. The Potential Rate Increase Disclosure Form was previously filed.

Actuarial Memorandum. Our actuarial memorandum containing supporting rates and assumptions for this new policy and all optional riders is enclosed.

Filing Fees. A filing in the total amount of \$290.00 has been submitted through the SERFF electronic funds process.

This material has been concurrently submitted to our home state, New Jersey.

Correspondence: Please correspond directly with my associate if there are any questions concerning this filing.

Raenonna Prince, CLTC, LTCP
Lean Analyst
The Prudential Insurance Company of America
P. O. Box 7907
Philadelphia, PA 19101-7907
Voice: (800) 732-0416 or (215) 658-6281
Fax: (888) 294-6332
e-mail: raenonna.prince@prudential.com

Very truly yours,



Karen L. Smyth
Assistant Secretary

Attachment

The Prudential Insurance Company of America
Individual Long Term Care Insurance Forms

| FORM NUMBER | DESCRIPTION | FLESH SCORE |
|--------------------|---|--------------------|
| GRP 114018 | Individual Long Term Care Insurance Policy – Prudential LTC Evolution SM | 46.9 |
| GRP 114019 | Outline of Coverage | 42.1 |
| GRP 114020 | Long Term Care Insurance Optional Inflation Rider – 3% Automatic Compound Increase Option Rider | 43.9 |
| GRP 114021 | Long Term Care Insurance Optional Inflation Rider – 5% Automatic Compound Increase Option Rider | 43.9 |
| GRP 114022 | Long Term Care Insurance Rider – Non-Forfeiture Benefit | 43.1 |
| GRP 114023 | Long Term Care Insurance Rider – Shared Care | 48.3 |
| GRP 114024 | Application | 53.4 |
| GRP 114029 | Application with Underwriting for Employer Sponsored Program | 53.8 |
| GRP 114027 | Application with Modified Underwriting (Short-Form) for Employer Sponsored Program | 50.7 |
| GRP 114025 | Plan Design | 58.2 |
| GRP 114028 | Plan Design for Employer Sponsored Program | 60.3 |
| GRP 114030 | Plan Design for Employer Sponsored Program – Employee Buy-Ups, Qualified Family Members | 62.8 |
| GRP 114031 | Personal Worksheet | 59.0 |



Karen L. Smyth, FLMI, ACS, AIAA,
AIRC, CLTC, LTCP
Assistant Secretary
Group Insurance

The Prudential Insurance Company of
America
Long Term Care Unit
2101 Welsh Road
Dresher, Pennsylvania 19025
Tel 215 658-6279 Fax 888 294-6332

September 30, 2008

Mr. Harris Shearer
Life and Health Division
Arkansas Department of Insurance
1200 West Third Street
Little Rock, AR 72201-1904

Re.: The Prudential Insurance Company of America
NAIC #304-68241
Individual Long Term Care Insurance
Form Numbers: GRP 114018, et al
SERFF File Number: PRUD-125558856
State Tracking Number: 38516
Correspondence Dated: August 7, 2008

Dear Mr. Shearer:

This letter is in response to correspondence received via SERFF on August 7, 2008, regarding the above-captioned filing. I will respond to the issues raised in the same order they were presented.

1. Please be advised that we have amended the "Contingent Non-Forfeiture" provision located on page 20 of the Premium section of the Policy GRP 114018. A copy of the amended Policy is enclosed for your reference.
2. Please be advised that we have corrected the form number of the 3% Automatic Compound Increase Rider. A copy of the amended form GRP 114020 is enclosed for your reference.
3. We have enclosed a copy of form GRP 113124, the Agent /Producer Statement. This form will always be used in conjunction with the Applications (GRP 114024, GRP 114029 & GRP 114027). We believe the requirements of section IAR Rule 13, Section 14, are satisfied with this form.

Mr. Harris Shearer
September 30, 2008
Page 2

In addition to the above, during our review process we found it necessary to make revisions to the Application and complimenting Plan Design Forms. (GRP 114024, GRP 114025, GRP 114027, GRP 114028, GRP 114029 & GRP 114029)

Changes to the forms are as follows:

- The underwriting questions on the application forms (GRP 114024, GRP 114027 and GRP 114029) have been expanded.
- The format on the plan design election forms (GRP 114025, GRP 114028 and GRP 114030) has been modified to avoid confusion during the completion process.

The changes noted did not require a change to the form numbers.

We trust the Department will find this material acceptable and look forward to your response. Should you have any additional questions, please do not hesitate to contact my associate:

Raenonna Prince, CLTC, LTCP
Lead Analyst
The Prudential Insurance Company of America
2101 Welsh Road, LTC Unit
Dresher, PA 19025
Voice: (800) 732-0416 or (215) 658-6281
Fax: (888) 294-6332
e-mail: raenonna.prince@prudential.com

Very truly yours,



Karen L. Smyth
Assistant Secretary

Enclosures

PRODUCER'S STATEMENT

Please print all information except where signatures are required. Use black ink. Read all questions carefully. Please provide complete details to avoid delays in processing.

Applicant's Name

- 1 Did you personally interview the Applicant face-to-face and witness his or her signature? Yes No
- 2 Does the Applicant appear to be in good health? Yes No
- 3 Did you observe any physical or mental impairments with regard to walking, talking, or any form of tremor? Yes No
If yes, please describe

- 4 Has the Applicant purchased any other health insurance policy from you during the past **5 years**? Yes No
If Yes, provide the information below:

| COMPANY | POLICY NUMBER | CURRENT STATUS (IF TERMINATED, INDICATE YEAR) | |
|---------|---------------|---|--------------------------------------|
| _____ | _____ | <input type="checkbox"/> In force | <input type="checkbox"/> terminated: |
| _____ | _____ | <input type="checkbox"/> In force | <input type="checkbox"/> terminated: |
| _____ | _____ | <input type="checkbox"/> In force | <input type="checkbox"/> terminated: |

- 5 Indicate Rating Class quoted for this Applicant: Preferred Standard I Standard II
- 6 I received the initial, modal premium, in full where permitted by law, with the Application and provided to the Applicant as receipt of \$ _____, a Premium Receipt. Yes No
- 7 Special requests, remarks and instructions: _____

BY MY SIGNATURE ON THIS FORM:

- I have reviewed the Applicant's current insurance coverage, financial needs, and resources and certify that this purchase is suitable for the Applicant.
- I understand that Medical Underwriting will determine the appropriate rate class.
- I certify I have personally seen the Applicant and have accurately recorded information supplied to me by the Applicant at the time application was made.
- I certify that I comply with applicable Long Term Care insurance licensing requirements in the Applicant's state of residence as shown on the application.
- I certify that I have delivered the Outline of Coverage to the Applicant at the time of first solicitation.

X _____
Producer's Signature Date

_____ Contract Number

_____ License Number

_____ Phone Number

PREMIUM CLASSIFICATIONS

Prudential offers three underwriting classifications or rating categories: Preferred, Standard I and Standard II.

To be eligible for a Preferred rating, the Applicant must exhibit the following characteristics, and weigh within the acceptable ranges according to the Prudential's Height and Weight Guide below.

- Maintains a high level of activity outside the home (including but not limited to full or part-time employment, regular exercise, regular social activities or volunteer activities).
- Blood pressure controlled to 140/90 or better, as an average.
- Refrained from smoking or using tobacco products within the past 36 months (3 years).
- No prior history of: Any Cardiac history requiring medication, Diabetes Leukemia, Memory Loss, Rheumatoid Arthritis, Congestive Heart Failure, Hodgkin's Disease, Lymphoma, Osteoporosis, TIA, Cancer (except skin cancer other than Melanoma), Joint Replacement, Chronic Pulmonary Disease (any respiratory disease that requires medication), the use of multiple medications (includes but is not limited to multiple medications used to control hypertension, multiple anxiety or depression medications, and cholesterol lowering drugs or other circulatory medications), Circulatory Disease (Aortic Artery Disease, Coronary Artery Disease or Peripheral Vascular Disease) or any chronic condition that is progressing in severity with age).
- Comorbids or combination of conditions will be individually considered.

Applicants who do not qualify for Preferred as outlined above, but are otherwise insurable according to Prudential's Underwriting Guidelines, may be quoted under Standard I rating if they exhibit the following characteristics, and weigh within the acceptable ranges according to the Prudential's Height and Weight Guide below.

- Smokes less than one pack of cigarettes per day or the equivalent use of another tobacco product and does not have a cardiac, respiratory or vascular/circulatory condition.
- Does not have a history of Hodgkin's Disease, Leukemia or Lymphoma.
- Does not have any of the following medical conditions requiring daily prescription medication: Congestive Heart Failure, Diabetes, Chronic Obstructive Pulmonary Disease (COPD), or Emphysema.

Applicants who do not qualify for Preferred or Standard I as outlined above, but are otherwise insurable according to Prudential's Underwriting Guidelines, should be quoted Standard II.

HEIGHT AND WEIGHT GUIDE

| Height | Min Std 1 & 2 | Max Std 1 | Max Std 2 | Min Pref | Max Pref |
|--------|---------------|-----------|-----------|----------|----------|
| 4'11" | 94 lbs | 172 lbs | 187 lbs | 99 lbs | 128 lbs |
| 5'0" | 97 lbs | 178 lbs | 193 lbs | 102 lbs | 133 lbs |
| 5'1" | 100 lbs | 184 lbs | 200 lbs | 106 lbs | 137 lbs |
| 5'2" | 104 lbs | 190 lbs | 206 lbs | 109 lbs | 142 lbs |
| 5'3" | 107 lbs | 196 lbs | 213 lbs | 113 lbs | 146 lbs |
| 5'4" | 110 lbs | 203 lbs | 220 lbs | 116 lbs | 151 lbs |
| 5'5" | 114 lbs | 209 lbs | 227 lbs | 120 lbs | 156 lbs |
| 5'6" | 118 lbs | 215 lbs | 234 lbs | 124 lbs | 161 lbs |
| 5'7" | 121 lbs | 222 lbs | 241 lbs | 127 lbs | 166 lbs |
| 5'8" | 125 lbs | 229 lbs | 248 lbs | 131 lbs | 171 lbs |
| 5'9" | 128 lbs | 235 lbs | 256 lbs | 135 lbs | 176 lbs |
| 5'10" | 132 lbs | 242 lbs | 263 lbs | 139 lbs | 181 lbs |
| 5'11" | 136 lbs | 249 lbs | 271 lbs | 143 lbs | 186 lbs |
| 6'0" | 140 lbs | 257 lbs | 278 lbs | 147 lbs | 191 lbs |
| 6'1" | 144 lbs | 264 lbs | 287 lbs | 151 lbs | 197 lbs |
| 6'2" | 148 lbs | 271 lbs | 294 lbs | 155 lbs | 202 lbs |
| 6'3" | 152 lbs | 278 lbs | 302 lbs | 160 lbs | 208 lbs |
| 6'4" | 156 lbs | 286 lbs | 311 lbs | 164 lbs | 213 lbs |
| 6'5" | 160 lbs | 295 lbs | 320 lbs | 168 lbs | 217 lbs |

PRODUCER PLEASE COMPLETE INFORMATION

- Agency Distribution Independent Producer _____
 Other _____

More than one Producer: No Yes: How many?

If Yes, on Producer Statement, record additional agent(s) name, contract number, as well as % splits, and applicant's name.

Producer's Name _____

Affiliation Affiliation Code _____

Name of Affiliation _____

Quoted how? Choose one:

- Preferred Standard I Standard II (Attach Pru Quote)

SERFF Tracking Number: PRUD-125558856 State: Arkansas
 Filing Company: The Prudential Insurance Company of America State Tracking Number: 38516
 Company Tracking Number: IIGH-GRP114018-RP-AR
 TOI: LTC03I Individual Long Term Care Sub-TOI: LTC03I.001 Qualified
 Product Name: Individual Long Term Care Insurance
 Project Name/Number: ILTC-4/01768

Superseded Attachments

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

| Original Date: | Schedule | Document Name | Replaced Date | Attach Document |
|------------------|----------|---|---------------|--|
| No original date | Form | Individual Long Term Care Insurance Policy - Prudential LTC Evolution | 03/19/2008 | GRP 114018-ILTC-4 Standard Policy.pdf |
| No original date | Form | 3% Automatic Compound Increase option Rider | 03/19/2008 | GRP 114020 - 3% Automatic Compound Increase Option Rider.pdf |
| No original date | Form | ILTC-4 Application | 03/19/2008 | GRP 114024 - LTC4 IND Application.pdf |
| No original date | Form | ILTC-4 ESP Buy-Up Application | 03/19/2008 | GRP 114029 - LTC4 ESP Buy Up Application.pdf |
| No original date | Form | ILTC-4 ESP Application | 03/19/2008 | GRP 114027 - LTC4 ESP Application.pdf |
| No original date | Form | ILTC-4 Plan Design Form | 03/19/2008 | GRP 114025 - LTC-4 IND Plan Design - Standard.pdf |

SERFF Tracking Number: PRUD-125558856 *State:* Arkansas
Filing Company: The Prudential Insurance Company of America *State Tracking Number:* 38516
Company Tracking Number: IIGH-GRP114018-RP-AR
TOI: LTC03I Individual Long Term Care *Sub-TOI:* LTC03I.001 Qualified
Product Name: Individual Long Term Care Insurance
Project Name/Number: ILTC-4/01768

| | | | | |
|------------------|------|---------------------------------------|------------|--|
| No original date | Form | ILTC-4 ESP Plan Design Form | 03/19/2008 | GRP 114028 - LTC-4 ESP Plan Design - Standard.pdf |
| No original date | Form | ILTC-4 ESP Buy-Up Plan Design Form | 03/19/2008 | GRP 114030 - LTC4 ESP Buy Up Plan Design - Standard.pdf |

The Prudential Insurance Company of America

751 Broad Street, Newark, New Jersey 07102

Individual Long Term Care Insurance Policy

Prudential LTC EvolutionSM

READ YOUR POLICY CAREFULLY. Prudential will provide the coverage described in this Policy, subject to all stated terms, conditions, limitations and exclusions. Your coverage consists of this Policy, any optional Benefit Riders and any Amendatory Riders attached to it. Please refer to your Policy's Glossary for definitions.

THIS IS NOT A MEDICARE SUPPLEMENT POLICY. If you are eligible for Medicare, review the *Guide to Health Insurance for People with Medicare* that you received at the time of application.

THIS POLICY DOES NOT CONTAIN A PRE-EXISTING CONDITIONS LIMITATION.





CORPORATE ADDRESS: The Prudential Insurance Company of America
751 Broad Street, Newark NJ 07102

CONTACT ADDRESS: The Prudential Long Term Care Customer Service Center
P. O. Box 8519, Philadelphia, PA 19176-8519

In your Policy, The Prudential Insurance Company of America is referred to as Prudential, we, our, or us. The insured is referred to as you, your, or yours.

Thank you for choosing a Prudential Long Term Care Insurance Policy. Your Policy is a contract between you and Prudential. The coverage begins as stated herein at 12:01 A. M., Standard Time, if the first full modal premium is paid.

TAX STATUS: Your Policy is intended to be a federally tax-qualified long-term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986, as amended.

RENEWABILITY: Your Policy is guaranteed renewable. It begins on the Original Effective Date shown in the **Schedule of Policy Benefits**. You can continue your Policy as long as the full modal premium is paid on time and the Policy Lifetime Maximum has not been exhausted. Prudential cannot change the terms of your Policy on its own, except it may change the premiums. (See "Premiums" provisions.) Certain provisions of your Policy may be changed to conform with changes in state or federal law or regulation that apply to your Policy.

IMPORTANT 30-DAY REVIEW: You have 30 days from receipt of your Policy to review it. If you decide you do not want the Policy, you may return it, during these 30 days, to your Producer or to Prudential at the Contact Address shown above. Your Policy will be deemed void from its Original Effective Date and any premium paid will be returned to you.

CAUTION: The issuance of this long-term care insurance Policy is based upon your responses to the questions on your Application. A copy of your Application is enclosed. If your answers are incorrect or untrue, Prudential has the right to deny benefits or rescind your Policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact Prudential at the Contact Address shown above.

NOTICE TO BUYER: This Policy may not cover all of the costs associated with Long-Term Care incurred by you during the period of coverage. You are advised to carefully review all Policy limitations.

Handwritten signature of Kathleen M. Gibson in black ink.

Secretary

GRP 114018

Handwritten signature of Arthur F. Ryan in black ink.

Chairman of the Board

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2/2008

For Residents of the State of Arkansas

You may reach the Arkansas Insurance Department at this address: Arkansas Insurance Department, Consumer Services Division, 1200 West Third Street, Little Rock, AR 72201-1904 or call 1-501-371-2640 or 1-800-852-5494.

For Residents of the State of Wisconsin

THE WISCONSIN INSURANCE COMMISSIONER HAS ESTABLISHED MINIMUM STANDARDS FOR LONG-TERM CARE INSURANCE. THIS POLICY MEETS THOSE STANDARDS.

THIS POLICY COVERS CERTAIN TYPES OF NURSING HOME AND HOME HEALTH CARE SERVICES. THERE MAY BE LIMITATIONS ON THE SERVICES COVERED. READ THIS POLICY CAREFULLY.

FOR MORE INFORMATION ON LONG-TERM CARE SEE THE *GUIDE TO LONG-TERM CARE* GIVEN TO YOU WHEN YOU APPLIED FOR THIS POLICY. THIS POLICY'S BENEFITS ARE NOT RELATED TO MEDICARE.

PROBLEMS WITH YOUR INSURANCE? – If you are having problems with your insurance company or Producer, do not hesitate to contact the insurance company or Producer to resolve your problem.

**The Prudential Insurance Company of America
Long Term Care Customer Service Center
P.O. Box 8519
Philadelphia, PA 19176-8519
800-732-0416**

You can also contact the **OFFICE OF THE COMMISSIONER OF INSURANCE**, a state agency that enforces Wisconsin's insurance laws, and file a complaint. You can contact the Office of the Commissioner of Insurance by contacting:

OFFICE OF THE COMMISSIONER OF INSURANCE
Complaints Department
P.O. Box 7873
Madison, WI 53707-7873
800-236-8517
608-266-0103

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YOUR LONG-TERM CARE INSURANCE BENEFITS

This Policy provides benefits for Qualified Long-Term Care Services. Benefit descriptions are stated below. Not all charges are covered. Please refer to the **Policy Exclusions** section.

The benefit payment for covered services and the Policy Lifetime Maximum are shown in the **Schedule of Policy Benefits**. These benefits are subject to change if you have elected additional optional inflation protection or exercise an option under the Guaranteed Increase Feature. Prudential will pay benefits for Eligible Charges up to the benefit limit that applies for the charges incurred, after all terms and conditions of coverage have been met. No dollar limit will be applied to any particular day you receive Qualified Long Term Care Services; however, there are limits on certain benefits. Limits on specific benefits are stated in the **Benefit Descriptions** section.

Please refer to **The Claims Process** provisions. Prudential will pay benefits if the conditions described in these provisions are met. Only charges related to services included in the Plan of Care will be considered Eligible Charges. Benefits for Eligible Charges are provided if the Calendar Day Elimination Period, if applicable, has been satisfied. All benefits are subject to the Calendar Day Elimination Period except the Hospice Care Benefit, the Starter Benefit and the Home Support Services Benefit. All benefits paid reduce your Policy Lifetime Maximum.

Your Policy gives you access to information on long-term care resources and care providers in your community. Prudential's Long Term Care Resource Center can help provide this information or you may access this information from Prudential's website at www.prudential.com. You do not need to meet the Benefit Eligibility Criteria in order to use this service. Call the Prudential Long Term Care Customer Service Center at 1-800-732-0416 for assistance.

BENEFIT DESCRIPTIONS

FACILITY CARE

NURSING HOME, ADULT FOSTER HOME OR BOARD AND CARE FACILITY, ASSISTED LIVING FACILITY, OR RESIDENTIAL HEALTH CARE FACILITY BENEFIT

Your Policy provides benefits for Eligible Charges for covered services you receive as a resident of a Nursing Home, an Adult Foster Home or Board and Care Facility, Assisted Living Facility or Residential Health Care Facility. This includes covered services you receive as Respite Care.

80% of the Eligible Charges will be paid for each day you are a resident in one of the above listed facilities.

Benefits will not be paid for Facility Care or Home Care and the Starter Benefit on the same day.

BED RESERVATION

Your Policy provides benefits to retain your bed at a facility if you are a resident in such a facility and you are absent for any reason

BENEFIT

for 24 hours or more.

Charges for Bed Reservation are Eligible Charges if they satisfy the following requirements.

- 1) The charge is a separate, customary facility charge to reserve the bed during a temporary absence from the facility.
- 2) You would be required to pay the charge in the absence of insurance.
- 3) The charge is incurred while you are receiving benefits for care in a facility.
- 4) Benefits were payable immediately prior to your absence due to your need to receive Qualified Long-Term Care Services on a 24-hour per day basis.

80% of the Eligible Charges to reserve your bed will be paid. Benefits will not be paid for other Facility Care or Home Care for the same day on which a Bed Reservation benefit is paid.

HOSPICE CARE BENEFIT

Your Policy provides benefits for Eligible Charges for Hospice Care when you are Terminally Ill. 80% of the Eligible Charges will be paid for each day you receive Hospice Care as a resident in a facility or in your Home.

HOME CARE

ADULT DAY CARE, HOME HEALTH CARE, HOMEMAKER SERVICES, AND PERSONAL CARE SERVICES BENEFIT

Your Policy provides benefits for Eligible Charges you receive as Home Health Care, Homemaker Services or Personal Care Services. Such services must be received from a Caregiver. This Policy also provides coverage when you receive Adult Day Care.

80% of the Eligible Charges will be paid for each day you receive Adult Day Care, Home Health Care, Homemaker Services or Personal Care Services from a Caregiver.

Benefits will not be paid for Facility Care or Home Care and the Starter Benefit on the same day.

ADDITIONAL POLICY BENEFITS

STARTER BENEFIT

At your option, your Policy will pay a Starter Benefit to you in cash in lieu of reimbursement for Eligible Charges for Facility Care or Home Care. The Starter Benefit is a fixed monthly amount shown in your **Schedule of Policy Benefits**.

The Starter Benefit is subject to the following criteria.

- 1) You can only elect this benefit on a monthly basis. This election is made on the claim form.

2) Benefits are paid in lieu of Facility Care or Home Care benefits.

3) The Starter Benefit Policy Maximum is 12 months.

The Starter Benefit is only available during the first 12 cumulative months that you have a Chronic Illness or Disability. The Starter Benefit is not subject to the Calendar Day Elimination Period. The months in your Calendar Day Elimination Period during which you receive the Starter Benefit count towards the Starter Benefit Policy Maximum.

If your Policy Lifetime Maximum is exhausted in less than 12 months, you may continue to receive the Starter Benefit as long as you satisfy the Benefit Eligibility Criteria until the 12-month Starter Benefit Policy Maximum has been reached.

Under the Starter Benefit, charges for Qualified Long Term Care services do NOT need to be incurred and any **Policy Exclusions** related to covered charges shall not apply.

HOME SUPPORT SERVICES BENEFIT

Your Policy provides benefits for goods or services that help you remain independent in your Home and relate to your Qualified Long-Term Care Service needs. These goods or services must be recommended in writing by a Licensed Health Care Practitioner and be part of your Plan of Care. 100% of the Eligible Charges will be paid for Home Support Services. Benefits for Home Support Services are subject to the Home Support Services Policy Maximum. Eligible Charges are listed below.

Assistive Devices or Technology means adaptive tools, devices or technology that helps you function independently in your Home. Examples of such items include but are not limited to, specially adaptive eating and dressing utensils, a “Health Buddy” prompting device, “smart shoes” with GPS (global positioning system), or “Wander Mats.”

Caregiver Training means a training program provided by a Home Health Care Agency, Nursing Home, hospital or other similarly licensed medical facility acceptable to Prudential which provides instruction to Primary Informal Caregivers in basic care giving techniques which will allow you to remain in your Home. Such training is to help your Primary Informal Caregiver tend to your specific long-term care needs. The Primary Informal Caregiver may be a relative or someone chosen by you, but in no event will we pay for training provided to someone who will be paid to care for you.

Durable Medical Equipment means equipment you rent or purchase that is designed to be used more than once in your Home to assist you in performing Activities of Daily Living.

Examples include walkers, hospital-style beds, crutches and wheelchairs and those items routinely considered Durable Medical Equipment under the Medicare Program. Durable Medical Equipment does not include prescription drugs, athletic equipment, equipment placed in your body or items commonly found in a household.

Emergency Medical Response System means a communication system that is installed in your Home and used to call for assistance in the event of a medical emergency. It does not include a home security system or normal telephonic equipment or service.

Home Modifications means modifications to your Home that are primarily being made to improve your ability to perform Activities of Daily Living and to allow you to live safely and independently in your Home. Examples of Home Modifications include the following items.

- 1) Installation of ramps for wheelchair access.
- 2) Installation of grab bars.
- 3) Widening doorways.
- 4) Other similar accessibility modifications.

Home Modifications do not include hot tubs, swimming pools, home repair or maintenance or other similar modifications. This benefit will not cover normal home modification that would only provide an incidental benefit to your Chronic Illness or Disability.

Private Care Manager means charges by a Private Care Manager or Geriatric Care Manager for the following types of services.

- 1) Advocacy for your care with respect to appropriate use of your own as well as community resources.
- 2) Development of or revisions to your Plan of Care.
- 3) Arrangement for delivery of Qualified Long-Term Care Services appropriate to your needs.
- 4) Counseling, support and education with respect to your long-term care needs and resources.

Transportation Services means transportation provided by a licensed transportation carrier, which carries passengers for a fare, to and from your Home directly from and to a Provider solely for the purpose of receiving medically necessary health care, if the care is included in your Plan of Care.

ALTERNATE PLAN

Your Policy provides coverage for a broad range of services including Facility and Home Care. Prudential will consider a claim

OF CARE BENEFIT

for services designed to help you function independently in your home or for stays in facilities not otherwise covered by your Policy. 80% of such Eligible Charges will be paid.

Eligible Charges must be for a service that meets the following requirements.

- 1) It must be considered a Qualified Long-Term Care Service within the terms of Internal Revenue Code Section 7702B.
- 2) It must be clearly specified in your Plan of Care.
- 3) It must be agreed to by you, your Licensed Health Care Practitioner and Prudential as an appropriate alternative to services covered by your Policy. However, you may choose to stop the covered alternative services at any time and use other services covered by your Policy.

WAIVER OF PREMIUMS BENEFIT

After you meet the Benefit Eligibility Criteria and satisfy any applicable Calendar Day Elimination Period, the premiums for your Policy will be waived.

Waiver of premiums is subject to these rules.

- 1) Waiver begins on the day following the date you satisfy your Calendar Day Elimination Period.
- 2) Waiver ends on the date your Chronic Illness or Disability ends.

If premiums for your Policy are paid in advance at the time of waiver, Prudential will refund the pro-rated portion of the advanced premium. Premiums will again become due as of the first day after the date your Chronic Illness or Disability ends.

GUARANTEED INCREASE FEATURE

Every five years on your Policy Anniversary Date, Prudential will increase your Policy Lifetime Maximum with an associated increase in premium. You will be notified of this benefit increase at least 60 days prior to your Policy Anniversary Date. You will not have to provide proof of good health to receive this benefit increase.

All benefit increases will occur even if you are receiving benefits or have met the Benefit Eligibility Criteria at the time of the increase takes effect. No further benefit increases will be put into effect on or after the date of your 76th birthday.

The additional premium for the increase in coverage will be based on your attained age. These increases will occur without your taking any action. If you want to decline any increase, you must notify Prudential in writing, within 30 days of receipt of the notification. You may decline any number of these increases without affecting the availability of or your acceptance of future

increases.

With each benefit increase, your Policy Lifetime Maximum will be increased by 25% of the Policy Lifetime Maximum then in effect on that Policy Anniversary (not including any prior benefit increases applied under this Guaranteed Issue Feature, and excluding any amounts paid in claims).

The value of your remaining Policy Lifetime Maximum will be determined as follows. Your Policy Lifetime Maximum in effect on your Policy Anniversary plus all benefit increases applied under this Guaranteed Issue Feature, less the total of all benefits paid under your Policy.

With each benefit increase, your Starter Benefit will increase by \$375. The Home Support Services Policy Maximum will increase by \$2,500. However, if you have exhausted the Starter Benefit Policy Maximum or the Home Support Services Policy Maximum before accepting a benefit increase, these benefits will not increase.

You will receive a new **Schedule of Policy Benefits** following each benefit increase.

THE CLAIMS PROCESS

In accordance with the provisions below, this section describes what Prudential needs to determine if benefits are payable under your Policy. You must have a Chronic Illness or Disability while Your Policy is in force. You must undergo an Assessment and be certified by a Licensed Health Care Practitioner as having a Chronic Illness or Disability. A Licensed Health Care Practitioner must then develop a Plan of Care, consistent with the certification. Prudential must be provided with satisfactory proof of loss, including a completed claim form and other documentation. Once these requirements are met, Prudential will review your claim and determine whether benefits are payable.

LIMITATIONS OR CONDITIONS ON ELIGIBILITY FOR PAYMENT OF BENEFITS

BENEFIT ELIGIBILITY CRITERIA

Before incurring Eligible Charges and submitting a claim, you must undergo an Assessment and be certified by a Licensed Health Care Practitioner as having a Chronic Illness or Disability. A Chronic Illness or Disability is one that meets either definition below.

- 1) A loss of the ability to perform, without Substantial Assistance, at least two Activities of Daily Living due to a loss of functional capacity. This inability must be expected to continue for at least 90 consecutive days. This expectation is not a waiting or elimination period. Activities of Daily Living are Bathing, Continence, Dressing, Eating, Toileting and Transferring.
- 2) A severe Cognitive Impairment that requires Substantial Supervision to protect you from threats to health and safety.

A Licensed Health Care Practitioner must then develop a Plan of Care. All benefits are paid pursuant to the Plan of Care.

NOTICE OF CLAIM

If you think you have a Chronic Illness or Disability that is expected to last at least 90 days, you should call the Prudential Long Term Care Customer Service Center at 1-800-732-0416. Either you or your representative may call. This notice should be given to Prudential within 20 days of the onset of a potential Chronic Illness or Disability, or as soon as reasonably possible. Notice may be given to The Prudential Insurance Company of America at its Long Term Care Customer Service Center. The notice should include your name and Policy Number. The address for the Customer Service Center appears on the first page of your Policy.

CERTIFICATION PROCESS

Prudential will arrange for an Assessment to determine if you have a Chronic Illness or Disability. As part of the Assessment process, you will be interviewed. The Assessment will be based

on objective standards of measurement. The Assessment must be made at a time when the chronic nature of the condition can be determined. The Assessment should take place in your home or in the setting in which care is to be rendered.

Your Chronic Illness or Disability must be certified by a Licensed Health Care Practitioner. After your Chronic Illness or Disability is certified, a Plan of Care must be developed consistent with your needs. Prudential reserves the right to verify that all of the Benefit Eligibility Criteria have been satisfied and determine if you are eligible for benefits. You will be sent a written notice to confirm the date you become eligible. If you are not eligible, you will be sent a written notice explaining the reasons you are not eligible.

You can select your own Licensed Health Care Practitioner to certify your Chronic Illness or Disability. If you wish to do so, you should notify us when you call our Long Term Care Customer Service Center. Prudential will send you an Assessment Form that your Licensed Health Care Practitioner must complete and return together with the Plan of Care to us prior to submitting proof of loss. Prudential must receive proof that a Licensed Health Care Practitioner has certified, in writing, that you have a Chronic Illness or Disability. Prudential must receive such proof within 12 months of the certification date. The certification must occur on or after your Effective Date. Prudential reserves the right to verify that all of the Benefit Eligibility Criteria have been satisfied and determine if you are eligible for benefits.

CLAIM FORMS

When Prudential is notified, you will be sent a claim form. It will be sent no later than 10 working days following the date of your notice. If you do not receive the claim form within this time, you may send us the documentation identified in the Proof of Loss section of your Policy.

PROOF OF LOSS

For reimbursement of Eligible Charges, your Proof of Loss must include the Provider's bill, together with the completed claim form. Any bill must include all of the following items.

- 1) The name of the person who received the service.
- 2) The name and address of the Provider who rendered the service.
- 3) The date(s) of service.
- 4) Each type of service rendered.
- 5) The charge for that service.

At your own expense, you must obtain and submit all required documentation to us in English.

If you are submitting Proof of Loss for charges for Qualified Long-Term Care Services rendered by a Nursing Home, Assisted Living Facility, Residential Health Care Facility, Adult Foster Home or Board and Care Facility, or by a vendor providing such services on behalf of the facility, you must submit a written bill that itemizes and separately details each service, cost and expense that you sustained. This bill must include an itemized listing of all services, costs and expenses. Prudential reserves the right to require that facility bills be sufficiently itemized to allow us to determine which charges, if any, from a facility may be Eligible Charges under your Coverage. You are responsible for obtaining a sufficiently itemized bill from the facility you use.

A provider's bill does not need to be submitted for a claim under the Starter Benefit. Only a completed Claim Forms needs to be submitted.

This proof of loss should be sent within 90 days of the date loss begins. Failure to furnish such proof within the time required will not invalidate or reduce any claim if both of the following apply.

- 1) It was not reasonably possible to furnish the proof within that time.
- 2) Proof is furnished as soon as reasonably possible.

Except in the absence of legal capacity, the required proof must be given no later than one year (Fifteen months for residents of Hawaii) from the time specified.

PHYSICAL EXAMINATION

You may be required to have a physical examination to be eligible for benefits. Prudential may do this when and as often as is reasonable, while your claim is pending, at its own expense.

TIME OF CLAIM PAYMENT

Benefits are payable where Prudential receives satisfactory proof of loss. An explanation of benefits notice that explains the resolution of your claim will be sent to you within 30 days from the date Prudential receives satisfactory proof of loss.

At your request, you may assign all or a portion of any benefits payable under your Policy directly to the eligible Provider. Benefits not assigned will be paid directly to you.

Benefits will be calculated and paid in United States currency.

FACILITY OF PAYMENT

Benefits due and unpaid at your death will be paid to your estate.

Prudential may pay benefits to a person whom we deem entitled to the benefits if they would otherwise be paid to your estate, or to a person who is a minor or to a person otherwise not competent to give a valid release.

We may pay up to \$1,000 under this provision. Any payment

made by us, in good faith pursuant to this provision, shall fully discharge Prudential to the extent of such payment.

At your written request, all or a portion of any benefits payable under your Policy may be paid directly to the eligible Provider.

LATE PAYMENTS

If benefits are not paid in a timely fashion, Prudential will pay interest on any such late claim payments in accordance with the laws then in effect.

REASSESSMENT

You will be reassessed periodically to determine if you are still eligible for benefits. To comply with federal income tax requirements, you must be assessed at least once in a 12-month period. Prudential reserves the right to verify at any time that all of the Benefit Eligibility Criteria have been satisfied and determine if you continue to be eligible for benefits.

APPEALS

You have the right to appeal decisions made about your eligibility for benefits or a claim.

If your claim or benefit is denied, Prudential will explain the procedure you must follow if you choose to appeal a claim decision.

Prudential will send you a written acknowledgement of your appeal within 10 days of receipt. If no additional information is required and the appeal is denied, the acknowledgment will include an explanation of the reasons for the denial. If additional information is required, we will explain what information is needed. If we do not receive the requested data within 21 days, we will notify you in writing. Within 30 days of the receipt of the required information, Prudential will notify you in writing of the decision concerning your claim.

The Appeals process does not in any way negate or reduce your rights under the Legal Actions provision.

LEGAL ACTIONS

No action at law or in equity can be brought against Prudential to recover benefits from this Policy until 60 days after the required proof of loss is furnished to Prudential. No such action shall be brought more than three years (five years in Kansas; six years in South Carolina) after you incur Eligible Charges.

For Florida residents, no such action shall be brought after the end of the applicable Florida statute of limitations from the time within which proof of loss is required.

For Missouri and Texas residents, no such action shall be brought more than three years after the expiration of the period within which proof of loss must be furnished.

**CALENDAR DAY
ELIMINATION
PERIOD**

The Calendar Day Elimination Period must be satisfied once during your lifetime before benefits are paid. The number of calendar days is stated in the **Schedule of Policy Benefits**.

Prudential will begin to count days to satisfy your Calendar Day Elimination Period with the date you are certified by a Licensed Health Care Practitioner as having a Chronic Illness or Disability. Each day your Chronic Illness or Disability continues counts in satisfaction of this Calendar Day Elimination Period.

Once a day of the Calendar Day Elimination Period is satisfied, it is satisfied for the life of your Policy.

POLICY EXCLUSIONS

Your Policy is designed to provide benefits to pay for your Qualified Long-Term Care Services. Your Policy does not provide benefits for any of the following.

- 1) Illness, treatment or medical conditions arising out of
 - a) War or an act of war, whether declared or undeclared, while you are insured; or
 - b) Your participation in a felony, riot or insurrection; or
 - c) Alcoholism and drug addiction.
- 2) Treatment provided in a government facility, unless payment of the charge is required by law or services provided by any law or governmental plan under which you are covered. This does not apply to a state plan under Medicaid or to any law or plan when, by law, its benefits are excess to those of any private insurance program or other non-governmental program.
- 3) Charges for services or supplies in excess of those normally charged by the Provider in the absence of insurance.
- 4) Charges for care or treatment received outside the United States of America, its territories or possessions.
- 5) Charges for care or treatment rendered by a member of your Immediate Family, unless he or she is a Caregiver (other than an Independent Health Care Practitioner), and he or she receives no compensation other than the normal compensation for employees in his or her job category.
- 6) Charges for any care received while in a hospital, except in a unit specifically designated and licensed as a Nursing Home or Hospice facility.

NON-DUPLICATION OF MEDICARE BENEFITS

Benefits under your Policy are not payable for expenses for Qualified Long-Term Care Services to the extent that either of the following applies.

- 1) Such expenses are reimbursable under Medicare.
- 2) Such expenses would be reimbursable under Medicare but for the application of a deductible or coinsurance amount.

This provision does not apply if such expenses are reimbursable by Medicare as a secondary payer or to claims for the Starter Benefit.

COORDINATION WITH OTHER PRUDENTIAL INDIVIDUAL LONG TERM CARE INSURANCE POLICIES

Benefits under your Policy may be reduced if we also pay benefits for Eligible Charges under any other Prudential Individual Long Term Care Insurance Policy. Benefits will be reduced under this Policy only when payment under this Policy and all other Prudential Individual Long Term Care Insurance Policies combined would exceed the actual amount you incur for Eligible Charges. In no event will we pay more under this Policy than the difference between

your actual expenses and the amount payable by your other Prudential policies.

If you are insured under more than one Prudential Individual Long Term Care Insurance Policy with a similar Coordination provision, the policy with the earliest effective date will be deemed primary and will pay its benefits first. Thereafter, payment will be made under any additional policy (secondary coverage) in order of effective date, from the earliest to the latest. A Prudential policy without a similar Coordination provision will pay first, without any reduction in its benefits.

This provision does not apply to claims for the Starter Benefit.

PREMIUMS

AMOUNT OF PREMIUM

Your age at the time you purchase a benefit is used to rate that benefit. The amount of your premium is calculated using this rate for the benefits you have chosen. Premiums for the base Policy and any options will not automatically increase solely due to your becoming older. Premiums will not automatically increase because benefits are paid.

CHANGES IN PREMIUMS

Premiums for your Policy are shown in the **Schedule of Policy Benefits**. Your initial premium is based on the rates in effect on the Effective Date of your insurance. Prudential has the right to change rates only if both items 1) and 2) occur.

- 1) The change occurs after the first Policy Anniversary Date.
- 2) The change applies to all insureds in your premium class. "Class" means a group of insured risks that exhibit a trait requiring a separate premium rate due to risk characteristics.

Any change in rates is subject to review by the appropriate state regulatory agency. We will not change premium rates more frequently than once a year. We will notify you at least 60 days before a change in the premium rates.

The premium for your Policy can also change under the following circumstances.

- 1) You change your benefit amounts or plan options.
- 2) A benefit increase is automatically applied to your Policy under the Guaranteed Increase Feature, if available under your Policy.

MISSTATEMENT OF AGE

The age shown on your Application is used to determine your eligibility for coverage and to calculate your premium. If that age is in error, we may either reduce your Policy benefits or rescind your Policy.

If we need to reduce your benefits, your benefits will be reduced to those that the premium paid would have purchased at your correct age.

If we need to rescind your Policy, Prudential's liability will be limited to a refund of the premiums paid for this Policy.

MISSTATEMENT OF INFORMATION

Since Prudential relied on information provided by you to calculate your premium, if it is later discovered that you were not rated properly, the premium rate will be adjusted prospectively with the next premium due.

GRACE PERIOD

Your first full modal premium must be paid for your Policy to take effect. A grace period does not apply to the first premium. Your renewal premium is due on or before the premium due date.

Your Policy provides a 31-day grace period for your renewal premiums. This means that if a renewal premium is not paid on or before the due date, it may be paid during the following grace period. During the grace period, your Policy will stay in effect. If the full modal premium is not received within the grace period, Prudential will mail a late payment notice to request payment within 31 days to you and your designee (if applicable). The notice will be deemed to have been given 5 days after the date mailed.

If we do not receive payment within 31 days of the date the late payment notice is given, your Policy will lapse (end) as of the premium due date.

PROTECTION AGAINST UNINTENTIONAL LAPSE

You have the right to name a person, in addition to yourself, to receive notice that your Policy will lapse because your full modal premium was not received. You may exercise or waive this right at the time you apply for your Policy or any time thereafter. At least every two years, Prudential will notify you of your right to name a person for this purpose or to change the person currently named.

REINSTATEMENT

If your full modal premium is not paid within the time required, your Policy will lapse. To reinstate your Policy, all of the following must occur.

- 1) You must request reinstatement within 90 days from the date the last notice of unpaid premium is given by Prudential.
- 2) You must complete a reinstatement application.
- 3) Prudential must approve the reinstatement application.
- 4) You must pay all past due premium as of the date of reinstatement.

If Prudential or its Producer accepts payment for the past due and unpaid premiums without requesting a reinstatement application, your Policy will be reinstated.

You will be given a conditional receipt for any premium paid with your request for reinstatement. If Prudential approves the reinstatement, your Policy will be reinstated as of the approval date.

If approval of a reinstatement application is required, your Policy will be reinstated on the 45th day after the date of the conditional receipt unless we previously wrote you of its disapproval. If a reinstatement application is required and approved, the reinstated policy will cover only a Chronic Illness or Disability that starts after

the date of reinstatement.

If your Policy lapsed due to your Chronic Illness or Disability, you or your representative may request reinstatement, without a reinstatement application, if both of the following items apply.

- 1) The request is made within five months of the premium due date.
- 2) Your Chronic Illness or Disability is certified by a Licensed Health Care Practitioner and existed on the premium due date.

Your Policy will be reinstated as of the premium due date provided all past due premium has been received.

In all other respects, your rights and Prudential's rights will remain the same. You will have the same level of coverage you had before your Policy lapsed. All benefits paid before the reinstatement count towards your Policy Lifetime Maximum under the reinstated policy.

Call the Prudential Long Term Care Customer Service Center at 1-800-732-0416 to determine if your Policy can be reinstated.

**REFUND OF
UNEARNED
PREMIUM**

Unless satisfactory proof is provided to Prudential to indicate a third party has the legal right to a refund of premiums made in connection with this Policy, all premium refunds shall be made to the insured or the insured's estate.

Upon proper notice of the cancellation of your Policy after the 30-day period described on page one, Prudential will refund on a pro-rata basis any part of the premium paid in advance that applies to the period after cancellation.

Upon receipt of proper notice of your death, Prudential will refund to your estate on a pro-rata basis any part of the premium paid in advance that applies to the period of time after death.

**CONTINGENT NON
FORFEITURE
PROVISION**

If the Non-Forfeiture Benefit Rider is not a part of your Policy, these Contingent Non-Forfeiture provisions apply. These provisions change your Long-Term Care insurance to provide options to you in the event your Policy ends due to non-payment of premium after a Substantial Premium Increase.

A Substantial Premium Increase is one that results in a cumulative increase to your Annual Premium that is equal to or exceeds a certain percentage of that premium. It does not include premium increases that result from a voluntary purchase of additional coverage including benefit increases under the Guaranteed Increase Feature. The limits of cumulative increase as a percentage of your Annual Premium are based on your age as of the Policy's Original Effective Date shown in your **Schedule of**

Policy Benefits.

You will be notified of any Substantial Premium Increase at least 60 days prior to the change to your premium. The notice will include the amount of the premium and its due date, and the following contingency options in the event of lapse.

- 2) Reduced benefits at the premium in effect prior to the increase, without undergoing medical underwriting.
- 2) A lesser Policy Lifetime Maximum, with no further premium payment required. You will have 120 days following the premium due date to elect this option. Under this option, the same benefit amounts in effect at the time of lapse will be payable, but the Policy Lifetime Maximum will be equal to the greater of the following items.
 - 2) The total amount of premiums paid for your Policy.
 - 2) 3% of your initial Policy Lifetime Maximum as of your Original Effective Date.

The total of all benefits paid under your Policy will not exceed the Policy Lifetime Maximum that would have been payable if your Policy did not lapse.

Option 2 will automatically take effect if both of the following apply.

- 2) Your Policy lapses within 120 days of the premium due date for the Substantially Increased Premium.
- 2) You have not made an election.

The table below shows the cumulative increase that will trigger the Contingent Non-Forfeiture Provision.

| SUBSTANTIAL PREMIUM INCREASE TABLE | | | |
|---|----------------------------|--------------------|----------------------------|
| PREMIUM AGE | PERCENT OF INCREASE | PREMIUM AGE | PERCENT OF INCREASE |
| Less than 30 | 200% | 72 | 36% |
| 30 - 34 | 190% | 73 | 34% |
| 35 - 39 | 170% | 74 | 32% |
| 40 - 44 | 150% | 75 | 30% |
| 45 - 49 | 130% | 76 | 28% |
| 50 - 54 | 110% | 77 | 26% |
| 55 - 59 | 90% | 78 | 24% |
| 60 | 70% | 79 | 22% |
| 61 | 66% | 80 | 20% |
| 62 | 62% | 81 | 19% |
| 63 | 58% | 82 | 18% |
| 64 | 54% | 83 | 17% |
| 65 | 50% | 84 | 16% |
| 66 | 48% | 85 | 15% |
| 67 | 46% | 86 | 14% |
| 68 | 44% | 87 | 13% |
| 69 | 42% | 88 | 12% |
| 70 | 40% | 89 | 11% |
| 71 | 38% | 90 and over | 10% |

GENERAL INFORMATION

TAX STATUS OF PREMIUMS AND BENEFITS

Your Policy is intended to be a **Qualified Long-Term Care Insurance Contract as defined by the Internal Revenue Code Section 7702B(b)**. The benefits you may receive under your Policy should not be considered taxable income. In addition, some or all of the premiums you pay for your Policy may be tax deductible as a medical expense subject to certain limitations. Consult a tax advisor for more information concerning this deduction.

Public guidance issued by the Internal Revenue Service or Treasury Department may provide that a provision of your Policy does not comply with the requirements of Code Section 7702B. In this event, this provision will be automatically nullified without any further action by Prudential.

ENTIRE CONTRACT

The entire contract between you and Prudential consists of your Policy, all attached pages, any optional Riders and your Application. A change in this contract will be valid only when approved by a Prudential officer and made a part of the contract. A Producer may not change the contract or waive any part of it.

DIVIDENDS

Your Policy is non-participating. It will not share in Prudential's profits or surplus earnings. Prudential will pay no dividends on it.

COMMUNICATION THROUGH ELECTRONIC MEANS

Prudential reserves the right to designate the form and means for all communications or notices required by your Policy.

With our prior consent, communications made by you or your representative pursuant to or in connection with your Policy, using electronic means or technologies, may be made to us.

With your prior consent, communications made by Prudential pursuant to or in connection with your Policy, using electronic means or technologies, may be made to you.

The transmittal of information, that is authorized or not otherwise prohibited by state or federal law, by electronic means or technology, is intended to have the same legal effect, validity, and enforceability as it would if the information were provided in other than an electronic form.

OTHER GOODS AND SERVICES

From time to time, Prudential may offer or provide certain goods and services to you in addition to the insurance coverage. Prudential also may arrange for third party vendors to provide goods and services at a discount (including without limitation beneficiary financial counseling services, estate guidance and employee assistance programs) to you. Though Prudential may

make the arrangements, the third party vendors are solely liable for providing the goods and services. Prudential shall not be responsible for providing or failing to provide the goods and services to you. Further, Prudential shall not be liable to you for the negligent provision of the goods and services by third party vendors.

OWNERSHIP

You are the owner of your Policy.

**REDUCING
COVERAGE**

You may make a request to reduce your Policy Lifetime Maximum to lower your premium while your Policy is in force.

Prudential may limit any reduction in coverage to options available for this Policy and to those for which benefits will be available after consideration of claims paid or payable. The age to determine the premium for reduced coverage shall be based on the age used to determine the premiums for the coverage currently in force. We will not require any additional proof of good health to reduce benefits.

To make a request, you can choose one of the following options.

- 1) You may contact your Producer to initiate a request to reduce your coverage.
- 2) You may write to us at the Contact Address in your Policy.
- 3) You may call the Prudential Long Term Care Customer Service Center at 1-800-732-0416 for assistance.

WHEN YOUR POLICY ENDS

TERMINATION OF YOUR POLICY

Your Policy and any applicable Riders will end at 12:01 A. M., Standard Time on the earliest of the following dates.

- 1) The premium due date if you fail to pay the full modal premium required for your Policy when due or in accordance with the Grace Period provision. This will not apply if the premium is being waived under the Waiver of Premiums provision.
- 2) The later of the date you have exhausted your Policy Lifetime Maximum or the date you have exhausted your Starter Benefit.
- 3) The date of your death.
- 4) The date we receive written notice requesting cancellation of your Policy or the date requested in such notice, if later.

Termination of your Policy will be without prejudice to benefits payable for your care in a Nursing Home, an Adult Foster Home, an Assisted Living Facility, or a Residential Health Care Facility if such care began while your Policy was in force and continues without interruption after your Policy ends. Benefits will be extended until the earlier of the following dates.

- 1) The date on which you no longer incur Eligible Charges for such care.
- 2) The date your Policy Lifetime Maximum has been exhausted.

If you are receiving benefits when the Policy terminated, you will be considered covered under your Policy for purposes of the Waiver of Premiums provision.

INCONTESTABILITY PROVISIONS

Your Policy was issued based on information given in your Application. All statements made in your Application are considered to be to the best of your knowledge and belief. Such statements will be deemed representations and not warranties. A statement will not be used in a contest to avoid this insurance or reduce benefits unless both of the following apply.

- 1) It is a written statement signed by you.
- 2) A copy of that statement is or has been furnished to you or your representative.

During the first six months your Policy is in force, if:

- 1) Information on your Application misrepresented any information about you or your health or medical history; and

- 2) As a result, we offered you insurance that you otherwise would not have been offered,

Prudential can rescind your Policy or deny an otherwise valid claim.

After your Policy has been in effect for six months, but less than two years, if:

- 1) Information on your Application misrepresented any information about you or your health or medical history; and
- 2) As a result, we offered you insurance that you otherwise would not have been offered; and
- 3) The misrepresentation pertains to the condition for which benefits are claimed,

Prudential can rescind your Policy or deny an otherwise valid claim.

After your Policy has been in effect for two years, if:

- 1) Relevant facts relating to your health were knowingly and intentionally misrepresented on your Application; and
- 2) As a result, we offered you insurance that you otherwise would not have been offered,

Prudential can rescind your Policy or deny an otherwise valid claim.

These provisions also apply if you provide additional evidence of insurability to purchase additional coverage after your Policy Effective Date.

GLOSSARY

This section defines certain of the terms used in your Policy. These definitions apply to the terms used in your Policy and any other attached forms.

ACTIVITIES OF DAILY LIVING (ADLs)

Bathing - Washing oneself by sponge bath, or in either a tub or shower, including the task of getting into or out of the tub or shower.

Continence - The ability to maintain control of bowel and bladder function, or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).

Dressing - Putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.

Eating - Feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by feeding tube or intravenously.

Toileting - Getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.

Transferring - Moving into or out of a bed, chair or wheelchair.

ADULT DAY CARE

A formal community based program for six (6) or more individuals, providing social and health related services during the day, to functionally and/or cognitively impaired adults. It must be licensed and/or certified as Adult Day Care according to the laws of the jurisdiction in which it is located. If licensure and/or certification is not required, then the Adult Day Care must satisfy all of the following requirements.

- 1) It must have a structured program that includes a variety of health, social and other related support services in a protective setting during daytime hours, but less than 24-hour care.
- 2) It must have established procedures for obtaining emergency medical services for clients.
- 3) It must maintain a written record of services provided to each client.
- 4) It must provide personal assistance with meals, toileting, continence and transferring.

ADULT FOSTER HOME OR BOARD AND CARE

A family home or other facility in which residential care is provided to five or fewer adults in a home-like environment for compensation. Residents must be unrelated to the Provider by

FACILITY

blood or marriage and be elderly or physically disabled. It must be licensed and/or certified as an Adult Foster Home or Board and Care Facility according to the laws of the jurisdiction in which it is located. For facilities located in a jurisdiction that does not license or certify Adult Foster Homes or Board and Care Facilities, it is a facility that provides ongoing services to a maximum of five residents in one location and is determined by Prudential to meet the following requirements.

- 1) It is a group residence that maintains records for services to each resident.
- 2) It provides services and oversight on a 24 hour a day basis.
- 3) It provides a combination of housing, supportive services, and personal assistance designed to respond to the resident's need for help with Activities of Daily Living and instrumental activities of daily living.
- 4) It provides, at a minimum, assistance with Bathing, Dressing and help with medications.
- 5) It is not licensed as a Nursing Home.

Adult Foster Home does not include any house, institution, hotel or other similar living arrangement that supplies room or board only, if you do not receive any Qualified Long-Term Care Services as a resident of the facility.

ASSESSMENT

An evaluation performed by a Licensed Health Care Practitioner to determine or verify that you have a Chronic Illness or Disability. The Assessment will be based on objective standards of measurement using generally accepted tests to produce verifiable results. The Assessment must be made at a time when the chronic nature of the condition can be determined. The Assessment should take place in your home or in the setting in which care is to be rendered.

ASSISTED LIVING FACILITY OR RESIDENTIAL HEALTH CARE FACILITY

It must be licensed and/or certified as an Assisted Living Facility or Residential Health Care Facility according to the laws of the jurisdiction in which it is located. For facilities located in a jurisdiction that does not license or certify Assisted Living Facilities or Residential Health Care Facilities, it is a facility that provides ongoing services to a minimum of three residents in one location and is determined by Prudential to meet the following requirements.

- 1) It is a group residence that maintains records for services to each resident.
- 2) It provides services and oversight on a 24 hour a day basis.
- 3) It provides a combination of housing, supportive services,

and personal assistance designed to respond to the resident's need for help with Activities of Daily Living and instrumental activities of daily living.

- 4) It provides, at a minimum, assistance with Bathing, Dressing and help with medications.
- 5) It is not licensed as a Nursing Home.

**CALENDAR DAY
ELIMINATION
PERIOD**

The number of calendar days that you have a Chronic Illness or Disability that must elapse before certain Policy benefits may be payable. The Calendar Day Elimination Period applies to all benefits except the Hospice Care Benefit, the Starter Benefit and the Home Support Services Benefit. The Calendar Day Elimination Period is shown in the **Schedule of Policy Benefits**.

CAREGIVER

Caregiver means any provider of Home Health Care, Homemaker Services or Personal Care Services who is licensed, certified or otherwise authorized by the state where the services are performed to perform Home Health Care, Homemaker Services or Personal Care Services.

Prudential recognizes that licensure, certification, and the names of eligible care providers vary from state-to-state. Therefore, we have developed alternative criteria to credential eligible care providers.

Care providers who meet the alternative criteria below when licensure, certification or other authorization to perform Home Health Care, Homemaker Services or Personal Care Services is not required by the state shall be considered eligible care providers.

Caregiver includes a Home Health Care Agency, Home Health Aide, Referral Agency, Nurse Registry, Independent Health Care Professional and Personal Care Agency, Assisted Living Facility or Residential Health Care Facility.

Caregiver also includes an entity that satisfies the Agencies as Caregivers requirements below, or an individual that satisfies the Independent Caregiver requirements below.

- 1) Agencies as Caregivers. If the Home Health Care, Homemaker Services or Personal Care Services are furnished through an agency but the state in which the services are provided does not require the agency to be licensed, certified or otherwise authorized by the state to provide Home Health Care, Homemaker Services or Personal Care Services, then the agency must satisfy all of the following requirements, to be a Caregiver.
 - a) The agency must employ a full-time agency administrator

responsible for the following activities.

- i) Developing and maintaining care standards for Home Health Care, Homemaker Services or Personal Care Services provided to individuals.
 - ii) Ensuring that care providers receive adequate training in medical and non-medical home care protocols, as appropriate, to effectively perform Home Health Care, Homemaker Services or Personal Care Services.
- b) The agency must employ or contract with a Registered Nurse to direct and supervise care providers who provide Home Health Care, Homemaker Services or Personal Care Services.
 - c) The agency must create a customized care plan to meet the needs of each individual to whom it provides Home Health Care, Homemaker Services or Personal Care Services.
 - d) The agency must maintain written records of services provided during each home care visit.
 - e) The agency must employ or contract with care providers who are appropriately licensed, certified or otherwise authorized by the state to provide medical and/or non-medical Home Health Care, Homemaker Services or Personal Care Services, if the state in which services are provided requires care providers to be licensed, certified or otherwise authorized to provide such services. If the state does not require care providers to be licensed, certified or otherwise authorized to provide such services, then the agency must employ or contract with care providers who satisfy the Independent Caregivers requirements below, or are otherwise adequately and appropriately trained to provide medical and/or non-medical Home Health Care, Homemaker Services or Personal Care Services.
 - f) The agency must hold a current business license from the state in which Home Health Care, Homemaker Services or Personal Care Services are provided.
- 2) Independent Caregivers. If a care provider works independently and is not an agency or affiliated with an agency, and the state in which Home Health Care, Homemaker Services or Personal Care Services are provided does not require the independent Home Health Care provider to be certified, licensed or otherwise authorized to provide such services, then the independent Home Health Care provider must satisfy all of the following requirements to

be a Caregiver.

- a) The independent care provider must submit documentation to Prudential confirming that he or she successfully completed a formal training program providing instruction and/or classroom training in topics relating to the provision of assistance with Activities of Daily Living or the provision of other Qualified Long-Term Care Services, such as body mechanics, nutrition, infection control, and safe transfer techniques. The training must be obtained from one of the following places.
 - i) community college.
 - ii) similar accredited educational institution or vocational school.
 - iii) an agency that meets the Agencies as Caregiver definition above.
 - iv) a state-approved training program for home care workers.
 - v) another school, organization or individual that is authorized to provide such training by the state in which Home Health Care, Homemaker Services or Personal Care Services are provided.
- b) The independent care provider must submit to Prudential proof of identity, such as a valid state issued driver's license.
- c) Upon request, the independent care provider must submit to Prudential written records documenting the Home Health Care, Homemaker Services or Personal Care Services provided during each home care visit.

**CHRONIC ILLNESS
OR DISABILITY**

An illness or disability certified by a Licensed Health Care Practitioner in which there is at least one of the following.

- 1) The loss of the ability to perform, without Substantial Assistance, at least two Activities of Daily Living due to a loss of functional capacity. This inability must be expected to continue for at least 90 consecutive days. This expectation is not a waiting period. The Activities of Daily Living are defined and listed above.
- 2) A Severe Cognitive Impairment that requires Substantial Supervision to protect you from threats to health or safety.

**DOMESTIC
PARTNER**

Each of two people who have registered or filed as domestic partners or members of a civil union with a government agency or office where such registration or filing is available. Or

Each of two people who meet all the criteria listed below.

- 1) Are 18 years of age or older.
- 2) Are living together.
- 3) Have a serious and committed relationship.
- 4) Are not legally married nor a Domestic Partner to anyone else.
- 5) Are financially interdependent, meaning both are jointly responsible for the cost of food and housing.

ELIGIBLE CHARGES

The charges for your Qualified Long-Term Care Services that are used as the basis for a claim determination by Prudential. Such Qualified Long-Term Care Services must be included in your Plan of Care in order for the charges to be considered Eligible Charges. These charges must be incurred

- 1) while your Coverage is in force.
- 2) after the Calendar Day Elimination Period, if any, is satisfied.
- 3) after the date you are certified as having a Chronic Illness or Disability.

Eligible Charges must be incurred for services and supplies described in **Your Long-Term Care Insurance Benefit Descriptions** section. Eligible Charges must be incurred from Providers who meet the criteria defined by your Coverage. A charge is considered incurred on the date you receive the service or supply.

Room and board charges and comparable expenses for residence in a facility shall not be Eligible Charges unless a Licensed Health Care Practitioner certifies in a Plan of Care both of the following requirements.

- 1) The primary reason for your residence in a Nursing Home, Assisted Living Facility, Residential Health Care Facility, Adult Foster Home or Board and Care Facility is your need to receive Qualified Long-Term Care Services in connection with your Chronic Illness or Disability on a 24-hour per day basis.
- 2) Such services are available at that Nursing Home, Assisted Living Facility, Residential Health Care Facility, Adult Foster Home or Board and Care Facility.

A charge is not an Eligible Charge if it is described in the Coverage Exclusions section. Eligible Charges do not include charges incurred during the Calendar Day Elimination Period.

Eligible Charges also do not include charges for ancillary or miscellaneous items or services, provided in or by a facility or as

part of Home Health Care provided to you which are not directly related to providing Qualified Long-Term Care Services in connection with your Chronic Illness or Disability. Examples include, but are not limited to, charges for utilities, newspapers, routine over-the-counter medical supplies, guest charges and convenience items.

Starter Benefits are paid without regard to Eligible Charges.

**PRIVATE CARE
MANAGER**

A Licensed Health Care Practitioner, not associated with Prudential, who is qualified to coordinate your necessary medical care, long-term care, Personal Care and social services. Qualifications are based on training and experience and can include health care industry, state or national standards.

HOME

The house, apartment or room that is the primary place where you live. You are not required to own your home. For example, if you live in an adult child's primary residence, that would be considered your Home.

**HOME HEALTH
AIDE**

A person whose function is to provide Personal Care Services or Homemaker Services. A Home Health Aide must be licensed or certified according to the laws of the jurisdiction in which care is rendered.

When licensing or certification is not required, a person will be deemed a Home Health Aide if he or she meets the following requirements.

- 1) He or she meets the minimum training qualifications recognized by the Foundation for Hospice & Home Care, National League of Nursing or Health Care Financing Administration.
- 2) He or she is employed through an eligible Home Health Care Agency, or is an Independent Health Care Professional.

**HOME HEALTH
CARE AGENCY**

An organization that meets at least one of these three criteria.

- 1) It is an agency licensed as a home health care agency in the jurisdiction in which the Home Health Care is delivered.
- 2) It is a home health care agency as defined by Medicare.
- 3) It is an agency or organization that provides a program of Home Health Care that meets all these tests.
 - a) It is licensed to provide the services for Home Health Care in the Plan of Care.
 - b) It maintains written records of services provided to patients.

- c) Its staff includes at least one Registered Nurse or nursing care by a Registered Nurse is available to it.

HOME HEALTH CARE

Medical and non-medical services, provided to ill, disabled or infirm persons in their Home.

HOMEMAKER SERVICES

Services that are designed to maintain your ability to function independently in your Home. Homemaker Services include but are not limited to the following activities.

- 1) Shopping.
- 2) Planning menus, preparing meals, and delivering meals to your Home.
- 3) Laundry and light house cleaning and maintenance. Light house cleaning includes vacuuming, dusting, dry mopping, dishwashing, cleaning the kitchen and bathroom and changing beds.

HOSPICE

A public agency or private organization providing palliative medical care (care which seeks to reduce pain and provide comfort, rather than provide a cure) to a Terminally Ill individuals. The agency or organization must meet federal certification requirements as a Hospice, or be licensed according to the laws of the jurisdiction in which it is located.

HOSPICE CARE

Services and supplies provided through a Hospice to meet the special physical, psychological, spiritual and social needs for a Terminally Ill person and his or her Immediate Family. Hospice Care provides palliative and supportive medical, nursing and other health services through home and inpatient care during the illness to one or both of the following persons.

- 1) A Terminally Ill person who has no reasonable prospect of cure as estimated by a Physician.
- 2) The Immediate Family or Primary Informal Caregiver of the person described in 1) above.

Hospice Care includes, but is not limited to the following care and services.

- 1) Part-time nursing care by or supervised by a Registered Nurse.
- 2) Counseling, including dietary counseling, for the Terminally Ill person.
- 3) Family counseling for the Immediate Family and the Primary Informal Caregiver before the death of the Terminally Ill person.

- 4) Medical supplies, equipment, and medication required to maintain the comfort and manage the pain of the Terminally Ill person.

IMMEDIATE FAMILY

Your spouse, Domestic Partner or anyone who is related to you or your spouse or Domestic Partner (including adopted, in-law and step-relatives) as a parent, child, grandchild, or sibling.

INDEPENDENT HEALTH CARE PROFESSIONAL

A Home Health Aide, Registered Nurse, Licensed Practical Nurse or Therapist independently providing Home Health Care services within the scope of his or her license.

LICENSED HEALTH CARE PRACTITIONER

A Physician, a Registered Nurse, a licensed or certified social worker, or another professional individual who meets the requirements prescribed by the United States Secretary of the Treasury.

LICENSED PRACTICAL NURSE

A professional nurse legally designated "LPN" who, where licensing is required, holds a valid license according to the laws of the jurisdiction in which the nursing service is performed. The term licensed practical nurse (LPN) shall include a licensed vocational nurse (LVN) and any other similarly designated nurse in those jurisdictions in which a professional nurse is designated as other than an LPN and for whom licensing is required.

LICENSED SOCIAL WORKER

A person who has a Baccalaureate, Master's or Doctoral degree in Social Work from a program accredited by the Council on Social Work Education and is appropriately licensed or certified, if licensing and certification is required, in the United States' jurisdiction where the social work is performed.

MEDICAID

Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time.

MEDICARE

The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as then constituted or later amended.

NURSE REGISTRY

An organization that meets the following requirements.

- 1) Its main function is to provide a referral service for Registered Nurses or Licensed Practical Nurses specialized in providing Home Health Care services.
- 2) It is appropriately licensed according to the laws of the jurisdiction in which the services are provided, if the jurisdiction in which the Nurse Registry is located requires licensure.

NURSING HOME

A facility whose primary purpose is to provide skilled, intermediate or custodial nursing care and meets one of the following requirements.

- 1) It is Medicare-approved as a Provider of skilled nursing care services.
- 2) It is licensed and operated according to the laws of the jurisdiction in which it is located as a skilled nursing home, an intermediate care facility or a custodial care facility.
- 3) It meets all the following requirements.
 - a) Its main function is to provide skilled, intermediate or custodial nursing care.
 - b) It is engaged in providing continuous room and board accommodations for three or more persons.
 - c) It has a Physician on staff or available to it under contract.
 - d) It is under the supervision of a Registered Nurse or Licensed Practical Nurse.
 - e) It maintains medical records for each patient.
 - f) It maintains control of and records of all medications dispensed.

A nursing home shall not include a facility that is primarily a facility for the treatment of alcoholism or chemical dependency.

PERSONAL CARE SERVICES

The provision of hands-on services to assist an individual with Activities of Daily Living.

PHYSICIAN

Any person licensed by a United States jurisdiction as a Medical Doctor (M.D.) or Doctor of Osteopathy (D.O.) practicing within the scope of his or her license.

PLAN OF CARE

A written, individualized plan that has been developed to meet your long-term care needs. The Plan of Care must meet the following requirements.

- 1) It is developed based on the results of an assessment by a Licensed Health Care Practitioner, a review of your health status, medical records and other available information.
- 2) It is prescribed by a Licensed Health Care Practitioner.
- 3) It names the type, frequency and duration of services you need and the appropriate Providers to furnish such services.
- 4) It fairly, accurately and appropriately addresses your needs in accordance with accepted medical and nursing standards of

practice for a person with a similar Chronic Illness or Disability.

Prudential reserves the right to review or discuss your Plan of Care with the Licensed Health Care Practitioner who prescribed it. We may also verify that the Plan of Care is consistent with accepted medical and nursing standards of practice for a person with a similar Chronic Illness or Disability. Your Plan of Care must be updated as your condition and care needs change. We must be provided with a revised Plan of Care each time it is updated. We may request periodic updates not more frequently than once every 30 days.

**POLICY LIFETIME
MAXIMUM**

The maximum lifetime benefit payable for Eligible Charges according to the benefits you have chosen. Your initial Policy Lifetime Maximum is the amount available for all benefits payable under your Policy as of the Policy's Original Effective Date. The Policy Lifetime Maximum is shown on your **Schedule of Policy Benefits**. Benefits paid are deducted from the Policy Lifetime Maximum.

**PRIMARY
INFORMAL
CAREGIVER**

An unpaid person who regularly provides one of the following types of care.

- 1) Substantial Assistance when you are unable to perform at least two of the Activities of Daily Living.
- 2) Substantial Supervision when you have a Severe Cognitive Impairment.

The Primary Informal Caregiver may be a relative or someone chosen by you, but in no event will we pay for training provided to someone who will be paid to care for you.

PROVIDER

A licensed or certified professional or entity that provides Qualified Long-Term Care Services.

**QUALIFIED LONG-
TERM CARE
SERVICES**

Necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, and rehabilitative services, and maintenance or Personal Care services, provided in a setting other than an acute care unit at a hospital which began while your Policy is in-force.

**REFERRAL
AGENCY**

An agency that meets the following requirements.

- 1) Its main function is to provide a referral service for Registered Nurses, Licensed Practical Nurses, Therapists or licensed Home Health Aides providing Home Health Care.
- 2) It is licensed according to the laws of the jurisdiction in which it is located to provide such services. If licensing is not required, the agency must be accredited by the Joint

Commission on Accreditation of Healthcare Organizations or other association that has substantially the same accreditation standards.

REGISTERED NURSE

A professional nurse legally designated “RN” who, where licensing is required, holds a valid license according to the laws of the United States jurisdiction in which the nursing service is performed.

RESPITE CARE

Short-term care provided by a third party to relieve your Primary Informal Caregiver from care giving responsibilities.

SEVERE COGNITIVE IMPAIRMENT

A loss or deterioration in intellectual capacity that is:

- 1) Comparable to (and includes) Alzheimer’s Disease and similar forms of irreversible dementia, and
- 2) Measured by clinical evidence and standardized tests that reliably measure impairment in the individual’s
 - a) Short-term or long-term memory,
 - b) Orientation as to people, places, or time and
 - c) Deductive or abstract reasoning.

SUBSTANTIAL ASSISTANCE

Hands-on assistance or stand-by assistance.

- 1) Hands-on assistance is the physical assistance (minimal, moderate or maximal) of another person without which an individual would be unable to perform an Activity of Daily Living.
- 2) Stand-by assistance is the presence of another person within arm’s reach that is necessary to prevent, by physical intervention, injury to an individual while the individual is performing an Activity of Daily Living.

SUBSTANTIAL SUPERVISION

Continual oversight that may include cueing by verbal prompting, gestures or other demonstrations by another person, and that is necessary to protect you from threats to your health or safety.

TERMINALLY ILL

A medical prognosis given by a Physician that your life expectancy is six months or less.

THERAPIST

A physical therapist, occupational therapist, respiratory therapist, speech pathologist or audiologist who is licensed according to the laws of the jurisdiction in where the services are performed.

SCHEDULE OF POLICY BENEFITS

Prudential LTC EvolutionSM

POLICY NUMBER: 1234567890

ORIGINAL EFFECTIVE DATE: 01/01/2009

CHANGE EFFECTIVE DATE: Not Applicable

PREMIUM AGE: 50

INSURED: John Doe

RATE CLASS: Standard 1

123 Main Street

POLICY ANNIVERSARY DATE: 01/01/2010

Dresher, PA 19025

and each 01/01 thereafter

PLAN INFORMATION

| | |
|---|-------------------------|
| CALENDAR DAY ELIMINATION PERIOD | 90 days |
| BENEFIT PAYMENT FOR COVERED SERVICES | 80% of Eligible Charges |
| CO-PAYMENT FOR COVERED SERVICES | 20% of Eligible Charges |
| STARTER BENEFIT | \$1,500 per month |
| STARTER BENEFIT POLICY MAXIMUM | 12 months |
| HOME SUPPORT SERVICES POLICY MAXIMUM | \$10,000 |
| POLICY LIFETIME MAXIMUM (does not reflect claims paid or payable) | \$ 500,000 |

THIS POLICY INCLUDES THE FOLLOWING OPTIONAL BENEFIT RIDERS

| OPTIONAL RIDER | EFFECTIVE DATE OF RIDER |
|--|-------------------------|
| INFLATION RIDER: 5% AUTOMATIC COMPOUND INCREASE OPTION RIDER | 01/01/2009 |
| NON-FORFEITURE BENEFIT RIDER | 01/01/2009 |
| SHARED CARE BENEFIT RIDER | 01/01/2009 |
| SHARED CARE PARTNER | Mary Doe |
| See next page for Premium Information. | |

SCHEDULE OF POLICY BENEFITS (Continued)

Prudential LTC EvolutionSM

POLICY NUMBER: 1234567890

INSURED: John Doe

PREMIUM INFORMATION

| | | |
|---|-----------|--------------------|
| Annual Premium For Base Policy | | \$ 2,000.00 |
| Optional Benefit Riders Premium | | \$ 1,500.00 |
| Optional Inflation Rider | \$ 500.00 | |
| Non-Forfeiture Benefit Rider | \$ 500.00 | |
| Shared Care Benefit Rider | \$ 500.00 | |
| Annual Premium Including All Optional Riders | | \$ 3,500.00 |
| Partner Discount* | 30% | |
| *Discounts are multiplicative. | | |
| Total Annual Premium Including Optional Riders and Less Discounts | | \$ 2,450.00 |
| Modal Premiums | | |
| Annual | | \$2,450.00 |
| Semi-Annual* | | \$1,261.75 |
| Quarterly | | \$649.25 |
| Monthly – EFT | | \$208.25 |
| *This is the modal premium you have elected. The total annual cost of your coverage will vary both by the frequency of premium payment (mode) as well as the method of payment chosen. The more frequent the premium payment mode the higher the annual cost. | | |

ALTERNATE BILLING ADDRESS
(if other than the insured)

ABC Company, Inc.
Attention: Jane Smith
456 Main Street
Dresher, PA 19025

Telephone Number:

215-555-1212

Producer: Sam Jones
789 Main Street
Dresher, PA 19025

Telephone Number:

215-555-2121



The Prudential Insurance Company of America
751 Broad Street, Newark, New Jersey 07102-3777

Long Term Care Insurance Optional Inflation Rider 3% AUTOMATIC COMPOUND INCREASE OPTION

This Rider is issued in consideration of your Application and payment of the full modal premium. It becomes a part of your Policy. It takes effect on the Effective Date stated for this Rider in the **Schedule of Policy Benefits**. Please refer to the **Glossary** in your Policy for definitions.

This Rider amends your Policy to increase the benefit limits as described below, by 3% compounded annually.

The following provision replaces the section entitled **GUARANTEED INCREASE OPTION**.

3% AUTOMATIC COMPOUND INCREASES

Your benefits will automatically increase on each Policy Anniversary. The first increase will take effect on the Policy Anniversary that follows the Effective Date of this Rider. The increase will occur even if you are receiving benefits.

If you have purchased additional benefits after the Effective Date of this Rider, increases will also occur for those benefits, in accordance with the terms and conditions described herein.

Your premium will not increase solely due to increases under this Rider.

INCREASES TO YOUR POLICY LIFETIME MAXIMUM

Your increased Policy Lifetime Maximum will be determined as follows.

- 1) The Policy Lifetime Maximum remaining as of the Prior Policy Anniversary will be increased by 3%.
- 2) Amounts are rounded to the nearest dollar.
- 3) Benefits paid under your Policy, if any, during the Prior Policy Year will be deducted from this amount.

INCREASES TO YOUR HOME SUPPORT SERVICES POLICY MAXIMUM

Your increased Home Support Services Policy Maximum will be determined as follows.

- 1) The Home Support Services Policy Maximum in effect on the Prior Policy Anniversary will be increased by 3%.
- 2) Amounts are rounded to the nearest dollar.
- 3) Home Support Services Benefits paid under your Policy, if any, during the Prior Policy Year will be deducted from this amount.

INCREASES TO YOUR

Your increased monthly Starter Benefit will be determined as follows.

- 1) The monthly Starter Benefit in effect on the Prior Policy

**STARTER
BENEFIT**

Anniversary will be increased by 3%.

- 2) Amounts are rounded to the nearest dollar.

If you have exhausted the Starter Benefit Policy Maximum before a Policy Anniversary Date, this benefit will not increase.

The following provisions are added to the section of your Policy entitled **WHEN YOUR POLICY ENDS.**

**TERMINATION
OF RIDER**

This Rider will terminate if any of the following events occur.

- 1) Your Policy lapses because you fail to pay the full modal premium when due or in accordance with the Grace Period provision. This Rider will end as of the due date of the unpaid premium.
- 2) You send a written request to terminate this Rider. This Rider will end as of the date the request is received, unless a later date is specified.

**EFFECT OF
LAPSE AND
TERMINATION
OF RIDER**

If your Policy ends and is later reinstated, automatic benefit increases will be made as if your Policy had remained in effect.

If your Policy lapses for non-payment of premium and coverage continues under the Non-Forfeiture Benefit Rider, no automatic benefit increases will be made after the due date of the unpaid premium.

If you elect a lesser Policy Lifetime Maximum under the Contingent Non-Forfeiture provision, no additional automatic benefit increases will be made.

Except as modified above, all other terms and conditions of your Policy remain the same.

THE PRUDENTIAL INSURANCE COMPANY OF AMERICA


Secretary

INSURANCE HISTORY

Indicate yes or no

If coverage is being replaced, please submit a completed Replacement Notice.

- 1 Are you covered by Medicaid or Medi-Cal (not Medicare)? Yes No
- 2 Do you have other long term care or accident and sickness insurance in force (including policies, certificates, health care service contracts, or health maintenance organization contracts)? Yes No
- 3 Did you have other long term care insurance in force during **the last 12 months**? Yes No
- 4 Do you intend to replace any of your medical health insurance with this insurance? Yes No

IF YOU ANSWERED YES TO QUESTIONS 2, 3, OR 4 OF THIS SECTION, PLEASE PROVIDE THE FOLLOWING INFORMATION

| | | | |
|--------------------------------|-------------------------------------|--|--|
| <input type="checkbox"/> Group | <input type="checkbox"/> Individual | <input type="checkbox"/> Intend to replace? | <input type="checkbox"/> Did insurance lapse? |
| <input type="checkbox"/> Group | <input type="checkbox"/> Individual | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Type of Coverage | Policy # | | If yes give date |

| | | | |
|--------------------------------|-------------------------------------|--|--|
| <input type="checkbox"/> Group | <input type="checkbox"/> Individual | <input type="checkbox"/> Intend to replace? | <input type="checkbox"/> Did insurance lapse? |
| <input type="checkbox"/> Group | <input type="checkbox"/> Individual | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Type of Coverage | Policy # | | If yes give date |

Full name and address of insurance company

MEDICAL HISTORY – PART 1 INSURABILITY PROFILE

Indicate yes or no

- 1 Have you had, do you currently have, or have you ever been diagnosed as having any of the following medical conditions:
 - a Acquired Immune Deficiency Syndrome (AIDS), or a Human Immunodeficiency Virus (HIV) infection? Yes No
 - b Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig's Disease)? Yes No
 - c Alzheimer's Disease, Chronic Memory Loss, frequent or persistent forgetfulness, senility, dementia, or Organic Brain Syndrome? Yes No
 - d Chronic Obstructive Pulmonary Disease (COPD) or Emphysema **in combination with:** Current Smoking; Congestive Heart Failure (CHF); Asthma; or Chronic Bronchitis? Yes No
 - e Congestive Heart Failure **in combination with:** Current Smoking, Angina or Heart Surgery; Asthma or Chronic Bronchitis; Diabetes; or Tuberculosis? Yes No
 - f Congestive Heart Failure, diagnosed or symptomatic, within **the past 12 months**? Yes No
 - g Immune System Disorder? Yes No
 - h Metastatic Cancer (Cancer that has spread from the original site or location)? Yes No
 - i Stroke or Cerebrovascular Accident (CVA)? Yes No
 - j Liver Cirrhosis? Yes No
 - k Multiple Sclerosis (MS), Muscular Dystrophy, Parkinson's Disease, Huntington's Disease? Yes No
 - l Transient Ischemic Attack (TIA) within **the past 5 years**; multiple TIA's; or TIA in combination with Diabetes or any Heart Surgery? Yes No
 - m Within **the past 6 months**, have you had open heart surgery, spine surgery, back surgery? Yes No
- 2 Within **the past 48 months** have you had cancer of the: Yes No
 - Bone Brain Esophagus Liver Lung Ovary Pancreas Stomach
- 3 Do you use a four pronged cane, kidney dialysis, motorized scooter, oxygen, respirator, walker, wheelchair? Yes No
- 4 Within **the past 12 months** have you: Yes No
 - Used adult day care Needed home health care
 - Been medically advised to enter or been confined to: A nursing home An assisted living facility Other long term care facility
- 5 Do you currently need assistance or supervision by another person in performing any of the following activities: Yes No
 - Bathing Eating Toileting Dressing Bowel or Bladder Control Moving in and out of bed or chair
 - Taking your medication

If you answered "Yes" to any question in this insurability profile, we recommend that you do not submit this Application.

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MEDICAL HISTORY – PART 2 PERSONAL PROFILE

Please provide the requested information about yourself.

1a

| | |
|-------------------|----------------|
| | |
| Height Ft./In. | Weight Lbs. |

1b Have you had any change in weight in the last 12 months?
 Gain _____ lbs. Loss _____ lbs. N/A

2a Are you retired? Yes No

2b If yes, what was your occupation? _____

3a Are you currently employed? Yes No

3b If yes, what occupation? _____

3c Is the work Full-time or Part-time? Inside the home or Outside the home?

4 Please list any activities in which you regularly participate outside your home. (For example, vigorous exercise, walking, gardening.) _____

5a Have you smoked or used tobacco products within the past three years? Yes No

5b Do you use more than 1 (one) pack of tobacco products per day? Yes No

6a Do you drive an automobile? Yes No

6b If yes, approximate number of miles driven each year? _____

7 With whom do you live? No one Spouse/Partner Other _____

8 Are you pregnant? Yes No

9a Are you living in a retirement community? Yes No

9b If yes, please list any services you currently receive (For example, housecleaning, laundry, meals, medications.) _____

10 Are you currently receiving any Disability benefits or have you during the past 1 year? Yes No

- Please check all that apply:
- Disability Income Insurance
 - State or Federal Workers Compensation
 - State Insurance Program
 - Social Security
 - Occupational Disease Law
 - Employer's Liability Insurance

11 Have two or more years passed since you received any treatment or examination by **any** health care professional? Yes No

12 Who is your Primary Care Doctor with most of your medical records?

| | | | |
|------|-------|--|--|
| | | | |
| Name | Phone | | |

| | |
|----------------|----------|
| | |
| Street Address | Apt. No. |

| | | | | |
|------|-------|----------|--|--|
| | | | | |
| City | State | Zip Code | | |

| | | |
|----------------|--|--|
| | | |
| Date last seen | | |

Reason(s) last seen _____

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MEDICAL HISTORY – PART 3 HEALTH PROFILE

Please answer every question in this section by indicating “Yes” or “No”

- 1 In the **past 12 months**, have you had an application rejected for long term care, nursing home care, or other health insurance? Yes No
- 2 Within the past **5 years, (10 years for cancer)**, have you received any medical advice, examination, or treatment from a health care professional; taken any medications; or been medically diagnosed for:

| Yes | No | Condition | Yes | No | Condition | Yes | No | Condition | | | |
|-----|--------------------------|--------------------------|---|----|--------------------------|--------------------------|---|-----------|--------------------------|--------------------------|---|
| a | <input type="checkbox"/> | <input type="checkbox"/> | Cardiovascular or circulatory disorder including congestive heart failure (CHF), peripheral vascular disease, heart attack, chest pain, angina, high blood pressure or irregular heart beat | h | <input type="checkbox"/> | <input type="checkbox"/> | Asthma, chronic bronchitis, chronic obstructive pulmonary disease (COPD), emphysema, shortness of breath | o | <input type="checkbox"/> | <input type="checkbox"/> | Fracture |
| b | <input type="checkbox"/> | <input type="checkbox"/> | Cancer or non-cancerous tumors | i | <input type="checkbox"/> | <input type="checkbox"/> | Brain disorder, convulsions, epilepsy or seizures, dizziness or balance problems, fainting spells or black outs | p | <input type="checkbox"/> | <input type="checkbox"/> | Osteoarthritis |
| c | <input type="checkbox"/> | <input type="checkbox"/> | Hodgkin’s Disease, Lymphoma, Leukemia, other blood disorder | j | <input type="checkbox"/> | <input type="checkbox"/> | Depression, anxiety, mental, emotional or nervous disorder, or confusion, or memory loss | q | <input type="checkbox"/> | <input type="checkbox"/> | Osteoporosis |
| d | <input type="checkbox"/> | <input type="checkbox"/> | Skin ulcers | k | <input type="checkbox"/> | <input type="checkbox"/> | Tremors | r | <input type="checkbox"/> | <input type="checkbox"/> | Paralysis, weakness or numbness of the extremities |
| e | <input type="checkbox"/> | <input type="checkbox"/> | Non-insulin dependent diabetes | l | <input type="checkbox"/> | <input type="checkbox"/> | Visual disturbances | s | <input type="checkbox"/> | <input type="checkbox"/> | Replacement of the hip, knee or other joint |
| f | <input type="checkbox"/> | <input type="checkbox"/> | Insulin dependent diabetes # of units per day _____ | m | <input type="checkbox"/> | <input type="checkbox"/> | Amputation | t | <input type="checkbox"/> | <input type="checkbox"/> | Rheumatoid arthritis, Lupus, Scleroderma or other connective tissue disease |
| g | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis | n | <input type="checkbox"/> | <input type="checkbox"/> | Disabling back or spine injury | u | <input type="checkbox"/> | <input type="checkbox"/> | Other conditions causing crippling or limited motion or requiring use of an adaptive device, chronic pain or fatigue, or Fibromyalgia |

- 3 Within the **past three years**, have you been medically advised to enter or been confined to a hospital or other health care facility? Yes No
- 4 Within the **past three years**, have you: been confined to a nursing home, assisted living facility, or long term care facility? been medically advised to have surgery which has not been performed? received home health care? used adult day care? None
- 5 Within the **past five years**, have you been advised to limit, reduce, discontinue or seek counseling for the use of alcohol or drugs? Yes No
- 6 Within the **past five years**, have you received any medical advice, examination or treatment from a health care professional for any reason not previously stated? Yes No

In the space below you MUST provide details for any “Yes” answers to questions 1 through 6.

If needed, complete the additional medical information page that is provided.

Refers to number/letter above _____ Diagnosis date _____ Treatment date last seen _____

Reason Consulted/treated _____

Check here if treated by primary care physician (PCP). If not treated by PCP, give name, address, and phone for other treating professional

Refers to number/letter above _____ Diagnosis date _____ Treatment date last seen _____

Reason Consulted/treated _____

Check here if treated by primary care physician (PCP). If not treated by PCP, give name, address, and phone for other treating professional

Refers to number/letter above _____ Diagnosis date _____ Treatment date last seen _____

Reason Consulted/treated _____

Check here if treated by primary care physician (PCP). If not treated by PCP, give name, address, and phone for other treating professional

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MEDICAL HISTORY – PART 4 MEDICATIONS

1 Please provide the requested information. Are you currently taking any drugs or medications? Yes No

If yes, provide the information requested in the space below. If needed, complete the Additional Medical Information Page that is provided.

a Drug or Medication _____ Dosage _____ How long been taking? _____

Reason for taking _____

Check here if prescribed by Primary Care Physician (PCP) only. If not prescribed by PCP, give name, address and phone number of treating professional:

b Drug or Medication _____ Dosage _____ How long been taking? _____

Reason for taking _____

Check here if prescribed by Primary Care Physician (PCP) only. If not prescribed by PCP, give name, address and phone number of treating professional:

c Drug or Medication _____ Dosage _____ How long been taking? _____

Reason for taking _____

Check here if prescribed by Primary Care Physician (PCP) only. If not prescribed by PCP, give name, address and phone number of treating professional:

d Drug or Medication _____ Dosage _____ How long been taking? _____

Reason for taking _____

Check here if prescribed by Primary Care Physician (PCP) only. If not prescribed by PCP, give name, address and phone number of treating professional:

e Drug or Medication _____ Dosage _____ How long been taking? _____

Reason for taking _____

Check here if prescribed by Primary Care Physician (PCP) only. If not prescribed by PCP, give name, address and phone number of treating professional:

f Drug or Medication _____ Dosage _____ How long been taking? _____

Reason for taking _____

Check here if prescribed by Primary Care Physician (PCP) only. If not prescribed by PCP, give name, address and phone number of treating professional:

g Drug or Medication _____ Dosage _____ How long been taking? _____

Reason for taking _____

Check here if prescribed by Primary Care Physician (PCP) only. If not prescribed by PCP, give name, address and phone number of treating professional:

If you are taking more than 7 medications, please list them on the “Additional Medical Information Page.”

NOTIFICATION OF UNINTENTIONAL LAPSE

You can provide Prudential with the name of a friend or relative to notify if your Policy should lapse because the premium is not paid when due. This designation does not constitute an acceptance of liability by the person named. Prudential will notify you each year of your right to designate or change the existing designation for this purpose.

ONLY COMPLETE THE APPROPRIATE SECTION: NAME A DESIGNEE OR WAIVER OF NOTIFICATION.

Check here ONLY to name a designee, and provide the requested information about that person:

| | | |
|----------------|-------|-----------|
| | | |
| First Name | M.I. | Last Name |
| | | |
| Street Address | | Apt. No. |
| | | |
| City | State | Zip Code |

Check here only if you do not wish to name a person for this purpose and sign below.

WAIVER OF NOTIFICATION OPTION:

I understand that I have the right to name at least one person other than myself to receive notice of lapse of termination of my long term care insurance policy for non-payment of premium. I understand that notice will not be given until thirty-one days after the premium is due and not paid. **By my signature, I elect NOT to name any person to receive such notice.**

X _____ Applicant Signature

TO RESIDENTS OF ILLINOIS

The policy is not approved for Medicaid Asset Protection under the Illinois Long Term Care Partnership Program. However, the policy is an approved long term care policy under state insurance regulations. For information about policies approved under the Illinois Long Term Care Partnership Program, call the Senior Help-Line at the Illinois Department on Aging at 1.800.252.8966.

TO RESIDENTS OF IOWA

The policy does not qualify for Medicaid Asset Protection under the Iowa Long Term Care Asset Preservation Program. However, the policy is an approved long term care policy under state insurance regulations. For information about policies and certificates qualifying under the Iowa Long Term Care Asset Preservation Program, call the Senior Health Insurance Information Program of the Iowa Division of Insurance at 1.800.281.5705.

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THE PRUDENTIAL
INSURANCE COMPANY
OF AMERICA

LONG TERM CARE
CUSTOMER
SERVICE CENTER

PO BOX 8519
PHILADELPHIA PA 19176-8519
1.800.732.0416

LONG TERM CARE INSURANCE APPLICATION FOR EMPLOYER SPONSORED PROGRAM (ESP)

New Policy **Reinstatement** **Employer Sponsored Program (ESP)**
 Coverage Change Type of Coverage: Employee Spouse Partner (Indicate Current Policy Number if Coverage Change or Reinstatement request)

TO: THE PRUDENTIAL INSURANCE COMPANY OF AMERICA
Please print all information except where signatures are required. Use black ink. Read all questions carefully.

APPLICANT INFORMATION

Mr. Ms. Mrs. _____ Male Female
Applicant's Social Security #

First Name M.I. Last Name
(As it should appear on your Policy)

Street Address (No PO Boxes) Apt. No.

City State Zip Code

Date of Birth Age Daytime Phone Evening Phone

IF THE MAILING ADDRESS IS OTHER THAN THE ADDRESS GIVEN ABOVE, PLEASE COMPLETE THE FOLLOWING:

Address Apt. No.

City State Zip Code

Best Time to Call AM PM Marital Status Yes, married No, not married

Is your Spouse/Partner applying for this insurance? Yes No

If No, does he/she currently have Prudential Long Term Care insurance? Yes No

If Yes, give Policy/Certificate Number

Spouse/Partner First Name M.I. Last Name

 Spouse Partner
Spouse/Partner Social Security #

880206778

INSURANCE HISTORY

Indicate yes or no

If coverage is being replaced, please submit a completed Replacement Notice.

- 1 Are you covered by Medicaid or Medi-Cal (not Medicare)? Yes No
- 2 Do you have other long term care or accident and sickness insurance in force (including policies, certificates, health care service contracts, or health maintenance organization contracts)? Yes No
- 3 Did you have other long term care insurance in force during **the last 12 months**? Yes No
- 4 Do you intend to replace any of your medical health insurance with this insurance? Yes No

IF YOU ANSWERED YES TO QUESTIONS 2, 3, OR 4 OF THIS SECTION, PLEASE PROVIDE THE FOLLOWING INFORMATION

| | | | | |
|--------------------------------|-------------------------------------|--|--|------------------|
| <input type="checkbox"/> Group | <input type="checkbox"/> Individual | <input type="checkbox"/> Intend to replace? | <input type="checkbox"/> Did insurance lapse? | |
| <input type="checkbox"/> Group | <input type="checkbox"/> Individual | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Type of Coverage | Policy # | | | If yes give date |

| | | | | |
|--------------------------------|-------------------------------------|--|--|------------------|
| <input type="checkbox"/> Group | <input type="checkbox"/> Individual | <input type="checkbox"/> Intend to replace? | <input type="checkbox"/> Did insurance lapse? | |
| <input type="checkbox"/> Group | <input type="checkbox"/> Individual | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Type of Coverage | Policy # | | | If yes give date |

Full name and address of insurance company

MEDICAL HISTORY – PART 1 INSURABILITY PROFILE

Indicate yes or no

- 1 Have you had, do you currently have, or have you ever been diagnosed as having any of the following medical conditions:
 - a Acquired Immune Deficiency Syndrome (AIDS), or a Human Immunodeficiency Virus (HIV) infection? Yes No
 - b Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig’s Disease)? Yes No
 - c Alzheimer’s Disease, Chronic Memory Loss, frequent or persistent forgetfulness, senility, dementia, or Organic Brain Syndrome? Yes No
 - d Chronic Obstructive Pulmonary Disease (COPD) or Emphysema **in combination with:** Current Smoking; Congestive Heart Failure (CHF); Asthma; or Chronic Bronchitis? Yes No
 - e Congestive Heart Failure **in combination with:** Current Smoking, Angina or Heart Surgery; Asthma or Chronic Bronchitis; Diabetes; or Tuberculosis? Yes No
 - f Congestive Heart Failure, diagnosed or symptomatic, within **the past 12 months**? Yes No
 - g Immune System Disorder? Yes No
 - h Metastatic Cancer (Cancer that has spread from the original site or location)? Yes No
 - i Stroke or Cerebrovascular Accident (CVA)? Yes No
 - j Liver Cirrhosis? Yes No
 - k Multiple Sclerosis (MS), Muscular Dystrophy, Parkinson’s Disease, Huntington’s Disease? Yes No
 - l Transient Ischemic Attack (TIA) within **the past 5 years**; multiple TIA’s; or TIA in combination with Diabetes or any Heart Surgery? Yes No
 - m Within **the past 6 months**, have you had open heart surgery, spine surgery, back surgery? Yes No
- 2 Within **the past 48 months** have you had cancer of the: Yes No
 - Bone Brain Esophagus Liver Lung Ovary Pancreas Stomach
- 3 Do you use a four pronged cane, kidney dialysis, motorized scooter, oxygen, respirator, walker, wheelchair? Yes No
- 4 Within **the past 12 months** have you: Yes No
 - Used adult day care Needed home health care
 - Been medically advised to enter or been confined to: A nursing home An assisted living facility Other long term care facility
- 5 Do you currently need assistance or supervision by another person in performing any of the following activities: Yes No
 - Bathing Eating Toileting Dressing Bowel or Bladder Control Moving in and out of bed or chair
 - Taking your medication

If you answered “Yes” to any question in this insurability profile, we recommend that you do not submit this Application.

8802006778

MEDICAL HISTORY – PART 3 HEALTH PROFILE

Please answer every question in this section by indicating “Yes” or “No”

- 1 In the **past 12 months**, have you had an application rejected for long term care, nursing home care, or other health insurance? Yes No
- 2 Within the **past 5 years, (10 years for cancer)**, have you received any medical advice, examination, or treatment from a health care professional; taken any medications; or been medically diagnosed for:

| Yes | No | Condition | Yes | No | Condition | Yes | No | Condition | | | |
|-----|--------------------------|--------------------------|---|----|--------------------------|--------------------------|---|-----------|--------------------------|--------------------------|---|
| a | <input type="checkbox"/> | <input type="checkbox"/> | Cardiovascular or circulatory disorder including congestive heart failure (CHF), peripheral vascular disease, heart attack, chest pain, angina, high blood pressure or irregular heart beat | h | <input type="checkbox"/> | <input type="checkbox"/> | Asthma, chronic bronchitis, chronic obstructive pulmonary disease (COPD), emphysema, shortness of breath | o | <input type="checkbox"/> | <input type="checkbox"/> | Fracture |
| b | <input type="checkbox"/> | <input type="checkbox"/> | Cancer or non-cancerous tumors | i | <input type="checkbox"/> | <input type="checkbox"/> | Brain disorder, convulsions, epilepsy or seizures, dizziness or balance problems, fainting spells or black outs | p | <input type="checkbox"/> | <input type="checkbox"/> | Osteoarthritis |
| c | <input type="checkbox"/> | <input type="checkbox"/> | Hodgkin’s Disease, Lymphoma, Leukemia, other blood disorder | j | <input type="checkbox"/> | <input type="checkbox"/> | Depression, anxiety, mental, emotional or nervous disorder, or confusion, or memory loss | q | <input type="checkbox"/> | <input type="checkbox"/> | Osteoporosis |
| d | <input type="checkbox"/> | <input type="checkbox"/> | Skin ulcers | k | <input type="checkbox"/> | <input type="checkbox"/> | Tremors | r | <input type="checkbox"/> | <input type="checkbox"/> | Paralysis, weakness or numbness of the extremities |
| e | <input type="checkbox"/> | <input type="checkbox"/> | Non-insulin dependent diabetes | l | <input type="checkbox"/> | <input type="checkbox"/> | Visual disturbances | s | <input type="checkbox"/> | <input type="checkbox"/> | Replacement of the hip, knee or other joint |
| f | <input type="checkbox"/> | <input type="checkbox"/> | Insulin dependent diabetes # of units per day _____ | m | <input type="checkbox"/> | <input type="checkbox"/> | Amputation | t | <input type="checkbox"/> | <input type="checkbox"/> | Rheumatoid arthritis, Lupus, Scleroderma or other connective tissue disease |
| g | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis | n | <input type="checkbox"/> | <input type="checkbox"/> | Disabling back or spine injury | u | <input type="checkbox"/> | <input type="checkbox"/> | Other conditions causing crippling or limited motion or requiring use of an adaptive device, chronic pain or fatigue, or Fibromyalgia |

- 3 Within the **past three years**, have you been medically advised to enter or been confined to a hospital or other health care facility? Yes No
- 4 Within the **past three years**, have you: been confined to a nursing home, assisted living facility, or long term care facility? been medically advised to have surgery which has not been performed? received home health care? used adult day care? None
- 5 Within the **past five years**, have you been advised to limit, reduce, discontinue or seek counseling for the use of alcohol or drugs? Yes No
- 6 Within the **past five years**, have you received any medical advice, examination or treatment from a health care professional for any reason not previously stated? Yes No

In the space below you **MUST** provide details for any “Yes” answers to questions 1 through 6.

If needed, complete the additional medical information page that is provided.

Refers to number/letter above _____ Diagnosis date _____ Treatment date last seen _____

Reason Consulted/treated _____

Check here if treated by primary care physician (PCP). If not treated by PCP, give name, address, and phone for other treating professional

Refers to number/letter above _____ Diagnosis date _____ Treatment date last seen _____

Reason Consulted/treated _____

Check here if treated by primary care physician (PCP). If not treated by PCP, give name, address, and phone for other treating professional

Refers to number/letter above _____ Diagnosis date _____ Treatment date last seen _____

Reason Consulted/treated _____

Check here if treated by primary care physician (PCP). If not treated by PCP, give name, address, and phone for other treating professional

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MEDICAL HISTORY – PART 4 MEDICATIONS

1 Please provide the requested information. Are you currently taking any drugs or medications? Yes No
If yes, provide the information requested in the space below. If needed, complete the Additional Medical Information Page that is provided.

a Drug or Medication _____ Dosage _____ How long been taking? _____
Reason for taking _____
 Check here if prescribed by Primary Care Physician (PCP) only. If not prescribed by PCP, give name, address and phone number of treating professional:

b Drug or Medication _____ Dosage _____ How long been taking? _____
Reason for taking _____
 Check here if prescribed by Primary Care Physician (PCP) only. If not prescribed by PCP, give name, address and phone number of treating professional:

c Drug or Medication _____ Dosage _____ How long been taking? _____
Reason for taking _____
 Check here if prescribed by Primary Care Physician (PCP) only. If not prescribed by PCP, give name, address and phone number of treating professional:

d Drug or Medication _____ Dosage _____ How long been taking? _____
Reason for taking _____
 Check here if prescribed by Primary Care Physician (PCP) only. If not prescribed by PCP, give name, address and phone number of treating professional:

e Drug or Medication _____ Dosage _____ How long been taking? _____
Reason for taking _____
 Check here if prescribed by Primary Care Physician (PCP) only. If not prescribed by PCP, give name, address and phone number of treating professional:

f Drug or Medication _____ Dosage _____ How long been taking? _____
Reason for taking _____
 Check here if prescribed by Primary Care Physician (PCP) only. If not prescribed by PCP, give name, address and phone number of treating professional:

g Drug or Medication _____ Dosage _____ How long been taking? _____
Reason for taking _____
 Check here if prescribed by Primary Care Physician (PCP) only. If not prescribed by PCP, give name, address and phone number of treating professional:

If you are taking more than 7 medications, please list them on the “Additional Medical Information Page.”

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INSURANCE HISTORY

Indicate yes or no

If coverage is being replaced, please submit a completed Replacement Notice.

- 1 Are you covered by Medicaid or Medi-Cal (not Medicare)? Yes No
- 2 Do you have other long term care or accident and sickness insurance in force (including policies, certificates, health care service contracts, or health maintenance organization contracts)? Yes No
- 3 Did you have other long term care insurance in force during **the last 12 months**? Yes No
- 4 Do you intend to replace any of your medical health insurance with this insurance? Yes No

IF YOU ANSWERED YES TO QUESTIONS 2, 3, OR 4 OF THIS SECTION, PLEASE PROVIDE THE FOLLOWING INFORMATION

| | | | | | | | |
|---|----------------------|----------------------|--|--|----------------------|----------------------|----------------------|
| <input type="checkbox"/> Group <input type="checkbox"/> Individual | <input type="text"/> | <input type="text"/> | Intend to replace? <input type="checkbox"/> Yes <input type="checkbox"/> No | Did insurance lapse? <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| | Type of Coverage | Policy # | | | If yes give date | | |
| <input type="checkbox"/> Group <input type="checkbox"/> Individual | <input type="text"/> | <input type="text"/> | Intend to replace? <input type="checkbox"/> Yes <input type="checkbox"/> No | Did insurance lapse? <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| | Type of Coverage | Policy # | | | If yes give date | | |

Full name and address of insurance company

MEDICAL HISTORY – PART 1 INSURABILITY PROFILE

Indicate yes or no

- Yes No 1 Do you use a: Walker Oxygen Respirator Kidney Dialysis?
- Yes No 2 Within **the past 12 months** have you: Used Adult Day Care Needed Home Health Care
- Yes No Been medically advised to enter or been confined to:
 A Nursing Home An Assisted Living Facility Other Long Term Care Facility
- Yes No 3 Do you currently need assistance or supervision by another person in performing any of the following activities:
 Bathing Eating Toileting Bowel or Bladder Control
 Moving In and Out of Bed or Chair Dressing Taking your Medication
- Yes No 4 Have you had, do you currently have, or have you ever been diagnosed as having any of the following medical conditions:
a Organic Brain Syndrome, Dementia, Senility, Confusion, Memory Loss, or Alzheimer’s Disease?
b Metastatic Cancer (cancer that has spread from the original site or location)?
c Multiple Sclerosis (MS) Muscular Dystrophy, Multiple Transient Ischemic Attacks (TIA), Parkinson’s Disease, Amyotrophic Lateral Sclerosis (ALS), Stroke or Cerebrovascular Accident (CVA), Huntington’s Disease?

Attention Agent: The above conditions are uninsurable.

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THE PRUDENTIAL
INSURANCE COMPANY
OF AMERICA

LONG TERM CARE
CUSTOMER
SERVICE CENTER

PO BOX 8519
PHILADELPHIA PA 19176-8519
1.800.732.0416

[PRODUCT NAME] EMPLOYER SPONSORED PROGRAM (ESP) PLAN DESIGN SELECTION* A selection must be made for every option listed below.

Lifetime Maximum \$ 100,000 \$ 300,000 \$ 500,000 \$ 700,000 \$ 900,000
(Choose one option only.) \$ 200,000 \$ 400,000 \$ 600,000 \$ 800,000 \$ 1,000,000

Inflation Riders Automatic 5% Compound Increase Option Rider Automatic 3% Compound Increase Option Rider
(Choose only one option where available.)

Shared Care Options Shared Care Rider None Shared Care Partner Name _____
(Choose one option only.) (If elected, both partners must elect identical Plan Designs.)

Shortened Benefit Period Rider
Nonforfeiture Benefit Yes No

Premium Payment Mode Annual Semi-annual Quarterly Monthly EFT List Bill
(Choose one option only.)

Full Modal Premium \$ _____

Cash Submitted with Application \$ _____

Spouse/Partner Discount Yes No

Producer Discount Yes No

Loyalty Discount Yes No
(If yes indicate - Applicant has Prudential Policy)
 Life Individual Policy Number _____
 Annuity Individual Policy Number _____

*Not available with any other Affiliation discount.

ESP Discount* 10%
(Only where available.) (Please complete the ESP code and ESP name fields below.)

_____ Employer Name

_____ M.I. _____ Last Name

_____ Applicant's Social Security #

* Minimum participation requirements apply.





THE PRUDENTIAL
INSURANCE COMPANY
OF AMERICA

LONG TERM CARE
CUSTOMER
SERVICE CENTER

PO BOX 8519
PHILADELPHIA PA 19101-8519
1.800.732.0416

[PRODUCT NAME] EMPLOYER SPONSORED PROGRAM (ESP) PLAN DESIGN SELECTION* A selection must be made for every option listed below.

Lifetime Maximum (Choose one option only.)
 \$ 100,000 \$ 200,000 \$ 300,000 \$ 400,000 \$ 500,000 \$ 600,000 \$ 700,000 \$ 800,000 \$ 900,000 \$ 1,000,000

Inflation Riders (Choose only one option where available.)
 3% Automatic Compound Increase Option Rider 5% Automatic Compound Increase Option Rider

Shared Care Options (Choose one option only.)
 Shared Care Rider None Shared Care Partner Name _____
(If elected, both partners must elect identical Plan Designs.)

Shortened Benefit Period Rider Nonforfeiture Benefit
 Yes No

Premium Payment Mode (Choose one option only.)
 Annual Semi-annual Quarterly Monthly EFT

Full Modal Premium \$ _____

Cash Submitted with Application \$ _____

Spouse/Partner Discount Yes No

Producer Discount Yes No

Loyalty Discount Yes No
(If yes indicate - Applicant has Prudential Policy)

Life Individual Policy Number _____

Annuity Individual Policy Number _____

*Not available with any other Affiliation discount.

ESP Discount (Only where available.) 5% 10%
(Please complete the ESP code and ESP name fields below.)

ESP Code Employer Name

First Name M.I. Last Name

Applicant's Social Security #

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