Filing at a Glance

Company: The Prudential Insurance Company of America

Product Name: ORD 96200-2010 ET AL (Pru)	SERFF Tr Num: PRUD-126226042	State: Arkansas
TOI: L08 Life - Other	SERFF Status: Closed-Approved-Closed	State Tr Num: 43422
Sub-TOI: L08.000 Life - Other	Co Tr Num: ORD 96200-2010 ET AL-JSAR (PRU)	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Linda Bird
	Authors: Diane Barrios, Marcelle Chapman, Susan Eckler-Kerns, Rozelyn Hayes, Jessica Kaimo, David Koonce, Gil Ortiz, Eula Armstrong, John Steiniger, Genetta Williams	Disposition Date: 09/02/2009
	Date Submitted: 08/28/2009	Disposition Status: Approved-Closed
Implementation Date Requested: 02/01/2010		Implementation Date:
State Filing Description:		

General Information

Project Name: ORD 96200-2010 ET AL (Pru)
Project Number:
Requested Filing Mode: Review & Approval

Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:
Filing Status Changed: 09/02/2009

Deemer Date:
Submitted By: Rozelyn Hayes

Filing Description:

Status of Filing in Domicile: Pending
Date Approved in Domicile:
Domicile Status Comments: This filing is under review in our Domicile State, New Jersey.
Market Type: Individual
Group Market Size:
Group Market Type:
Explanation for Other Group Market Type:
State Status Changed: 09/09/2009
Created By: David Koonce
Corresponding Filing Tracking Number: PRUD-126225942

In Re: The Prudential Insurance Company of America
NAIC # 30468241
Individual Life
Form Numbers: ORD 96200-2010 et al
New Submission

Dear Commissioner:

We submit the enclosed applications, supplements and related forms for filing.

These are all new/revised forms. To assist in your review, we have included a listing of the forms that will be replaced along with the prior approval date and a separate attached summary explanation of the changes.

The goal of the application revision is to provide an updated application that reflects our current product portfolio, includes questions that are easier to understand, provides better knowledge of the customer to address current and future statutory requirements (i.e., Patriot Act), utilizes supplements to gather less frequently needed data and reduces freeform entries to allow for easier completion.

We will transition to the use of these new forms in 2010. Currently we are planning to begin the introduction of the new business application forms in early 2010 with an initial pilot in a limited number of states followed by a full roll-out of the new/revised forms in all approved states, which we are expecting to be completed by the end of the second quarter.

Form ORD 96200-2010 is the Application for Life Insurance. Form ORD 96200SURV-2010 is the Application for Life Insurance for Survivorship Life and form ORD 96200JUV-2010 is the Application for Life Insurance on a Juvenile. These other versions of the application are similar to the life insurance application except for the changes that are specific to the use of the application for survivorship life and juvenile insureds. Form ORD 84379-2010 is the Part 2 of Application for Life Insurance.

The enclosed supplements will be included in the application form based on the answers provided in the application or a standalone version of the supplement(s) will be used if it is completed separately from the application. The only difference in the standalone forms is the inclusion of a separate signature line.

The form numbers for the standalone supplement forms are:

FORM NUMBER TITLE
ORD 96200-2010 Aviation Aviation Supplement
ORD 96200-2010 Avocation General Avocation Supplement
ORD 96200-2010 Business Business Supplement

ORD 96200-2010 Child Rider Child Rider Supplement
ORD 96200-2010 Diving Diving Supplement
ORD 96200-2010 Financial Financial Supplement
ORD 96200-2010 Mountain Climbing Mountain Climbing Supplement
ORD 96200-2010 Racing Motorized Vehicle Racing Supplement
ORD 96200-2010 Owner Statement Policyowner Statement Supplement
ORD 96200-2010 Variable Variable Supplement

ORD 96200-2010 Overflow Details and form ORD 84379-2010 Additional Details will be used with the application forms to provide additional details.

Form ORD 96200CHG-2010 is the Request for Policy Change, which will be used with the application for term conversions or placed changes, which require evidence of insurability. This form will only be used when the person required to sign for the request is not required to sign the new application.

Form ORD 112730-2010 is the Good Health Statement; there are separate versions of the Good Health Statement for use with the Survivorship and Juvenile applications.

ORD 10164-2010 is the Amendments form, which will be used for any authorized changes to the application.

Form ORD 96200A-2010 is the Limited Insurance Agreement, which will be used with the application. Form ORD 96200F-2010 is the Authorization, Acknowledgments and Limited Insurance Agreement. This form is designed to include the limited insurance agreement, an authorization to release information and a variable contract acknowledgement into a single form to make it easier to do business with our producers and customers.

The required agent's statement relating to replacement is on page [2] Section F of application form ORD 96200-2010 and ORD 96200JUV-2010, and on page [3] Section F of application form ORD 96200SURV-2010.

Variable information in the forms is bracketed and an explanation of variability is enclosed.

The submitted forms include the exact language and format that will appear on the final versions of the forms, except for any slight differences in the shading, coloring, or spacing or other minor differences in the computer-printed forms.

The above forms are also being submitted by our subsidiary, Pruco Life Insurance Company.

If you have any questions, please call us toll-free at (888)-800-8244 or contact me via e-mail at John.Steiniger@Prudential.Com.

Company and Contact

Filing Contact Information

John Steiniger, Second Vice President
Individual Insurance Group
213 Washington Street
Newark, NJ 07102-2992

John.Steiniger@Prudential.com
973-802-6104 [Phone]
973-367-8134 [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	

Filing Fees

Fee Required?	Yes
Fee Amount:	$420.00
Retaliatory?	No
Fee Explanation:	$20 Per Form X 21 Forms = $420.00
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
The Prudential Insurance Company of America	$420.00	08/28/2009	30200394

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	09/02/2009	09/02/2009

Disposition

Disposition Date: 09/02/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Statement of Variability		Yes
Supporting Document	ORD 96200A-2010 Limited Insurance Agreement and ORD 96200F-2010 Authorization, Acknowledgement and Limited Insurance Agreement.		Yes
Supporting Document	Filing Grids		Yes
Supporting Document	List of Replaced Forms-Attachment I.		Yes
Supporting Document	Copies of Replaced Forms		Yes
Form	Application For Life Insurance		Yes
Form	Application For Life Insurance On A Juvenile (Age 0-17)		Yes
Form	Application For Life Insurance Survivorship Life		Yes
Form	Aviation Supplement		Yes
Form	General Avocation Supplement		Yes
Form	Business Supplement		Yes
Form	Child Rider Supplement		Yes
Form	Diving Supplement		Yes
Form	Financial Supplement		Yes
Form	Mountain Climbing Supplement		Yes
Form	Motorized Vehicle Racing Supplement		Yes
Form	Policyowner Statement Supplement		Yes
Form	Request For Policy Change		Yes
Form	Variable Supplement		Yes
Form	Overflow Details Supplement		Yes
Form	Good Health Statement		Yes
Form	Good Health Statement		Yes
Form	Good Health Statement		Yes
Form	Amendments		Yes
Form	Part 2 of Application For Life Insurance		Yes
Form	Part 2 of Application For Life Insurance Additional Details		Yes

Form Schedule

Lead Form Number: ORD 96200-2010

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	ORD 96200-2010	Application/ Enrollment Form	Application For Life Insurance	Initial		50.300	ORD_96200-2010_073109_PRU_Prefilled_KIT.pdf
	ORD 96200JUV-2010	Application/ Enrollment Form	Application For Life Insurance On A Juvenile (Age 0-17)	Initial		52.700	ORD_96200JUV-2010_073109_PRU_Prefilled_KIT.pdf
	ORD 96200SURV-2010	Application/ Enrollment Form	Application For Life Insurance Survivorship Life	Initial		53.600	ORD_96200SURV-2010_073109_PRU_Prefilled_KIT.pdf
	ORD 96200-2010 Aviation	Application/ Enrollment Form	Aviation Supplement	Initial		74.800	ORD_96200AVA-2010_061109_Prefilled.pdf
	ORD 96200-2010 Avocation	Application/ Enrollment Form	General Avocation Supplement	Initial		47.100	ORD_96200AVO-2010_033009_Prefilled.pdf
	ORD 96200-2010 Business	Application/ Enrollment Form	Business Supplement	Initial		50.900	ORD_96200BS-2010_041509_Prefilled.pdf
	ORD 96200-2010 Child Rider	Application/ Enrollment Form	Child Rider Supplement	Initial		54.500	ORD_96200CRS-2010_041509_Prefilled.pdf
	ORD	Application/	Diving Supplement	Initial		76.600	ORD_96200D

96200-2010 Diving	Enrollment Form				IV-2010_040109_Prefilled.pdf
ORD 96200-2010 Financial	Application/ Enrollment Form	Financial Supplement	Initial	36.200	ORD_96200FS-2010_041709_Prefilled.pdf
ORD 96200-2010 Mountain Climbing	Application/ Enrollment Form	Mountain Climbing Supplement	Initial	69.900	ORD_96200MC-2010_033009_Prefilled.pdf
ORD 96200-2010 Racing	Application/ Enrollment Form	Motorized Vehicle Racing Supplement	Initial	55.900	ORD_96200RAC-2010_033009_Prefilled.pdf
ORD 96200-2010 Owner Statement	Application/ Enrollment Form	Policyowner Statement Supplement	Initial	50.200	ORD_96200OS-2010_072309_Prefilled.pdf
ORD 96200CHG-2010	Application/ Enrollment Form	Request For Policy Change	Initial	34.300	ORD_96200CHG-2010_081809_Prefilled.pdf
ORD 96200-2010 Variable	Application/ Enrollment Form	Variable Supplement	Initial	44.900	ORD_96200VAR-2010_042309_Prefilled.pdf
ORD 96200-2010 Overflow Details	Application/ Enrollment Form	Overflow Details Supplement	Initial	49.800	ORD_96200OD-2010_061209_prefilled.pdf
ORD 112730-2010 Individual	Application/ Enrollment Form	Good Health Statement	Initial	44.900	ORD_112730-2010_040109_Prefilled.pdf

ORD 112730-2010 Juvenile	Application/ Enrollment Form	Good Health Statement	Initial	40.500	ORD_112730 JUV-2010_040109 _Prefilled.pdf
ORD 112730-2010 Survivorship	Application/ Enrollment Form	Good Health Statement	Initial	52.400	ORD_112730 SURV-2010_040109 _Prefilled.pdf
COMB 10164-2010	Application/ Enrollment Form	Amendments	Initial	62.700	COMB_10164 -2010_071309 _prefilled.pdf
ORD 84379-2010	Application/ Enrollment Form	Part 2 of Application For Life Insurance	Initial	40.400	ORD_84379-2010_050809 _Prefilled.pdf
ORD 84379-2010 Additional Details	Application/ Enrollment Form	Part 2 of Application For Life Insurance Additional Details	Initial	39.400	ORD_84379-2010AD-2010_061709 _prefilled.pdf

Prudential

APPLICATION FOR LIFE INSURANCE

PART 1

☐ Pruco Life Insurance Company
☑ The Prudential Insurance Company of America
Both are Prudential Financial companies.
Corporate Offices, Newark, New Jersey

POLICY NUMBER (IF KNOWN): XX XXX XXX

A. PROPOSED INSURED (POLICY OWNER UNLESS SECTION D IS COMPLETED)

1. Name: John Doe
2. Previous name (if changed in the last 5 yrs.): _____
3. Social Security number: XXX XX XXXX 4. State of birth (Country if not U.S.): Name of State
5. Gender: ☐ Female ☑ Male 6. Date of birth: 9 / 25 / 1971 7. Date policy to Save Age? ☐ Yes ☐ No
8. Are you a permanent, legal US resident? ☐ Yes ☐ No
   If No, provide country of legal residence, type and number of visa, expiration date and length of US residence **:**
9. Driver's license issuing state: Name of State Number: XXXXX-XXXXX-XXXXX Expiration date: XX-XX-XXXX
   If None, why not? **:** _____
10. Residence address (No PO boxes): Street 123 Main Street Apt _____
    City Any City State Any State ZIP XXXXX
11. e-mail address: XXXXX@XXXX.net
12. Home telephone number: XXX-XXX-XXXX Business telephone number (ext.): XXX-XXX-XXXX
13. Current employer name: ABC Company
    Business address: Street 13 Main Street Suite _____
    City Any City State Any State ZIP XXXXX
14. Occupation: Manager
    Duties: Administrative duties
15. Earned annual income $ 50,000 Unearned annual income $_____ Net worth $_____

B. PLAN OF INSURANCE

1. Amount of insurance applied for: $ 50,000 **[If $5,000,000 or more, complete *Financial Supplement.*]**
2. Product applied for:
   [☐ Term Essential®: ☐ 10 ☐ 15 ☐ 20 ☐ 30
   [☐ Term Elite®: ☐ 10 ☐ 15 ☐ 20
   [☐ ROP Term: ☐ 15 ☐ 20 ☐ 30
   [☐ PruLife® Custom Premier II (VUL II)]
   [Complete the *Variable Supplement.*]
   ☐ PruLife® Universal Life Plus (UL Plus)]
   ☐ PruLife® Universal Life Protector (UL Protector)]
   ☐ VUL Protector℠ (VULP) **Complete the *Variable Supplement.*]**
   ☑ Other: PGL
3. For **[UL Plus, UL Protector, VULP** and **VUL II**:] Death Benefit type:
   [☐ Type A (Level) ☐ Type B (Variable) ☐ Type C (Return of Premium) – **Not available for UL or VUL Protector.** – Interest rate: _____%]
4. For **[UL Plus, VULP** and **VUL II**:] Definition of life insurance:
   [☐ Cash Value Accumulation Test (CVAT) ☐ Guideline Premium Test (GPT)]
5. Requested Optional Benefits (Not all benefits are available for all products.):
   [☐ Waiver of Premium/Enhanced Disability Benefit
   [☐ Acceleration of Death Benefit (Living Needs Benefit)
   [☐ Accidental Death Benefit: Amount $_____
   ☐ Other Riders/Benefits (indicate amount where applicable): _____
   ☐ Overloan Protection Rider]
   ☐ Child Rider **Complete *Child Rider Supplement.*]**
   ☐ Automatic Premium Loan]
   [☐ Enhanced Cash Value Rider]

C. PREMIUM

1. Send notices (check one): ☑ Policyowner ☐ Other recipient: _____
   Send notices (check one): ☑ Policyowner's residence ☐ Other address:
   Street _____ Apt _____
   City _____ State _____ ZIP _____
2. Premium payment mode: [☑ Annual ☐ Semiannual ☐ Quarterly ☐ Monthly – Electronic Funds Transfer]
3. **[For non-term plans,]** billed premium: $_____

ORD 96200-2010

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

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

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

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

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

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

E. BENEFICIARY DETAILS

[If insurance is for business purposes, also complete the Business Insurance Supplement. If beneficiary is a trust, provide name of trust and trustee(s), date of trust and if trust is revocable or irrevocable. If beneficiary is a business, please list name of business, city and state where located and the form of business.]

Name: First	Middle	Last	Relationship to Proposed Insured	Age	Beneficiary Class Primary	Secondary/Contingent
Mary		Doe	Spouse	35	☑	☐
Robert		Doe	Son	10	☐	☑
					☐	☐
					☐	☐

F. INSURANCE HISTORY

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

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

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

4. Are you applying for or reinstating life insurance with any company? ☐ Yes ☑ No
   If Yes, give company name, amount applied for and total amount to be placed, including this application **:**
   _____
   _____

5. Have you had life or health insurance declined, postponed, rated or issued with an increased premium? ☐ Yes ☑ No
   If Yes, give company name, type of insurance, date, action taken and reason for action **:**
   _____
   _____

F. INSURANCE HISTORY (CONTINUED)

6. Is the proposed insured or proposed owner considering the transfer or sale to a life settlement company or other investor of: policy ownership; or, any interest in the policy benefits, either directly as a named beneficiary or indirectly as a beneficiary or owner of a trust or other entity? ☐ Yes ☑ No

   If Yes, provide details : _____

G. GENERAL INFORMATION

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

   [***If Yes, to Question 1 or 2 above, complete the appropriate Supplement.***]
3. Have you ever used tobacco or any other nicotine products such as cigarettes, cigars, pipe, chewing tobacco, snuff, nicotine gum or nicotine patch? ***If Yes, provide details*** : ☐ Yes ☑ No

Product Type(s)	Date Last Used	Frequency of Use

4. In the past five years, have you:
   a. had your driver's license denied, suspended or revoked? ☐ Yes ☑ No
   b. been convicted of or pled guilty to driving under the influence of alcohol and/or drugs? ☐ Yes ☑ No
   c. been convicted of or pled guilty to any moving violations? ☐ Yes ☑ No
5. Within the past 10 years, have you been arrested, convicted, or imprisoned for any crime and/or are you currently awaiting trial for any crime? ☐ Yes ☑ No
6. Will you live or travel outside the United States within the next 12 months? ☐ Yes ☑ No

   Details required include location (city/country), frequency, duration and purpose of each trip.
7. Give complete details of any "Yes" answers for questions 4 – 6, including question number and appropriate details:

   Question # Details

H. SPECIAL REQUESTS

Prudential

AVIATION SUPPLEMENT

Supplementary Declarations Forming a Part of the Application for Insurance

Pruco Life Insurance Company
The Prudential Insurance Company of America
Both are Prudential Financial companies.
Policy is issued by the company named at the beginning of this application.

POLICY NUMBER (IF KNOWN): XX XXX XXX

PROPOSED INSURED: John Doe

A. PILOTS ONLY

1. Do you hold a valid FAA Medical Certificate? ☑ Yes ☐ No
   ***If Yes*:** a. What class: Third Class Original issue date: 1/2000
   b. Was the medical certificate issued under a special issuance or with any restrictions? ☐ Yes ☑ No
   ***If Yes*:** ☐ Special issuance ☐ Restriction For what condition? _____
2. Do you hold a valid FAA Airman Certificate? ☑ Yes ☐ No
   ***If Yes*:** a. What type: ☐ Student ☐ Sport ☐ Recreational ☑ Private ☐ Commercial ☐ Airline transport
   b. What class: ☑ Airplane ☐ Rotorcraft ☐ Powered lift ☐ Glider ☐ Lighter than air ☐ Other _____
   c. What rating: ☑ Single engine ☐ Multi-engine ☐ Instrument rating ☐ Sea ☐ Land ☐ Other _____
3. a. What is the make and model of the primary aircraft that you currently fly?
   Make: Beechcraft Model: Bonaza
   b. Who owns the aircraft listed above? ABC Flying Service
   c. ***If self, do you have a valid aircraft insurance policy?*** ☐ Yes ☐ No
4. Have you ever been in any aviation accidents; received any FAA safety violations? ***If Yes, provide details in section D.*** ☐ Yes ☑ No
5. Flight time in hours:

Total Time	All Aircraft	Primary Aircraft	Hours of IFR Flying	Military – Primary Aircraft: _____	If Flown: Rotorcraft	Glider
Pilot in Command (PIC)	900	900				
Instructor						
Last 24 Months	300	300				
Last 12 Months	150	150				
Total Time	1000	1000				
Next 12 Months	150	150				

B. CREW MEMBERS ONLY

1. Describe duties aboard the aircraft: _____
2. What is the make and model of the primary aircraft that you are a crew member of?
   Make: _____ Model: _____
3. Flight time in hours: Last 24 months: _____ Last 12 months: _____ Total time: _____ Next 12 months: _____

C. FUTURE FLIGHT PLANS (ALWAYS COMPLETE)

1. Do you plan to fly a different aircraft within the next 24 months? ☐ Yes ☑ No
   If Yes, provide details. What are the make(s) and model(s) of the aircraft you plan to fly?
   Make: _____ Model: _____ Anticipated date: _____
   Make: _____ Model: _____ Anticipated date: _____
2. Within the next 24 months, do you plan that your future flying will be of a different nature, including aerobatic flight, stunt flying or racing? ***If Yes, provide details in section D.*** ☐ Yes ☑ No

D. DETAILS

[

Prudential

General Avocation Supplement

Supplementary Declarations Forming a Part of the Application For Insurance

Pruco Life Insurance Company
The Prudential Insurance Company of America
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Policy is issued by the company named at the beginning of this application.

POLICY NUMBER (IF KNOWN): XX XXX XXX

PROPOSED INSURED: John Doe

A. BACKGROUND DETAILS (LIST EACH AVOCATION YOU PARTICIPATE IN. USE ADDITIONAL SUPPLEMENTS AS NECESSARY.)

A. Avocation: Bungee Jumping

1. Description of activity: Bungee Jumping
2. Frequency of activity: 1 times per year Date of last activity: 6/2008
3. Experience: ☑ Less than one year ☐ One to three years ☐ More than three years
4. Certificate or license required? ☐ Yes ☑ No
   If Yes, describe :
5. Are you a member of any related club or associations? ☐ Yes ☑ No
   If Yes, describe :
6. Is safety equipment used or required? ☑ Yes ☐ No
   If Yes, describe : Standard equipment at location
7. Have you engaged in: ☐ exhibitions ☐ stunting ☐ exploration ☐ rescue ☐ dare-devil ☐ record-setting activities
8. Do you have any future plans to engage in:
   ☐ exhibitions ☐ stunting ☐ exploration ☐ rescue ☐ dare-devil ☐ record-setting activities
9. Do you participate or plan to participate in any avocation outside the United States? ☐ Yes ☑ No
   If Yes, describe :
10. For aerial avocations only: a. Average height for participation: _____ ft. and duration: _____
    b. Maximum height for participation: _____ ft. and duration: _____

B. Avocation:

1. Description of activity:
2. Frequency of activity: _____ times per year Date of last activity: _____
3. Experience: ☐ Less than one year ☐ One to three years ☐ More than three years
4. Certificate or license required? ☐ Yes ☐ No
   If Yes, describe :
5. Are you a member of any related club or associations? ☐ Yes ☐ No
   If Yes, describe :
6. Is safety equipment used or required? ☐ Yes ☐ No
   If Yes, describe :
7. Have you engaged in: ☐ exhibitions ☐ stunting ☐ exploration ☐ rescue ☐ dare-devil ☐ record-setting activities
8. Do you have any future plans to engage in:
   ☐ exhibitions ☐ stunting ☐ exploration ☐ rescue ☐ dare-devil ☐ record-setting activities
9. Do you participate or plan to participate in any avocation outside the United States? ☐ Yes ☐ No
   If Yes, describe :
10. For aerial avocations only: a. Average height for participation: _____ ft. and duration: _____
    b. Maximum height for participation: _____ ft. and duration: _____

B. ADDITIONAL INFORMATION

]

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Prudential

BUSINESS SUPPLEMENT

Supplementary Declarations Forming a Part of the Application for Insurance

Pruco Life Insurance Company
The Prudential Insurance Company of America
Both are Prudential Financial companies.
Policy is issued by the company named at the beginning of this application.

POLICY NUMBER (IF KNOWN): XX XXX XXX

PROPOSED INSURED: John Doe

INSTRUCTIONS

[Required for all insurance where the purpose of the insurance is for business purposes such as buy-sell, key person coverage or as collateral for a business loan. Submit copies of material that supplements the information requested, such as loan commitments, written buy-sell arrangements, audited financial statements or letters.]

A. BUSINESS INFORMATION

1. Source of Financial Information. (Check all that apply.)
   [☑ Proposed Insured ☐ Accountant/CPA ☐ Banker ☐ Attorney ☐ Producer] ☐ Other (specify)_____
2. Who determined the amount of insurance applied for? (Check all that apply.)
   [☑ Proposed Insured ☐ Accountant/CPA ☐ Banker ☐ Attorney ☐ Producer] ☐ Other (specify)_____
3. Name of company: _____
4. When was the business established? (mo/yr) 4 / 2000
5. The Proposed Insured is an: ☐ Employee ☐ Owner If owner, percentage of ownership: 100 %
6. List amount of business insurance in force and applied for in all companies on each officer or member of the business.

Name	Age	Ownership %	In force Amount	Amount Applied For
John Doe	57	100 %	$ 750,000	$ 500,000
		%	$	$
		%	$	$
		%	$	$
		%	$	$

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

   a. ☐ **Buy-Sell Arrangement**
      1. Is there a written buy-sell agreement? ☐ Yes ☐ No
      2. Are all other parties to agreement already covered by or applying for comparable amounts of insurance? ☐ Yes ☐ No
         If No, explain : _____

   b. ☐ **Key Person**
      1. Are all other key persons covered by or applying for comparable amounts of insurance? ☐ Yes ☐ No
         If No, explain : _____
      2. Why is the Proposed Insured considered "Key"? (Detail special skills/knowledge/ability.)
         _____
         _____

   c. ☐ **Business Loan Collateral**
      1. Is the insurance required by the creditor? ☐ Yes ☐ No
      2. Is the Proposed Insured personally responsible for the loan? ☐ Yes ☐ No
      3. Name of creditor/lending institution: _____
      4. What is the purpose of the loan? _____
      5. What is the amount of the loan? $_____
      6. What is the repayment schedule? _____
      7. Date loan was committed: ____/____ If not yet committed, please explain: _____

]

[**A. BUSINESS INFORMATION (CONTINUED)**

8. What is the total fair market value of the business? $ 1,250,000

9. Business values:
   a. Assets: $ 850,000
   b. Liabilities: $ 400,000
   c. Gross annual sales and/or revenue: $ 800,000
   d. Net profit after taxes: $ 450,000

10. Additional Comments:

B. SIGNATURES

[If this proposed policy will be an "employer-owned contract" under Internal Revenue Code Section 101(j), I (the owner) acknowledge and understand:

- that the policy death benefit may be income taxable unless I have satisfied the conditions of Section 101(j) **before policy issue**;
- that it remains my responsibility to ensure compliance with the requirements of Sections 101(j) and 6039I; and
- that The Prudential Insurance Company of America, its affiliates and producers are not authorized to provide tax or legal advice and that I must look to my legal and tax advisors for information concerning this law.]]

[

Prudential

CHILD RIDER SUPPLEMENT

Supplementary Declarations Forming a Part of the Application For Insurance

Corporate Offices, Newark, New Jersey

Pruco Life Insurance Company
The Prudential Insurance Company of America
Both are Prudential Financial companies.
Policy is issued by the company named at the beginning of this application.

PRIMARY PROPOSED INSURED: John Doe

POLICY NUMBER (IF KNOWN): XX XXX XXX **AMOUNT OF RIDER (PER CHILD):** $ 50,000

A. COMPLETE FOR ALL CHILDREN PROPOSED FOR COVERAGE UNDER THE RIDER

Name *(first, middle initial, last)*	Date of birth	Place of birth	Sex
1. Mary J. Doe	1/1/98	New Jersey	☐ Male ☑ Female
2. Robert A. Doe	10/20/93	New Jersey	☑ Male ☐ Female
3.			☐ Male ☐ Female
4.			☐ Male ☐ Female

[List additional children details in Section E.]

B. GENERAL INFORMATION

1. Is any child listed above:
   a. a foster child or child whose legal adoption is not final? ☐ Yes ☑ No
   b. living elsewhere than in the household of primary proposed insured? ☐ Yes ☑ No
   c. dependent on someone other than the primary proposed insured? ☐ Yes ☑ No
2. Does the primary proposed insured have other children under age 18 who are not proposed for coverage? ☐ Yes ☑ No
3. Will any child live or travel outside the United States within the next 12 months? ☐ Yes ☑ No

[***If Yes to any of the above, provide full details in Section E.***]

C. MEDICAL INFORMATION

1. Has a member of the medical profession ever treated any child for or diagnosed any child with:
   a. a heart murmur, a heart valve disorder or any other disorder of the heart or blood vessels? ☐ Yes ☑ No
   b. anemia or other abnormality of the blood (other than HIV)? ☐ Yes ☑ No
   c. a tumor, cancer, leukemia or lymphoma? ☐ Yes ☑ No
   d. diabetes, high blood sugar, glucose intolerance or other endocrine disorder? ☐ Yes ☑ No
   e. anxiety, depression, or any mental or psychiatric illness such as an eating disorder, Attention Deficit Hyperactivity Disorder (ADHD) or autism? ☐ Yes ☑ No
   f. asthma, apnea or any other disorder of the lungs or respiratory system? ☐ Yes ☑ No
   g. a seizure, cerebral palsy, mental retardation, developmental delay, or any other disorder of the brain or nervous system? ☐ Yes ☑ No
   h. any disorder of the liver, stomach or intestines? ☐ Yes ☑ No
   i. any disorder of the kidneys, urinary tract or genital systems? ☐ Yes ☑ No
   j. arthritis or any other disorder of the joints, muscles or bones? ☐ Yes ☑ No
2. Other than what has already been disclosed, within the past 5 years, has any child:
   a. been a patient in a hospital or other medical facility, other than for normal childbirth? ☐ Yes ☑ No
   b. had any other disease, disorder, condition or birth defect? ☐ Yes ☑ No
   c. been advised to have surgery, medical treatments or diagnostic procedures (other than for HIV)? ☐ Yes ☑ No
3. Has any child ever had life or health insurance declined, postponed or issued with an increased premium? ☐ Yes ☑ No
4. Have disability benefits ever been requested for any child? ☐ Yes ☑ No
5. Is any child currently receiving medical treatment or taking any medication or herbal supplement that has not already been disclosed? ☐ Yes ☑ No]

[

D. ADDITIONAL INFORMATION (COMPLETE FOR AGES 15 - 17)

1. In the past five years, has any child:
   a. flown as a pilot, student pilot or crew member or plan to become a pilot? ☐ Yes ☑ No
      [***If Yes, complete the appropriate supplement.***]
   b. participated in any activities such as motorized vehicle racing, SCUBA diving, mountain climbing, skydiving, extreme sports such as BASE jumping, bungee jumping or cave exploration, or intends to do so? ☐ Yes ☑ No
      [***If Yes, complete the appropriate supplement.***]
2. Has any child:
   a. had his/her driver's license denied, suspended or revoked? ☐ Yes ☑ No
   b. been convicted of or pled guilty to driving under the influence of alcohol and/or drugs? ☐ Yes ☑ No
   c. been convicted of or pled guilty to any moving violations? ☐ Yes ☑ No

   If Yes to 2a, b or c, provide details **:**

   Driver's license issuing state: _____ Number: _____ Expiration date: _____
3. Has any child been arrested, convicted, or imprisoned for any crime and/or are they awaiting trial for any crime? ☐ Yes ☑ No
4. Has a member of the medical profession ever treated any child for or diagnosed any child with an infection caused by the Human Immunodeficiency Virus (HIV) [(**Not applicable in CA. In WI:** AIDS virus, HIV antibody testing is limited to FDA-licensed enzyme immunoassay and confirmatory HIV antibody tests. Any test performed at an anonymous counseling and testing site or home testing is confidential and need not be revealed on this application.),] Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), or any other sexually transmitted disease? ☐ Yes ☑ No
5. Has any child ever:
   a. used cocaine, crack, marijuana, heroin, Ecstasy, PCP, LSD, methamphetamine, any other hallucinogenic drug or controlled substance? ☐ Yes ☑ No
   b. used amphetamines, barbiturates, sedatives, opiates or methadone, or controlled substance, except as prescribed by a physician? ☐ Yes ☑ No
   c. had or been advised to have treatment or counseling for alcohol or drug use, or been asked to reduce or eliminate their use? ☐ Yes ☑ No

E. DETAILS

- [Include details for any child to be covered that are not listed in Section A.]
- Give details of any "Yes" answer for sections B, C and/or D 2–5 above. Details should include, but are not limited to: section & question number, name of child, date, duration and name of illness, hospitalization, reason for checkup, medication and any advice or treatment given by a medical professional, name and address of physician seen.

_____

_____

_____

_____

_____

_____

_____

_____

F. TERMS AND CONDITIONS

The Company will pay the beneficiary named in the application any applicable insurance benefit either at the death of the primary proposed insured or at the death of an insured child after the death of the primary insured.

The policyowner is the primary proposed insured unless a different policyowner is named in the application. This is subject to any provisions for the automatic transfer of ownership stated in the policy.]

[

Prudential

DIVING SUPPLEMENT

Supplementary Declarations Forming a Part of the Application For Insurance

Pruco Life Insurance Company
The Prudential Insurance Company of America
Both are Prudential Financial companies.
Policy is issued by the company named at the beginning of this application.

POLICY NUMBER (IF KNOWN): XX XXX XXX

PROPOSED INSURED: John Doe

A. BACKGROUND DETAILS

1. Date of last dive: 11/2008
2. Diving history:

Depth Attained	Last 12 Months # of Dives	Last 12 Months Average Time	Next 12 Months # of Dives	Next 12 Months Average Time
Less than 50 feet	1	30 min.	1	30 min.
50 – 100 feet				
101 – 150 feet				
Greater than 150 feet				

3. Do you plan any future dives? ☐ Yes ☑ No
   If Yes, please provide information about your diving experience and qualifications **:**
   a. When did you learn to dive? _____
   b. Are you an active member of a diving club? ☐ Yes ☐ No
      If Yes, name of club **:** _____
   c. Are you a certified diver? ☐ Yes ☐ No
      If Yes, level and issuer of certification **:** _____
   d. Have you suffered any illness or injury due to diving? ☐ Yes ☐ No
      If Yes, provide details **:** _____
   e. Do you use mixed gas equipment? ☐ Yes ☐ No
      If Yes, what types and frequency of use **:** _____
   f. What is the maximum depth you have dived to, and reason for that dive?
      _____
   g. Do you dive alone? ☐ Yes ☐ No
      If Yes, how often and under what conditions **:** _____
   h. Where do you dive?
      1. Environment type (Check all that apply.):
         ☐ Open ocean ☐ Deep sea ☐ Coastal waters ☐ Lakes ☐ Rivers
         ☐ Quarries ☐ Other: _____
      2. Location (State/Country): _____
   i. Do you participate in any of the following? (Check all that apply.)
      ☐ Wreck diving (observation, salvage, photography or exploration) ☐ Treasure diving ☐ Depth record attempts
      ☐ Diving at high altitudes (i.e. mountain lakes) ☐ Ice diving ☐ Rescue attempts ☐ Cave or sink hole diving
      If you checked any of the above, provide full details including how often:
      _____

B. ADDITIONAL INFORMATION

_____

]

[

Prudential

FINANCIAL SUPPLEMENT

Supplementary Declarations Forming a Part of the Application for Insurance

Pruco Life Insurance Company
The Prudential Insurance Company of America
Both are Prudential Financial companies.
Policy is issued by the company named at the beginning of this application.

POLICY NUMBER (IF KNOWN): XX XXX XXX

PROPOSED INSURED(S): John Doe

INSTRUCTIONS [(REQUIRED FOR APPLICATIONS WITH A FACE AMOUNT OF $5,000,000 OR MORE)]

[• Financial information prepared by an independent third party is required for applications with a face amount of $10,000,000 or more.

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

A. FINANCIAL INFORMATION

1. Source of Financial Information (Check all that apply.)
   [☑ Proposed Insured ☐ Accountant/CPA ☐ Banker ☐ Attorney ☐ Producer] ☐ Other (specify):_____

2. Who determined the amount of insurance applied for? (Check all that apply.)
   [☐ Proposed Insured ☐ Accountant/CPA ☐ Banker ☐ Attorney ☑ Producer] ☐ Other (specify):_____

	1st Proposed Insured	2ND Proposed Insured (Survivorship Applications only)
3. Current Annual Household Income		
a. Gross Compensation (e.g., Salary, Commissions, Bonuses, etc.):	$ 300,000	$
b. Other Income (e.g., Dividends, Interest, Net Real Estate Income, etc.):	$ 100,000	$
c. Total Annual Cash Income before taxes:	$ 400,000	$
4. Net Worth (excluding any business interest)		
a. Liquid Assets (assets that can be easily changed to cash):	$ 400,000	$
b. Other Assets:	$ 5,000,000	$
c. Liabilities:	$ 500,000	$
d. Net Worth (excluding business):	$ 7,500,000	$
5. Business Related Assets:	$ Ø	$

6. Have either the proposed insured(s) or owner filed for bankruptcy within the past five years? ☐ Yes ☑ No
   [***If Yes, please provide details including whether bankruptcy was dismissed or discharged; type of bankruptcy (chapter); whether it was personal or business related; current status; single or multiple occurrences; any outstanding judgments, liens or garnishments, etc.***]

7. Additional Comments:_____]

[

Prudential

MOUNTAIN CLIMBING SUPPLEMENT

Supplementary Declarations Forming a Part of the Application for Insurance

Pruco Life Insurance Company
The Prudential Insurance Company of America
Both are Prudential Financial companies.
Policy is issued by the company named at the beginning of this application.

POLICY NUMBER (IF KNOWN): XX XXX XXX

PROPOSED INSURED: John Doe

A. BACKGROUND DETAILS

1. How long have you been mountain climbing? 5 Years
2. Date of your last climb: 7/2008
3. Total number of climbs: 7
4. Average height climbed: 10,000 feet
5. Are you a member of a climbing club? ☑ Yes ☐ No
   If Yes, name of club **:** Colorado Mountain Club
6. Do you ever climb solo or free (without use of climbing aids)? ☐ Yes ☑ No
   If Yes, provide details **:** _____

7a. Countries outside the U.S. where you have climbed or intend to climb:
None

7b. Geographic regions you have climbed in:
☐ Arctic ☐ Himalayan
☐ Antarctica ☐ Other _____

8. Type(s) of terrain involved in climbing:
☑ Rock ☐ Artificial Climbing Walls
☐ Snow/Ice ☐ Other (Describe): _____

9. Do you have any plans to climb in other/different regions or terrains in the future? ☐ Yes ☑ No
   If Yes, provide details (including each location planned, increase in altitude, time of year, climbing style, etc.) **:**

10. Season(s) of the year when you climb:
☐ Winter ☑ Spring
☑ Summer ☐ Fall

11. Any climbs above 13,000 feet (4,000 meters)? ☐ Yes ☑ No
   If Yes, provide details including total number of climbs, heights attained, frequency and safety equipment used **:**

B. ADDITIONAL INFORMATION

]

[

Prudential

POLICYOWNER STATEMENT SUPPLEMENT

Supplementary Declarations Forming a Part of the Application For Insurance

Corporate Offices, Newark, New Jersey

Pruco Life Insurance Company
The Prudential Insurance Company of America
Both are Prudential Financial companies.
Telephone: 973-802-6000

POLICY NUMBER (IF KNOWN): XX XXX XXX

PROPOSED INSURED(S): Mary Doe

POLICYOWNER: John Doe

Prudential will not knowingly participate in a life insurance sale where the sale of the policy in a secondary market or the participation of investors in the policy death benefits is being considered. Accordingly, the Policyowner is asked to answer the following questions:

1. Have you or the proposed insured been offered "free insurance" or any inducement such as a cash payment, gifts, loan proceeds in excess of the amount necessary to fund the policy, or anything else of value as an encouragement to apply for this life insurance policy? ☐ Yes ☑ No
2. Have you or the proposed insured been solicited to sell or transfer, or had any discussions about selling any of the following to a life settlement company or group of investors in the next five years: the proposed life insurance policy; any other life insurance policy on the life of the proposed insured; or, a trust, limited liability company or other entity that has been or will be established to own the policy? ☐ Yes ☑ No
3. Have you or the proposed insured entered into or been offered a financing arrangement where a lender or other third party, other than your employer or family member, will receive any portion of the death benefit of the policy applied for in excess of repayment of the principal and interest? ☐ Yes ☑ No

Provide details to any Yes answers to Questions 1 – 3:

Producer's statement:

1. I represent that all answers to the above questions are correct, true and complete, to the best of my knowledge and belief.
2. I have no knowledge of any plans for the policy being applied for to be sold to a life settlement or viatical company.]

[

Prudential

MOTORIZED VEHICLE RACING SUPPLEMENT

Supplementary Declarations Forming a Part of the Application for Insurance

Pruco Life Insurance Company
The Prudential Insurance Company of America
Both are Prudential Financial companies.
Policy is issued by the company named at the beginning of this application.

POLICY NUMBER (IF KNOWN): XX XXX XXX

PROPOSED INSURED: John Doe

A. BACKGROUND DETAILS

1. How long have you been racing? 5 Years
2. Date of your last race: 9/2008
3. Total number of races: 15
4. What type of vehicle is being driven?
   ☑ Automobile ☐ Motorcycle ☐ Boat ☐ Snowmobile ☐ Other: _____
5. What kind of track do you race on?
   ☐ Automobile: ☐ Permanent/Paved Road Course ☐ Temporary/Paved Road Course ☐ Hill Climb ☑ Drag Strip
   ☐ Permanent/Paved Oval ☐ Temporary Oval ☐ Off-Road ☐ Other: _____
   ☐ Motorcycle: ☐ Permanent/Paved Road Course ☐ Temporary/Paved Road Course ☐ Hill Climb ☐ Motocross
   ☐ Permanent/Paved Oval ☐ Temporary Oval ☐ Off-Road ☐ Supercross
   ☐ Drag Strip ☐ Other: _____
   ☐ Boat: ☐ Closed Course (Inland) ☐ Closed Course (Ocean) ☐ Open Ocean
   ☐ Snowmobile (explain): _____
   ☐ Other (explain): _____
6. Are the events you participate in sanctioned by any regulatory body? ☑ Yes ☐ No
   If Yes, provide name of sanctioning body **:** NHRA
   What specific safety requirements are mandated by the sanctioning body?
   ☐ Roll Cages ☐ Head and Neck Restraints
   ☐ On-site Medical Personnel ☑ Other: fire resistant suit
7. Have you had any formalized training? ☑ Yes ☐ No
   If Yes, please list racing schools **:** Skip Barber Racing School
8. Is participation in the above racing your: ☐ Occupation ☑ Avocation (not primary source of income)
9. Have you been involved in any accidents that required hospitalization as a result of your racing? ☐ Yes ☑ No
   If Yes, please describe **:** _____

B. VEHICLE DETAILS

1. Generic type (e.g., drag racer, stock, hydrofoil): Drag Racing
2. Make: Chevy
3. Model: Camaro
4. Engine Displacement (cc): 5 Liters
5. Horsepower: 475
6. Average Speed (mph): 100 MPH
7. Maximum Speed (mph): 120 MPH

C. ADDITIONAL INFORMATION

]

[

Prudential

VARIABLE SUPPLEMENT

Supplementary Declarations Forming a Part of the Application for Insurance

Pruco Life Insurance Company
The Prudential Insurance Company of America
Both are Prudential Financial companies.
Policy is issued by the company named at the beginning of this application.

PROPOSED INSURED: John Doe

POLICY NUMBER (IF KNOWN): xx xxx xxx

1. INVESTMENT OPTIONS AND ALLOCATIONS

[I request that net premium payments be allocated to the investment options selected below. **Investment allocations must be made in whole numbers and the total allocation must equal 100%.**

Investment Option	Code	Allocation	Investment Option	Code	Allocation
Equity	CSTK	50 %	Fixed Rate Option	FXRT	50 %
		%			%
		%			%
		%			%
		%			%
		%			%
		%			%
		%			%
		%			%
		%			%]
				Total	**1 0 0** %

2. ALLOCATED CHARGES

[You may select up to two variable investment options from which your monthly charges will be deducted.

- Allocations must be in whole percentages.
- The Fixed Rate Option can not be chosen.
- If you do not specify an allocation of monthly charges or if there is not enough money to deduct from the selected investment options, charges will be deducted from the remaining investment options on a pro-rata basis.
- The sum of all percentages must equal 100 percent.

Investment Option	Code	Allocation	Investment Option	Code	Allocation
		%			%
				Total	**1 0 0** %]

3. TELEPHONE REALLOCATIONS / TRANSFER PRIVILEGES

[If more than one owner, telephone reallocations/transfer privileges are **not** allowed.

☐ I do not wish to authorize telephone reallocations/transfers. I understand that by not taking this option any future request for this option must be submitted in writing.]

I believe this contract meets my insurance needs and financial objectives. I acknowledge receipt of a current prospectus for the contract. I understand that the contract's value and death benefit may vary depending on the contract's investment experience. ☐ Yes ☐ No

An illustration of values is available upon request.]

PART 2

A. PERSONAL PHYSICIAN INFORMATION

Name Dr. William Smith

Address: Street 23 Main Street Suite _____

City Any City State Any State ZIP XXXXX

Telephone number: (XXX) XXX-XXXX Date last seen: 10/31/2001

Reason last seen: Check up

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

B. PHYSICAL MEASUREMENTS

1. Height: 5' feet 11" inches Weight: 180 pounds
2. Within the last 12 months, have you had a change of weight (gain or loss) of more than 10 pounds? ☐ Yes ☑ No
   If Yes, provide details :_____

C. FAMILY HISTORY

1. Have any immediate family members (mother, father, brother, sister) been diagnosed with or died from coronary artery disease, cerebrovascular disease, diabetes or cancer before age 70? ☐ Yes ☑ No
   If Yes, provide details including which member and medical condition, age at diagnosis, and age at death (if applicable) :
   _____
   _____
   _____
   _____
2. **Father:** Current age 65 or Age at death: _____ **Mother:** Current age 65 or Age at death: _____

D. MEDICAL INFORMATION

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

(CONTINUED)

D. MEDICAL INFORMATION (CONTINUED)

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

Question #	Diagnosis	Date of Onset	Date of Recovery	Medication/ Treatment Prescribed	Physician/Hospital Name, Address & Phone Number
1g	Cold	10/1/2001	10/3/2001		Dr. William Smith
					23 Main Street
					Any City, Any State XXXXX
					XXX-XXX-XXXX

AGREEMENTS

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

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

FRAUD WARNING

[(Not applicable in **AZ**.)] Any person who knowingly:

[• **AR, HI, LA, NM, TN, VA and WA**: and intentionally gives false or deceptive information when completing an application for insurance or filing a claim, for the purpose of defrauding an insurance company may be subject to fines, denial of insurance benefits, or confinement in prison.

- **CO:** and intentionally gives false or deceptive information when completing an application for insurance or filing a claim, for the purpose of defrauding an insurance company may have committed fraud, or may have violated state law. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.
- **DC:** presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
- **MD:** and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
- **OH:** and with 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 is guilty of insurance fraud.
- **PA:** 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 commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.]

[• **All other states:**] and intentionally gives false or deceptive information when completing an application for insurance or filing a claim, for the purpose of defrauding an insurance company may have committed fraud, or may have violated state law.

SIGNATURES

[Check applicable boxes:

IRS Certification: Under penalties of perjury, the policyowner certifies that:

☐ The number shown on the application is my correct Social Security/Tax ID number.

☐ I am not subject to backup withholding under Section 3406(a)(1)(C) of the Internal Revenue Code.

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

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

Signed at (**STATE**) Name of State _____ on (**DATE**) 02/01/2007 _____

➔ Signature of proposed insured **X** *John Doe* _____

If policyowner is different from the proposed insured:

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

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

Name of entity _____

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

Title of officer/trustee(s) _____

➔ **Signature of producer** **X** *Richard Roe* _____

ORD 96200-2010

Prudential

Application for Life Insurance on a Juvenile (Age 0 – 17)

PART 1

☐ Pruco Life Insurance Company
☑ The Prudential Insurance Company of America
Both are Prudential Financial companies.
Corporate Offices, Newark, New Jersey

POLICY NUMBER (IF KNOWN): XX XXX XXX

A. PROPOSED INSURED

1. Name: Jane Doe
2. Previous name (if changed in the last 5 yrs.): _____
3. Social Security number: XXX XX XXXX 4. State of birth (Country if not U.S.): Name of State
5. Gender: ☑ Female ☐ Male 6. Date of birth: 2 / 4 / 94 7. Date policy to Save Age? ☐ Yes ☐ No
8. Is the child a permanent, legal US resident? ☐ Yes ☐ No
   If No, provide country of legal residence, type and number of visa, expiration date and length of US residence **:**
   _____
9. Residence address (No PO boxes): Street 123 Main Street Apt _____
   City Any City State Any State ZIP XXXXX
10. Home telephone number: XXX-XXX-XXXX
11. Is the child:
    a. a foster child or child whose legal adoption is not final? ☐ Yes ☑ No
    b. living elsewhere than in the household of the policyowner? ☐ Yes ☑ No
    c. dependent on someone other than the policyowner? ☐ Yes ☑ No

B. PLAN OF INSURANCE

1. Amount of insurance applied for: $ 50,000
2. Product applied for:
   [☐ PruLife® Universal Life Plus (UL Plus)]
   [☐ PruLife® Universal Life Protector (UL Protector)]
   ☑ Other: PGL
   [☐ PruLife® Custom Premier II (VUL II)]
   [**Complete the *Variable Supplement.***]
   [☐ VUL Protector℠ (VULP) **Complete the *Variable Supplement.***]
3. For [**UL Plus, UL Protector, VULP** and **VUL II**:] Death Benefit type:
   [☑ Type A (Level) ☐ Type B (Variable) ☐ Type C (Return of Premium) – **Not available for UL or VUL Protector.** – Interest rate: _____%]
4. For [**UL Plus, VULP** and **VUL II**:] Definition of life insurance:
   [☐ Cash Value Accumulation Test (CVAT) ☐ Guideline Premium Test (GPT)]
5. Requested Optional Benefits (Not all benefits are available for all products.):
   [☐ Waiver of Premium/Enhanced Disability Benefit
   ☐ Acceleration of Death Benefit (Living Needs Benefit)
   ☐ Overloan Protection Rider
   ☐ Enhanced Cash Value Rider
   ☐ Accidental Death Benefit: Amount $_____]
   ☐ Other Riders/Benefits *(indicate amount where applicable)*: _____

C. PREMIUM

1. Send notices (check one): ☑ Policyowner ☐ Other recipient: _____
   Send notices (check one): ☑ Policyowner's residence ☐ Other address:
   Street _____ Apt _____
   City _____ State _____ ZIP _____
2. Premium payment mode: [☑ Annual ☐ Semiannual ☐ Quarterly ☐ Monthly – Electronic Funds Transfer]
3. Billed premium: $_____

D. OWNER

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

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

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

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

E. BENEFICIARY DETAILS

[If beneficiary is a trust, provide name of trust and trustee(s), date of trust and if trust is revocable or irrevocable.]

Name: First	Middle	Last	Relationship to Proposed Insured	Age	Beneficiary Class Primary	Beneficiary Class Secondary/Contingent
John		Doe	Father	37	☑	☐
Mary		Doe	Mother	35	☐	☑
					☐	☐
					☐	☐

F. INSURANCE HISTORY

1. Family Insurance Program:

Family Member	Age	Amount of Existing Life Insurance	Family Member	Age	Amount of Existing Life Insurance
Father	37	$ 100,000	Brother(s)		$
Mother	35	$ 100,000	Sister(s)		$

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

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

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

5. Are there other applications for new life insurance or the reinstatement of life insurance on the life of the child? ☐ Yes ☑ No
   ***If Yes, give company name, amount applied for and total amount to be placed*:**
   _____
6. Has the child ever had life or health insurance declined, postponed, rated or issued with an increased premium? ☐ Yes ☑ No
   ***If Yes, give company name, type of insurance, date, action taken and reason for action*:**
   _____

G. GENERAL INFORMATION

1. Will the child live or travel outside the United States within the next 12 months? ☐ Yes ☑ No
   If Yes, list location (cities/countries), purpose and duration of each trip : _____

For Age 15 – 17 only:

2. In the past five years, has the child flown as a pilot, student pilot or crew member or does he/she intend to become a pilot? ☐ Yes ☑ No
3. In the past five years, has the child participated in any activities such as motorized vehicle racing, SCUBA diving, mountain climbing, skydiving, extreme sports such as BASE jumping, bungee jumping or cave exploration, or does he/she intend to? ☐ Yes ☑ No
   [***If Yes, to Question 2 or 3 above, complete the appropriate Supplement.***]
4. Has the child ever used tobacco or any other nicotine products such as cigarettes, cigars, pipe, chewing tobacco, snuff, nicotine gum or nicotine patch? ***If Yes, provide details*** : ☐ Yes ☑ No

Product Type(s)	Date Last Used	Frequency of Use

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

   If Yes to 5a, b or c, provide the following :

   Driver's license issuing state: _____ Number: _____ Expiration date: _____
6. Has the child been arrested, convicted, or imprisoned for any crime and/or is he/she currently awaiting trial for any crime? ☐ Yes ☑ No
7. Give complete details of any "Yes" answers for questions 5 and 6, including question number and appropriate details:

   Question # Details

H. SPECIAL REQUESTS

Prudential

AVIATION SUPPLEMENT

Supplementary Declarations Forming a Part of the Application for Insurance

Pruco Life Insurance Company
The Prudential Insurance Company of America
Both are Prudential Financial companies.
Policy is issued by the company named at the beginning of this application.

POLICY NUMBER (IF KNOWN): XX XXX XXX

PROPOSED INSURED: John Doe

A. PILOTS ONLY

1. Do you hold a valid FAA Medical Certificate? ☑ Yes ☐ No
   ***If Yes*:** a. What class: Third Class Original issue date: 1/2000
   b. Was the medical certificate issued under a special issuance or with any restrictions? ☐ Yes ☑ No
   ***If Yes*:** ☐ Special issuance ☐ Restriction For what condition? _____
2. Do you hold a valid FAA Airman Certificate? ☑ Yes ☐ No
   ***If Yes*:** a. What type: ☐ Student ☐ Sport ☐ Recreational ☑ Private ☐ Commercial ☐ Airline transport
   b. What class: ☑ Airplane ☐ Rotorcraft ☐ Powered lift ☐ Glider ☐ Lighter than air ☐ Other _____
   c. What rating: ☑ Single engine ☐ Multi-engine ☐ Instrument rating ☐ Sea ☐ Land ☐ Other _____
3. a. What is the make and model of the primary aircraft that you currently fly?
   Make: Beechcraft Model: Bonaza
   b. Who owns the aircraft listed above? ABC Flying Service
   c. ***If self, do you have a valid aircraft insurance policy?*** ☐ Yes ☐ No
4. Have you ever been in any aviation accidents; received any FAA safety violations? ***If Yes, provide details in section D.*** ☐ Yes ☑ No
5. Flight time in hours:

Total Time	All Aircraft	Primary Aircraft	Hours of IFR Flying	Military – Primary Aircraft: _____	If Flown: Rotorcraft	Glider
Pilot in Command (PIC)	900	900				
Instructor						
Last 24 Months	300	300				
Last 12 Months	150	150				
Total Time	1000	1000				
Next 12 Months	150	150				

B. CREW MEMBERS ONLY

1. Describe duties aboard the aircraft: _____
2. What is the make and model of the primary aircraft that you are a crew member of?
   Make: _____ Model: _____
3. Flight time in hours: Last 24 months: _____ Last 12 months: _____ Total time: _____ Next 12 months: _____

C. FUTURE FLIGHT PLANS (ALWAYS COMPLETE)

1. Do you plan to fly a different aircraft within the next 24 months? ☐ Yes ☑ No
   If Yes, provide details. What are the make(s) and model(s) of the aircraft you plan to fly?
   Make: _____ Model: _____ Anticipated date: _____
   Make: _____ Model: _____ Anticipated date: _____
2. Within the next 24 months, do you plan that your future flying will be of a different nature, including aerobatic flight, stunt flying or racing? ***If Yes, provide details in section D.*** ☐ Yes ☑ No

D. DETAILS

_____

Prudential

General Avocation Supplement

Supplementary Declarations Forming a Part of the Application For Insurance

Pruco Life Insurance Company
The Prudential Insurance Company of America
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Policy is issued by the company named at the beginning of this application.

POLICY NUMBER (IF KNOWN): XX XXX XXX

PROPOSED INSURED: John Doe

A. BACKGROUND DETAILS (LIST EACH AVOCATION YOU PARTICIPATE IN. USE ADDITIONAL SUPPLEMENTS AS NECESSARY.)

A. Avocation: Bungee Jumping

1. Description of activity: Bungee Jumping
2. Frequency of activity: 1 times per year Date of last activity: 6/2008
3. Experience: ☑ Less than one year ☐ One to three years ☐ More than three years
4. Certificate or license required? ☐ Yes ☑ No
   If Yes, describe :
5. Are you a member of any related club or associations? ☐ Yes ☑ No
   If Yes, describe :
6. Is safety equipment used or required? ☑ Yes ☐ No
   If Yes, describe : Standard equipment at location
7. Have you engaged in: ☐ exhibitions ☐ stunting ☐ exploration ☐ rescue ☐ dare-devil ☐ record-setting activities
8. Do you have any future plans to engage in:
   ☐ exhibitions ☐ stunting ☐ exploration ☐ rescue ☐ dare-devil ☐ record-setting activities
9. Do you participate or plan to participate in any avocation outside the United States? ☐ Yes ☑ No
   If Yes, describe :
10. For aerial avocations only: a. Average height for participation: _____ ft. and duration: _____
    b. Maximum height for participation: _____ ft. and duration: _____

B. Avocation:

1. Description of activity:
2. Frequency of activity: _____ times per year Date of last activity: _____
3. Experience: ☐ Less than one year ☐ One to three years ☐ More than three years
4. Certificate or license required? ☐ Yes ☐ No
   If Yes, describe :
5. Are you a member of any related club or associations? ☐ Yes ☐ No
   If Yes, describe :
6. Is safety equipment used or required? ☐ Yes ☐ No
   If Yes, describe :
7. Have you engaged in: ☐ exhibitions ☐ stunting ☐ exploration ☐ rescue ☐ dare-devil ☐ record-setting activities
8. Do you have any future plans to engage in:
   ☐ exhibitions ☐ stunting ☐ exploration ☐ rescue ☐ dare-devil ☐ record-setting activities
9. Do you participate or plan to participate in any avocation outside the United States? ☐ Yes ☐ No
   If Yes, describe :
10. For aerial avocations only: a. Average height for participation: _____ ft. and duration: _____
    b. Maximum height for participation: _____ ft. and duration: _____

B. ADDITIONAL INFORMATION

[

Prudential

DIVING SUPPLEMENT

Supplementary Declarations Forming a Part of the Application For Insurance

Pruco Life Insurance Company
The Prudential Insurance Company of America
Both are Prudential Financial companies.
Policy is issued by the company named at the beginning of this application.

POLICY NUMBER (IF KNOWN): XX XXX XXX

PROPOSED INSURED: John Doe

A. BACKGROUND DETAILS

1. Date of last dive: 11/2008
2. Diving history:

Depth Attained	Last 12 Months # of Dives	Last 12 Months Average Time	Next 12 Months # of Dives	Next 12 Months Average Time
Less than 50 feet	1	30 min.	1	30 min.
50 – 100 feet				
101 – 150 feet				
Greater than 150 feet				

3. Do you plan any future dives? ☐ Yes ☑ No
   If Yes, please provide information about your diving experience and qualifications **:**
   a. When did you learn to dive? _____
   b. Are you an active member of a diving club? ☐ Yes ☐ No
      If Yes, name of club **:** _____
   c. Are you a certified diver? ☐ Yes ☐ No
      If Yes, level and issuer of certification **:** _____
   d. Have you suffered any illness or injury due to diving? ☐ Yes ☐ No
      If Yes, provide details **:** _____
   e. Do you use mixed gas equipment? ☐ Yes ☐ No
      If Yes, what types and frequency of use **:** _____
   f. What is the maximum depth you have dived to, and reason for that dive?
      _____
   g. Do you dive alone? ☐ Yes ☐ No
      If Yes, how often and under what conditions **:** _____
   h. Where do you dive?
      1. Environment type (Check all that apply.):
         ☐ Open ocean ☐ Deep sea ☐ Coastal waters ☐ Lakes ☐ Rivers
         ☐ Quarries ☐ Other: _____
      2. Location (State/Country): _____
   i. Do you participate in any of the following? (Check all that apply.)
      ☐ Wreck diving (observation, salvage, photography or exploration) ☐ Treasure diving ☐ Depth record attempts
      ☐ Diving at high altitudes (i.e. mountain lakes) ☐ Ice diving ☐ Rescue attempts ☐ Cave or sink hole diving
      If you checked any of the above, provide full details including how often:
      _____
      _____
      _____
      _____

B. ADDITIONAL INFORMATION

_____
_____
_____
_____
_____
_____

]

Prudential

MOUNTAIN CLIMBING SUPPLEMENT

Supplementary Declarations Forming a Part of the Application for Insurance

Pruco Life Insurance Company
The Prudential Insurance Company of America
Both are Prudential Financial companies.
Policy is issued by the company named at the beginning of this application.

POLICY NUMBER (IF KNOWN): XX XXX XXX

PROPOSED INSURED: John Doe

A. BACKGROUND DETAILS

1. How long have you been mountain climbing? 5 Years
2. Date of your last climb: 7/2008
3. Total number of climbs: 7
4. Average height climbed: 10,000 feet
5. Are you a member of a climbing club? ☑ Yes ☐ No
   If Yes, name of club **:** Colorado Mountain Club
6. Do you ever climb solo or free (without use of climbing aids)? ☐ Yes ☑ No
   If Yes, provide details **:** _____

7a. Countries outside the U.S. where you have climbed or intend to climb:
None

7b. Geographic regions you have climbed in:
☐ Arctic ☐ Himalayan
☐ Antarctica ☐ Other _____

8. Type(s) of terrain involved in climbing:
☑ Rock ☐ Artificial Climbing Walls
☐ Snow/Ice ☐ Other (Describe): _____

9. Do you have any plans to climb in other/different regions or terrains in the future? ☐ Yes ☑ No
   If Yes, provide details (including each location planned, increase in altitude, time of year, climbing style, etc.) **:**

10. Season(s) of the year when you climb:
☐ Winter ☑ Spring
☑ Summer ☐ Fall

11. Any climbs above 13,000 feet (4,000 meters)? ☐ Yes ☑ No
   If Yes, provide details including total number of climbs, heights attained, frequency and safety equipment used **:**

B. ADDITIONAL INFORMATION

[

Prudential

MOTORIZED VEHICLE RACING SUPPLEMENT

Supplementary Declarations Forming a Part of the Application for Insurance

Pruco Life Insurance Company
The Prudential Insurance Company of America
Both are Prudential Financial companies.
Policy is issued by the company named at the beginning of this application.

POLICY NUMBER (IF KNOWN): XX XXX XXX

PROPOSED INSURED: John Doe

A. BACKGROUND DETAILS

1. How long have you been racing? 5 Years
2. Date of your last race: 9/2008
3. Total number of races: 15
4. What type of vehicle is being driven?
   ☑ Automobile ☐ Motorcycle ☐ Boat ☐ Snowmobile ☐ Other: _____
5. What kind of track do you race on?
   ☐ Automobile: ☐ Permanent/Paved Road Course ☐ Temporary/Paved Road Course ☐ Hill Climb ☑ Drag Strip
   ☐ Permanent/Paved Oval ☐ Temporary Oval ☐ Off-Road ☐ Other: _____
   ☐ Motorcycle: ☐ Permanent/Paved Road Course ☐ Temporary/Paved Road Course ☐ Hill Climb ☐ Motocross
   ☐ Permanent/Paved Oval ☐ Temporary Oval ☐ Off-Road ☐ Supercross
   ☐ Drag Strip ☐ Other: _____
   ☐ Boat: ☐ Closed Course (Inland) ☐ Closed Course (Ocean) ☐ Open Ocean
   ☐ Snowmobile (explain): _____
   ☐ Other (explain): _____
6. Are the events you participate in sanctioned by any regulatory body? ☑ Yes ☐ No
   If Yes, provide name of sanctioning body **:** NHRA
   What specific safety requirements are mandated by the sanctioning body?
   ☐ Roll Cages ☐ Head and Neck Restraints
   ☐ On-site Medical Personnel ☑ Other: fire resistant suit
7. Have you had any formalized training? ☑ Yes ☐ No
   If Yes, please list racing schools **:** Skip Barber Racing School
8. Is participation in the above racing your: ☐ Occupation ☑ Avocation (not primary source of income)
9. Have you been involved in any accidents that required hospitalization as a result of your racing? ☐ Yes ☑ No
   If Yes, please describe **:** _____

B. VEHICLE DETAILS

1. Generic type (e.g., drag racer, stock, hydrofoil): Drag Racing
2. Make: Chevy
3. Model: Camaro
4. Engine Displacement (cc): 5 Liters
5. Horsepower: 475
6. Average Speed (mph): 100 MPH
7. Maximum Speed (mph): 120 MPH

C. ADDITIONAL INFORMATION

]

[

Prudential

VARIABLE SUPPLEMENT

Supplementary Declarations Forming a Part of the Application for Insurance

Pruco Life Insurance Company
The Prudential Insurance Company of America
Both are Prudential Financial companies.
Policy is issued by the company named at the beginning of this application.

PROPOSED INSURED: John Doe

POLICY NUMBER (IF KNOWN): xx xxx xxx

1. INVESTMENT OPTIONS AND ALLOCATIONS

[I request that net premium payments be allocated to the investment options selected below. **Investment allocations must be made in whole numbers and the total allocation must equal 100%.**

Investment Option	Code	Allocation	Investment Option	Code	Allocation
Equity	CSTK	50 %	Fixed Rate Option	FXRT	50 %
		%			%
		%			%
		%			%
		%			%
		%			%
		%			%
		%			%
		%			%
		%			%]
				Total	**1 0 0** %

2. ALLOCATED CHARGES

[You may select up to two variable investment options from which your monthly charges will be deducted.

- Allocations must be in whole percentages.
- The Fixed Rate Option can not be chosen.
- If you do not specify an allocation of monthly charges or if there is not enough money to deduct from the selected investment options, charges will be deducted from the remaining investment options on a pro-rata basis.
- The sum of all percentages must equal 100 percent.

Investment Option	Code	Allocation	Investment Option	Code	Allocation
		%			%
				Total	**1 0 0** %]

3. TELEPHONE REALLOCATIONS / TRANSFER PRIVILEGES

[If more than one owner, telephone reallocations/transfer privileges are **not** allowed.

☐ I do not wish to authorize telephone reallocations/transfers. I understand that by not taking this option any future request for this option must be submitted in writing.]

I believe this contract meets my insurance needs and financial objectives. I acknowledge receipt of a current prospectus for the contract. I understand that the contract's value and death benefit may vary depending on the contract's investment experience. ☐ Yes ☐ No

An illustration of values is available upon request.]

PART 2

A. PERSONAL PHYSICIAN INFORMATION FOR CHILD

Name Dr. Michelle Smith

Address: Street 23 Main Street Suite

City Any City State Any State ZIP XXXXX

Telephone number: (XXX) XXX-XXXX Date last seen: 12/2008

Reason last seen: Physical

If more than one personal physician, provide details in section C, number 8.

B. PHYSICAL MEASUREMENTS

1. Height: 5' feet 4" inches Weight: 115 pounds
2. Within the last 12 months, has the child had a loss of weight? ☐ Yes ☑ No

   If Yes, provide details :

C. MEDICAL INFORMATION

1. Has a member of the medical profession ever treated the child for or diagnosed the child with:
   - a. a heart murmur, a heart valve disorder or any other disorder of the heart or blood vessels? ☐ Yes ☑ No
   - b. anemia or other abnormality of the blood (other than HIV)? ☐ Yes ☑ No
   - c. a tumor, cancer, leukemia or lymphoma? ☐ Yes ☑ No
   - d. diabetes, high blood sugar, glucose intolerance or other endocrine disorder? ☐ Yes ☑ No
   - e. anxiety, depression, or any mental or psychiatric illness such as an eating disorder, Attention Deficit Hyperactivity Disorder (ADHD) or autism? ☐ Yes ☑ No
   - f. asthma, apnea or any other disorder of the lungs or respiratory system? ☐ Yes ☑ No
   - g. a seizure, cerebral palsy, mental retardation, developmental delay, or any other disorder of the brain or nervous system? ☐ Yes ☑ No
   - h. any disorder of the liver, stomach or intestines? ☐ Yes ☑ No
   - i. any disorder of the kidneys, urinary tract or genital systems? ☐ Yes ☑ No
   - j. arthritis or any other disorder of the joints, muscles or bones? ☐ Yes ☑ No
2. Other than what has already been disclosed, within the past 5 years, has the child:
   - a. been a patient in a hospital or other medical facility, other than for normal childbirth? ☐ Yes ☑ No
   - b. had any other disease, disorder, condition or birth defect? ☐ Yes ☑ No
   - c. been advised to have surgery, medical treatments or diagnostic procedures (other than for HIV)? ☐ Yes ☑ No
3. Have disability benefits ever been requested for the child? ☐ Yes ☑ No
4. Is the child currently receiving medical treatment or taking any other medication or herbal supplement that has not already been disclosed? ☐ Yes ☑ No

For Ages 15 – 17 only:

5. Has a member of the medical profession ever treated the child for or diagnosed the child with an infection caused by the Human Immunodeficiency Virus (HIV) [(**Not applicable in CA. In WI:** AIDS virus, HIV antibody testing is limited to FDA-licensed enzyme immunoassay and confirmatory HIV antibody tests. Any test performed at an anonymous counseling and testing site or home testing is confidential and need not be revealed on this application.),] Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), or any other sexually transmitted disease? ☐ Yes ☑ No
6. Has the child ever used:
   - a. cocaine, crack, marijuana, heroin, Ecstasy, PCP, LSD, methamphetamine, any other hallucinogenic drug or controlled substance? ☐ Yes ☑ No
   - b. amphetamines, barbiturates, sedatives, opiates or methadone, or controlled substance except as prescribed by a physician? ☐ Yes ☑ No
7. Has the child had or been advised to have treatment or counseling for alcohol or drug use or been asked to reduce or eliminate their usage? ☐ Yes ☑ No

(CONTINUED)

C. MEDICAL INFORMATION (CONTINUED)

8. Give complete details of any "Yes" answers for questions 1-7, including: **Question number, diagnosis, date of onset and recovery, medication/treatment prescribed and the name, address and telephone number of all attending physicians and hospitals.**

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

AGREEMENTS

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

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

FRAUD WARNING

[(Not applicable in **AZ**.)] Any person who knowingly:

- **[AR, HI, LA, NM, TN, VA and WA**: and intentionally gives false or deceptive information when completing an application for insurance or filing a claim, for the purpose of defrauding an insurance company may be subject to fines, denial of insurance benefits, or confinement in prison.
- **CO:** and intentionally gives false or deceptive information when completing an application for insurance or filing a claim, for the purpose of defrauding an insurance company may have committed fraud, or may have violated state law. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.
- **DC:** presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
- **MD:** and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
- **OH:** and with 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 is guilty of insurance fraud.
- **PA:** 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 commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.]
- **[All other states:]** and intentionally gives false or deceptive information when completing an application for insurance or filing a claim, for the purpose of defrauding an insurance company may have committed fraud, or may have violated state law.

SIGNATURES

[Check applicable boxes:

IRS Certification: Under penalties of perjury, the policyowner certifies that:

- ☐ The number shown on the application is my correct Social Security/Tax ID number.
- ☐ I am not subject to backup withholding under Section 3406(a)(1)(C) of the Internal Revenue Code.
- ☐ I am a U.S. person (including a U.S. resident alien). *If not a U.S. person (including U.S. resident alien), submit the applicable Form W-8(BEN, ECI, EXP or IMY). In most cases, Form W-8BEN will be the appropriate form.*

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

Signed at (**STATE**) (Name of State) _____ on (**DATE**) 2/1/2007

➔ Signature of parent or guardian **X** *John Doe*

If policyowner is different from the parent or guardian:

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

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

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

Title of officer/trustee(s) _____

➔ **Signature of producer** **X** *Richard Roe*

ORD 96200JUV-2010

Prudential

Application for Life Insurance
Survivorship Life

Corporate Offices, Newark, New Jersey

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

POLICY NUMBER (IF KNOWN): XX XXX XXX

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

1. Name: John Doe
2. Previous name (if changed in the last 5 yrs.): _____
3. Social Security number: XXX XX XXXX 4. State of birth (Country if not U.S.): Name of State
5. Gender: ☐ Female ☑ Male 6. Date of birth: 9 / 25 / 1971 7. Date policy to Save Age? ☐ Yes ☐ No
8. Are you a permanent, legal US resident? ☐ Yes ☐ No
   If No, provide country of legal residence, type and number of visa, expiration date and length of US residence **:**
9. Driver's license issuing state: Name of State Number: XXXXX-XXXXX-XXXXX Expiration date: XX-XX-XXXX
   If None, why not? **:** _____
10. Residence address (No PO boxes): Street 123 Main Street Apt _____
    City Any City State Any State ZIP XXXXX
11. e-mail address: XXXXX@XXXX.net
12. Home telephone number: XXX-XXX-XXXX Business telephone number (ext.): XXX-XXX-XXXX
13. Current employer name: ABC Company
    Business address: Street 13 Main Street Suite _____
    City Any City State Any State ZIP XXXXX
14. Occupation: Manager
    Duties: Administrative duties
15. Earned annual income $ 50,000 Unearned annual income $_____ Net worth $_____

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

1. Name: Mary Doe
2. Previous name (if changed in the last 5 yrs.): _____
3. Social Security number: XXX XX XXXX 4. State of birth (Country if not U.S.): Name of State
5. Gender: ☑ Female ☐ Male 6. Date of birth: 12 / 2 / 1972 7. Date policy to Save Age? ☐ Yes ☐ No
8. Are you a permanent, legal US resident? ☐ Yes ☐ No
   If No, provide country of legal residence, type and number of visa, expiration date and length of US residence **:**
9. Driver's license issuing state: Name of State Number: XXXXX-XXXXX-XXXXX Expiration date: XX-XX-XXXX
   If None, why not? **:** _____
10. Residence address (If different from 1st PI. No PO boxes.): Street _____ Apt _____
    City _____ State _____ ZIP _____
11. e-mail address: XXXXX@XXXX.net
12. Home telephone number: XXX-XXX-XXXX Business telephone number (ext.): XXX-XXX-XXXX
13. Current employer name: ABC Company
    Business address: Street 13 Main Street Suite _____
    City Any City State Any State ZIP XXXXX
14. Occupation: Project Manager
    Duties: Develops project plans
15. Earned annual income $ 65,000 Unearned annual income $_____ Net worth $_____

B. PLAN OF INSURANCE

1. Amount of insurance applied for: $ 50,000 **[If $5,000,000 or more, complete *Financial Supplement.*]**
2. Product applied for: [☐ PruLife® SUL Protector] ☑ Other: Survivorship Policy
3. For **[SUL Protector:]** Death Benefit type: [☑ Type A (Level) ☐ Type B (Variable)]
4. Requested Optional Benefits: [☐ Estate Protection Rider: Amount $_____]
   ☐ Other Riders/Benefits *(indicate where applicable)*: _____

C. PREMIUM

1. Send notices (check one): ☑ Policyowner ☐ Other recipient: _____
   Send notices (check one): ☑ Policyowner's residence ☐ Other address:
   Street _____ Apt _____
   City _____ State _____ ZIP _____
2. Premium payment mode: [☑ Annual ☐ Semiannual ☐ Quarterly ☐ Monthly – Electronic Funds Transfer]
3. Billed premium: $_____

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

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

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

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

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

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

E. BENEFICIARY DETAILS

[If insurance is for business purposes, also complete the Business Insurance Supplement. If beneficiary is a trust, provide name of trust and trustee(s), date of trust and if trust is revocable or irrevocable. If beneficiary is a business, please list name of business, city and state where located and the form of business.]

Name: First	Middle	Last	Relationship to Proposed Insured	Age	Beneficiary Class Primary	Secondary/Contingent
Mary		Doe	Spouse		☑	☐
Robert		Doe	Son		☐	☑
					☐	☐
					☐	☐

F. INSURANCE HISTORY

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

1st PI

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

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

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

2nd PI

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

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

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

	1st PI	2nd PI
4. Are you applying for or reinstating life insurance with any company? ***If Yes, give name of insured, amount applied for and total amount to be placed, including this application.***	☐ Yes ☐ No	☐ Yes ☐ No
5. Have you had life or health insurance declined, postponed or issued with an increased premium? ***If Yes, give name of insured, company name, type of insurance, date, action taken and reason for action.***	☐ Yes ☐ No	☐ Yes ☐ No
6. Is either proposed insured or proposed owner considering the transfer or sale to a life settlement company or other investor of: policy ownership; or, any interest in the policy benefits, either directly as a named beneficiary or indirectly as a beneficiary or owner of a trust or other entity? ***If Yes, provide details*** : _____	☐ Yes ☐ No	☐ Yes ☐ No

G. GENERAL INFORMATION

	1st PI	2nd PI
1. In the past five years, have you flown as a pilot, student pilot or crew member or do you intend to become a pilot?	☐ Yes ☑ No	☐ Yes ☑ No
2. In the past five years, have you participated in any activities such as motorized vehicle racing, SCUBA diving, mountain climbing, skydiving, extreme sports such as BASE jumping, bungee jumping or cave exploration, or do you intend to?	☐ Yes ☑ No	☐ Yes ☑ No
[***If Yes, to Question 1 or 2 above, complete the appropriate Supplement.***]		
3. Have you ever used tobacco or any other nicotine products such as cigarettes, cigars, pipe, chewing tobacco, snuff, nicotine gum or nicotine patch? ***If Yes, provide details*** **:**	☐ Yes ☑ No	☐ Yes ☑ No

1st PI

Product Type(s)	Date Last Used	Frequency of Use

2nd PI

Product Type(s)	Date Last Used	Frequency of Use

	1st PI	2nd PI
4. In the past five years, have you:		
a. had your driver's license denied, suspended or revoked?	☐ Yes ☑ No	☐ Yes ☑ No
b. been convicted of or pled guilty to driving under the influence of alcohol and/or drugs?	☐ Yes ☑ No	☐ Yes ☑ No
c. been convicted of or pled guilty to any moving violations?	☐ Yes ☑ No	☐ Yes ☑ No
5. Within the past 10 years, have you been arrested, convicted, or imprisoned for any crime and/or are you currently awaiting trial for any crime?	☐ Yes ☑ No	☐ Yes ☑ No
6. Will you live or travel outside the United States within the next 12 months? ***Details required include location (city/country), frequency, duration and purpose of each trip.***	☐ Yes ☑ No	☐ Yes ☑ No

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

Question # PI Details

H. SPECIAL REQUESTS

Prudential

AVIATION SUPPLEMENT

Supplementary Declarations Forming a Part of the Application for Insurance

Pruco Life Insurance Company
The Prudential Insurance Company of America
Both are Prudential Financial companies.
Policy is issued by the company named at the beginning of this application.

POLICY NUMBER (IF KNOWN): XX XXX XXX

PROPOSED INSURED: John Doe

A. PILOTS ONLY

1. Do you hold a valid FAA Medical Certificate? ☑ Yes ☐ No
   ***If Yes*:** a. What class: Third Class Original issue date: 1/2000
   b. Was the medical certificate issued under a special issuance or with any restrictions? ☐ Yes ☑ No
   ***If Yes*:** ☐ Special issuance ☐ Restriction For what condition? _____
2. Do you hold a valid FAA Airman Certificate? ☑ Yes ☐ No
   ***If Yes*:** a. What type: ☐ Student ☐ Sport ☐ Recreational ☑ Private ☐ Commercial ☐ Airline transport
   b. What class: ☑ Airplane ☐ Rotorcraft ☐ Powered lift ☐ Glider ☐ Lighter than air ☐ Other _____
   c. What rating: ☑ Single engine ☐ Multi-engine ☐ Instrument rating ☐ Sea ☐ Land ☐ Other _____
3. a. What is the make and model of the primary aircraft that you currently fly?
   Make: Beechcraft Model: Bonaza
   b. Who owns the aircraft listed above? ABC Flying Service
   c. ***If self, do you have a valid aircraft insurance policy?*** ☐ Yes ☐ No
4. Have you ever been in any aviation accidents; received any FAA safety violations? ***If Yes, provide details in section D.*** ☐ Yes ☑ No
5. Flight time in hours:

Total Time	All Aircraft	Primary Aircraft	Hours of IFR Flying	Military – Primary Aircraft: _____	If Flown: Rotorcraft	Glider
Pilot in Command (PIC)	900	900				
Instructor						
Last 24 Months	300	300				
Last 12 Months	150	150				
Total Time	1000	1000				
Next 12 Months	150	150				

B. CREW MEMBERS ONLY

1. Describe duties aboard the aircraft: _____
2. What is the make and model of the primary aircraft that you are a crew member of?
   Make: _____ Model: _____
3. Flight time in hours: Last 24 months: _____ Last 12 months: _____ Total time: _____ Next 12 months: _____

C. FUTURE FLIGHT PLANS (ALWAYS COMPLETE)

1. Do you plan to fly a different aircraft within the next 24 months? ☐ Yes ☑ No
   If Yes, provide details. What are the make(s) and model(s) of the aircraft you plan to fly?
   Make: _____ Model: _____ Anticipated date: _____
   Make: _____ Model: _____ Anticipated date: _____
2. Within the next 24 months, do you plan that your future flying will be of a different nature, including aerobatic flight, stunt flying or racing? ***If Yes, provide details in section D.*** ☐ Yes ☑ No

D. DETAILS

[

Prudential

General Avocation Supplement

Supplementary Declarations Forming a Part of the Application For Insurance

Pruco Life Insurance Company
The Prudential Insurance Company of America
Both are Prudential Financial companies.
Policy is issued by the company named at the beginning of this application.

POLICY NUMBER (IF KNOWN): XX XXX XXX

PROPOSED INSURED: John Doe

A. BACKGROUND DETAILS (LIST EACH AVOCATION YOU PARTICIPATE IN. USE ADDITIONAL SUPPLEMENTS AS NECESSARY.)

A. Avocation: Bungee Jumping

1. Description of activity: Bungee Jumping
2. Frequency of activity: 1 times per year Date of last activity: 6/2008
3. Experience: ☑ Less than one year ☐ One to three years ☐ More than three years
4. Certificate or license required? ☐ Yes ☑ No
   If Yes, describe :
5. Are you a member of any related club or associations? ☐ Yes ☑ No
   If Yes, describe :
6. Is safety equipment used or required? ☑ Yes ☐ No
   If Yes, describe : Standard equipment at location
7. Have you engaged in: ☐ exhibitions ☐ stunting ☐ exploration ☐ rescue ☐ dare-devil ☐ record-setting activities
8. Do you have any future plans to engage in:
   ☐ exhibitions ☐ stunting ☐ exploration ☐ rescue ☐ dare-devil ☐ record-setting activities
9. Do you participate or plan to participate in any avocation outside the United States? ☐ Yes ☑ No
   If Yes, describe :
10. For aerial avocations only: a. Average height for participation: _____ ft. and duration: _____
    b. Maximum height for participation: _____ ft. and duration: _____

B. Avocation:

1. Description of activity:
2. Frequency of activity: _____ times per year Date of last activity: _____
3. Experience: ☐ Less than one year ☐ One to three years ☐ More than three years
4. Certificate or license required? ☐ Yes ☐ No
   If Yes, describe :
5. Are you a member of any related club or associations? ☐ Yes ☐ No
   If Yes, describe :
6. Is safety equipment used or required? ☐ Yes ☐ No
   If Yes, describe :
7. Have you engaged in: ☐ exhibitions ☐ stunting ☐ exploration ☐ rescue ☐ dare-devil ☐ record-setting activities
8. Do you have any future plans to engage in:
   ☐ exhibitions ☐ stunting ☐ exploration ☐ rescue ☐ dare-devil ☐ record-setting activities
9. Do you participate or plan to participate in any avocation outside the United States? ☐ Yes ☐ No
   If Yes, describe :
10. For aerial avocations only: a. Average height for participation: _____ ft. and duration: _____
    b. Maximum height for participation: _____ ft. and duration: _____

B. ADDITIONAL INFORMATION

]

[

Prudential

BUSINESS SUPPLEMENT

Supplementary Declarations Forming a Part of the Application for Insurance

Pruco Life Insurance Company
The Prudential Insurance Company of America
Both are Prudential Financial companies.
Policy is issued by the company named at the beginning of this application.

POLICY NUMBER (IF KNOWN): XX XXX XXX

PROPOSED INSURED: John Doe

INSTRUCTIONS

[Required for all insurance where the purpose of the insurance is for business purposes such as buy-sell, key person coverage or as collateral for a business loan. Submit copies of material that supplements the information requested, such as loan commitments, written buy-sell arrangements, audited financial statements or letters.]

A. BUSINESS INFORMATION

1. Source of Financial Information. (Check all that apply.)
   [☑ Proposed Insured ☐ Accountant/CPA ☐ Banker ☐ Attorney ☐ Producer] ☐ Other (specify)_____
2. Who determined the amount of insurance applied for? (Check all that apply.)
   [☑ Proposed Insured ☐ Accountant/CPA ☐ Banker ☐ Attorney ☐ Producer] ☐ Other (specify)_____
3. Name of company: _____
4. When was the business established? (mo/yr) 4 / 2000
5. The Proposed Insured is an: ☐ Employee ☐ Owner If owner, percentage of ownership: 100 %
6. List amount of business insurance in force and applied for in all companies on each officer or member of the business.

Name	Age	Ownership %	In force Amount	Amount Applied For
John Doe	57	100 %	$ 750,000	$ 500,000
		%	$	$
		%	$	$
		%	$	$
		%	$	$

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

   a. ☐ **Buy-Sell Arrangement**
      1. Is there a written buy-sell agreement? ☐ Yes ☐ No
      2. Are all other parties to agreement already covered by or applying for comparable amounts of insurance? ☐ Yes ☐ No
         If No, explain : _____

   b. ☐ **Key Person**
      1. Are all other key persons covered by or applying for comparable amounts of insurance? ☐ Yes ☐ No
         If No, explain : _____
      2. Why is the Proposed Insured considered "Key"? (Detail special skills/knowledge/ability.)
         _____
         _____

   c. ☐ **Business Loan Collateral**
      1. Is the insurance required by the creditor? ☐ Yes ☐ No
      2. Is the Proposed Insured personally responsible for the loan? ☐ Yes ☐ No
      3. Name of creditor/lending institution: _____
      4. What is the purpose of the loan? _____
      5. What is the amount of the loan? $_____
      6. What is the repayment schedule? _____
      7. Date loan was committed: ____/____ If not yet committed, please explain: _____

]

[

A. BUSINESS INFORMATION (CONTINUED)

8. What is the total fair market value of the business? $ 1,250,000

9. Business values:
   a. Assets: $ 850,000
   b. Liabilities: $ 400,000
   c. Gross annual sales and/or revenue: $ 800,000
   d. Net profit after taxes: $ 450,000

10. Additional Comments:

B. SIGNATURES

[If this proposed policy will be an "employer-owned contract" under Internal Revenue Code Section 101(j), I (the owner) acknowledge and understand:

- that the policy death benefit may be income taxable unless I have satisfied the conditions of Section 101(j) **before policy issue**;
- that it remains my responsibility to ensure compliance with the requirements of Sections 101(j) and 6039I; and
- that The Prudential Insurance Company of America, its affiliates and producers are not authorized to provide tax or legal advice and that I must look to my legal and tax advisors for information concerning this law.]]

[

Prudential

DIVING SUPPLEMENT

Supplementary Declarations Forming a Part of the Application For Insurance

Pruco Life Insurance Company
The Prudential Insurance Company of America
Both are Prudential Financial companies.
Policy is issued by the company named at the beginning of this application.

POLICY NUMBER (IF KNOWN): XX XXX XXX

PROPOSED INSURED: John Doe

A. BACKGROUND DETAILS

1. Date of last dive: 11/2008
2. Diving history:

Depth Attained	Last 12 Months # of Dives	Last 12 Months Average Time	Next 12 Months # of Dives	Next 12 Months Average Time
Less than 50 feet	1	30 min.	1	30 min.
50 – 100 feet				
101 – 150 feet				
Greater than 150 feet				

3. Do you plan any future dives? ☐ Yes ☑ No
   If Yes, please provide information about your diving experience and qualifications **:**
   a. When did you learn to dive? _____
   b. Are you an active member of a diving club? ☐ Yes ☐ No
      If Yes, name of club **:** _____
   c. Are you a certified diver? ☐ Yes ☐ No
      If Yes, level and issuer of certification **:** _____
   d. Have you suffered any illness or injury due to diving? ☐ Yes ☐ No
      If Yes, provide details **:** _____
   e. Do you use mixed gas equipment? ☐ Yes ☐ No
      If Yes, what types and frequency of use **:** _____
   f. What is the maximum depth you have dived to, and reason for that dive?
      _____
   g. Do you dive alone? ☐ Yes ☐ No
      If Yes, how often and under what conditions **:** _____
   h. Where do you dive?
      1. Environment type (Check all that apply.):
         ☐ Open ocean ☐ Deep sea ☐ Coastal waters ☐ Lakes ☐ Rivers
         ☐ Quarries ☐ Other: _____
      2. Location (State/Country): _____
   i. Do you participate in any of the following? (Check all that apply.)
      ☐ Wreck diving (observation, salvage, photography or exploration) ☐ Treasure diving ☐ Depth record attempts
      ☐ Diving at high altitudes (i.e. mountain lakes) ☐ Ice diving ☐ Rescue attempts ☐ Cave or sink hole diving
      If you checked any of the above, provide full details including how often:
      _____

B. ADDITIONAL INFORMATION

_____

]

[

Prudential

FINANCIAL SUPPLEMENT

Supplementary Declarations Forming a Part of the Application for Insurance

Pruco Life Insurance Company
The Prudential Insurance Company of America
Both are Prudential Financial companies.
Policy is issued by the company named at the beginning of this application.

POLICY NUMBER (IF KNOWN): XX XXX XXX

PROPOSED INSURED(S): John Doe

INSTRUCTIONS [(REQUIRED FOR APPLICATIONS WITH A FACE AMOUNT OF $5,000,000 OR MORE)]

[• Financial information prepared by an independent third party is required for applications with a face amount of $10,000,000 or more.

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

A. FINANCIAL INFORMATION

1. Source of Financial Information (Check all that apply.)
   [☑ Proposed Insured ☐ Accountant/CPA ☐ Banker ☐ Attorney ☐ Producer] ☐ Other (specify):_____

2. Who determined the amount of insurance applied for? (Check all that apply.)
   [☐ Proposed Insured ☐ Accountant/CPA ☐ Banker ☐ Attorney ☑ Producer] ☐ Other (specify):_____

	1st Proposed Insured	2ND Proposed Insured (Survivorship Applications only)
3. Current Annual Household Income		
a. Gross Compensation (e.g., Salary, Commissions, Bonuses, etc.):	$ 300,000	$
b. Other Income (e.g., Dividends, Interest, Net Real Estate Income, etc.):	$ 100,000	$
c. Total Annual Cash Income before taxes:	$ 400,000	$
4. Net Worth (excluding any business interest)		
a. Liquid Assets (assets that can be easily changed to cash):	$ 400,000	$
b. Other Assets:	$ 5,000,000	$
c. Liabilities:	$ 500,000	$
d. Net Worth (excluding business):	$ 7,500,000	$
5. Business Related Assets:	$ Ø	$

6. Have either the proposed insured(s) or owner filed for bankruptcy within the past five years? ☐ Yes ☑ No
   [***If Yes, please provide details including whether bankruptcy was dismissed or discharged; type of bankruptcy (chapter); whether it was personal or business related; current status; single or multiple occurrences; any outstanding judgments, liens or garnishments, etc.***]

7. Additional Comments:_____]

[

Prudential

MOUNTAIN CLIMBING SUPPLEMENT

Supplementary Declarations Forming a Part of the Application for Insurance

Pruco Life Insurance Company
The Prudential Insurance Company of America
Both are Prudential Financial companies.
Policy is issued by the company named at the beginning of this application.

POLICY NUMBER (IF KNOWN): XX XXX XXX

PROPOSED INSURED: John Doe

A. BACKGROUND DETAILS

1. How long have you been mountain climbing? 5 Years
2. Date of your last climb: 7/2008
3. Total number of climbs: 7
4. Average height climbed: 10,000 feet
5. Are you a member of a climbing club? ☑ Yes ☐ No
   If Yes, name of club **:** Colorado Mountain Club
6. Do you ever climb solo or free (without use of climbing aids)? ☐ Yes ☑ No
   If Yes, provide details **:** _____

7a. Countries outside the U.S. where you have climbed or intend to climb:
None

7b. Geographic regions you have climbed in:
☐ Arctic ☐ Himalayan
☐ Antarctica ☐ Other _____

8. Type(s) of terrain involved in climbing:
☑ Rock ☐ Artificial Climbing Walls
☐ Snow/Ice ☐ Other (Describe): _____

9. Do you have any plans to climb in other/different regions or terrains in the future? ☐ Yes ☑ No
   If Yes, provide details (including each location planned, increase in altitude, time of year, climbing style, etc.) **:**

10. Season(s) of the year when you climb:
☐ Winter ☑ Spring
☑ Summer ☐ Fall

11. Any climbs above 13,000 feet (4,000 meters)? ☐ Yes ☑ No
   If Yes, provide details including total number of climbs, heights attained, frequency and safety equipment used **:**

B. ADDITIONAL INFORMATION

]

[

Prudential

POLICYOWNER STATEMENT SUPPLEMENT

Supplementary Declarations Forming a Part of the Application For Insurance

Corporate Offices, Newark, New Jersey

Pruco Life Insurance Company
The Prudential Insurance Company of America
Both are Prudential Financial companies.
Telephone: 973-802-6000

POLICY NUMBER (IF KNOWN): XX XXX XXX

PROPOSED INSURED(S): Mary Doe

POLICYOWNER: John Doe

Prudential will not knowingly participate in a life insurance sale where the sale of the policy in a secondary market or the participation of investors in the policy death benefits is being considered. Accordingly, the Policyowner is asked to answer the following questions:

1. Have you or the proposed insured been offered "free insurance" or any inducement such as a cash payment, gifts, loan proceeds in excess of the amount necessary to fund the policy, or anything else of value as an encouragement to apply for this life insurance policy? ☐ Yes ☑ No
2. Have you or the proposed insured been solicited to sell or transfer, or had any discussions about selling any of the following to a life settlement company or group of investors in the next five years: the proposed life insurance policy; any other life insurance policy on the life of the proposed insured; or, a trust, limited liability company or other entity that has been or will be established to own the policy? ☐ Yes ☑ No
3. Have you or the proposed insured entered into or been offered a financing arrangement where a lender or other third party, other than your employer or family member, will receive any portion of the death benefit of the policy applied for in excess of repayment of the principal and interest? ☐ Yes ☑ No

Provide details to any Yes answers to Questions 1 – 3:

Producer's statement:

1. I represent that all answers to the above questions are correct, true and complete, to the best of my knowledge and belief.
2. I have no knowledge of any plans for the policy being applied for to be sold to a life settlement or viatical company.]

[

Prudential

MOTORIZED VEHICLE RACING SUPPLEMENT

Supplementary Declarations Forming a Part of the Application for Insurance

Pruco Life Insurance Company
The Prudential Insurance Company of America
Both are Prudential Financial companies.
Policy is issued by the company named at the beginning of this application.

POLICY NUMBER (IF KNOWN): XX XXX XXX

PROPOSED INSURED: John Doe

A. BACKGROUND DETAILS

1. How long have you been racing? 5 Years
2. Date of your last race: 9/2008
3. Total number of races: 15
4. What type of vehicle is being driven?
   ☑ Automobile ☐ Motorcycle ☐ Boat ☐ Snowmobile ☐ Other: _____
5. What kind of track do you race on?
   ☐ Automobile: ☐ Permanent/Paved Road Course ☐ Temporary/Paved Road Course ☐ Hill Climb ☑ Drag Strip
   ☐ Permanent/Paved Oval ☐ Temporary Oval ☐ Off-Road ☐ Other: _____
   ☐ Motorcycle: ☐ Permanent/Paved Road Course ☐ Temporary/Paved Road Course ☐ Hill Climb ☐ Motocross
   ☐ Permanent/Paved Oval ☐ Temporary Oval ☐ Off-Road ☐ Supercross
   ☐ Drag Strip ☐ Other: _____
   ☐ Boat: ☐ Closed Course (Inland) ☐ Closed Course (Ocean) ☐ Open Ocean
   ☐ Snowmobile (explain): _____
   ☐ Other (explain): _____
6. Are the events you participate in sanctioned by any regulatory body? ☑ Yes ☐ No
   If Yes, provide name of sanctioning body **:** NHRA
   What specific safety requirements are mandated by the sanctioning body?
   ☐ Roll Cages ☐ Head and Neck Restraints
   ☐ On-site Medical Personnel ☑ Other: fire resistant suit
7. Have you had any formalized training? ☑ Yes ☐ No
   If Yes, please list racing schools **:** Skip Barber Racing School
8. Is participation in the above racing your: ☐ Occupation ☑ Avocation (not primary source of income)
9. Have you been involved in any accidents that required hospitalization as a result of your racing? ☐ Yes ☑ No
   If Yes, please describe **:** _____

B. VEHICLE DETAILS

1. Generic type (e.g., drag racer, stock, hydrofoil): Drag Racing
2. Make: Chevy
3. Model: Camaro
4. Engine Displacement (cc): 5 Liters
5. Horsepower: 475
6. Average Speed (mph): 100 MPH
7. Maximum Speed (mph): 120 MPH

C. ADDITIONAL INFORMATION

]

[

Prudential

VARIABLE SUPPLEMENT

Supplementary Declarations Forming a Part of the Application for Insurance

Pruco Life Insurance Company
The Prudential Insurance Company of America
Both are Prudential Financial companies.
Policy is issued by the company named at the beginning of this application.

PROPOSED INSURED: John Doe

POLICY NUMBER (IF KNOWN): xx xxx xxx

1. INVESTMENT OPTIONS AND ALLOCATIONS

[I request that net premium payments be allocated to the investment options selected below. **Investment allocations must be made in whole numbers and the total allocation must equal 100%.**

Investment Option	Code	Allocation	Investment Option	Code	Allocation
Equity	CSTK	50 %	Fixed Rate Option	FXRT	50 %
		%			%
		%			%
		%			%
		%			%
		%			%
		%			%
		%			%
		%			%
		%			%]
				Total	**1 0 0** %

2. ALLOCATED CHARGES

[You may select up to two variable investment options from which your monthly charges will be deducted.

- Allocations must be in whole percentages.
- The Fixed Rate Option can not be chosen.
- If you do not specify an allocation of monthly charges or if there is not enough money to deduct from the selected investment options, charges will be deducted from the remaining investment options on a pro-rata basis.
- The sum of all percentages must equal 100 percent.

Investment Option	Code	Allocation	Investment Option	Code	Allocation
		%			%
				Total	**1 0 0** %]

3. TELEPHONE REALLOCATIONS / TRANSFER PRIVILEGES

[If more than one owner, telephone reallocations/transfer privileges are **not** allowed.

☐ I do not wish to authorize telephone reallocations/transfers. I understand that by not taking this option any future request for this option must be submitted in writing.]

I believe this contract meets my insurance needs and financial objectives. I acknowledge receipt of a current prospectus for the contract. I understand that the contract's value and death benefit may vary depending on the contract's investment experience. ☐ Yes ☐ No

An illustration of values is available upon request.]

PART 2

A. PERSONAL PHYSICIAN INFORMATION

1st PI

Name Dr. William Smith

Address: Street 23 Main Street Suite _____

City Any City State Any State ZIP XXXXX

Telephone number (XXX) XXX-XXXX Date last seen 10/31/2000

Reason last seen: Cold

2nd PI

Name Dr. Michelle Jones

Address: Street 185 Main Street Suite _____

City Any City State Any State ZIP XXXXX

Telephone number (XXX) XXX-XXXX Date last seen 9/30/2000

Reason last seen: Physical

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

B. PHYSICAL MEASUREMENTS

1st PI

1. Height: 5' feet 11" inches Weight: 180 pounds
2. Within the last 12 months, have you had a change of weight (gain or loss) of more than 10 pounds? ☐ Yes ☑ No

   If Yes, provide details : _____

2nd PI

1. Height: 5' feet 7" inches Weight: 125 pounds
2. Within the last 12 months, have you had a change of weight (gain or loss) of more than 10 pounds? ☐ Yes ☑ No

   If Yes, provide details : _____

C. FAMILY HISTORY

1st PI

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

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

2. **Father:** Current age 65 or Age at death: _____ **Mother:** Current age 65 or Age at death: _____

2nd PI

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

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

2. **Father:** Current age 70 or Age at death: _____ **Mother:** Current age 66 or Age at death: _____

D. MEDICAL INFORMATION

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

(CONTINUED)

D. MEDICAL INFORMATION (CONTINUED)

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

PI	Question #	Diagnosis	Date of Onset	Date of Recovery	Medication/ Treatment Prescribed	Physician/Hospital Name, Address & Phone Number
	1g	Cold	10/25/2000	11/1/2000		Dr. William Smith 23 Main Street Any City, Any State XXXXX XXX-XXX-XXXX

AGREEMENTS

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

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

FRAUD WARNING

[(Not applicable in **AZ**.)] Any person who knowingly:

[• **AR, HI, LA, NM, TN, VA and WA**: and intentionally gives false or deceptive information when completing an application for insurance or filing a claim, for the purpose of defrauding an insurance company may be subject to fines, denial of insurance benefits, or confinement in prison.

- **CO:** and intentionally gives false or deceptive information when completing an application for insurance or filing a claim, for the purpose of defrauding an insurance company may have committed fraud, or may have violated state law. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.
- **DC:** presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
- **MD:** and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
- **OH:** and with 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 is guilty of insurance fraud.
- **PA:** 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 commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.**]**

[• **All other states:]** and intentionally gives false or deceptive information when completing an application for insurance or filing a claim, for the purpose of defrauding an insurance company may have committed fraud, or may have violated state law.

SIGNATURES

[Check applicable boxes:

IRS Certification: Under penalties of perjury, the policyowner certifies that:

☐ The number shown on the application is my correct Social Security/Tax ID number.
☐ I am not subject to backup withholding under Section 3406(a)(1)(C) of the Internal Revenue Code.
☐ I am a U.S. person (including a U.S. resident alien). *If not a U.S. person (including U.S. resident alien), submit the applicable Form W-8(BEN, ECI, EXP or IMY). In most cases, Form W-8BEN will be the appropriate form.*

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

Signed at (**STATE**) Name of State on (**DATE**) 02/01/2007

➔ Signature of 1st proposed insured **X** *John Doe*

➔ Signature of 2nd proposed insured **X** *Mary Doe*

If policyowner is different from the proposed insured:

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

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

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

Title of officer/trustee(s) _____

➔ **Signature of producer** **X** *Richard Roe*

Prudential

AVIATION SUPPLEMENT

Supplementary Declarations Forming a Part of the Application for Insurance

Pruco Life Insurance Company
The Prudential Insurance Company of America
Both are Prudential Financial companies.
Policy is issued by the company named at the beginning of this application.

POLICY NUMBER (IF KNOWN): XX XXX XXX

PROPOSED INSURED: John Doe

A. PILOTS ONLY

1. Do you hold a valid FAA Medical Certificate? ☑ Yes ☐ No
   ***If Yes*:** a. What class: Third Class Original issue date: 1/2000
   b. Was the medical certificate issued under a special issuance or with any restrictions? ☐ Yes ☑ No
   ***If Yes*:** ☐ Special issuance ☐ Restriction For what condition? _____
2. Do you hold a valid FAA Airman Certificate? ☑ Yes ☐ No
   ***If Yes*:** a. What type: ☐ Student ☐ Sport ☐ Recreational ☑ Private ☐ Commercial ☐ Airline transport
   b. What class: ☑ Airplane ☐ Rotorcraft ☐ Powered lift ☐ Glider ☐ Lighter than air ☐ Other _____
   c. What rating: ☑ Single engine ☐ Multi-engine ☐ Instrument rating ☐ Sea ☐ Land ☐ Other _____
3. a. What is the make and model of the primary aircraft that you currently fly?
   Make: Beechcraft Model: Bonaza
   b. Who owns the aircraft listed above? ABC Flying Service
   c. ***If self, do you have a valid aircraft insurance policy?*** ☐ Yes ☐ No
4. Have you ever been in any aviation accidents; received any FAA safety violations? ***If Yes, provide details in section D.*** ☐ Yes ☑ No
5. Flight time in hours:

Total Time	All Aircraft	Primary Aircraft	Hours of IFR Flying	Military – Primary Aircraft: _____	If Flown: Rotorcraft	Glider
Pilot in Command (PIC)	900	900				
Instructor						
Last 24 Months	300	300				
Last 12 Months	150	150				
Total Time	1000	1000				
Next 12 Months	150	150				

B. CREW MEMBERS ONLY

1. Describe duties aboard the aircraft: _____
2. What is the make and model of the primary aircraft that you are a crew member of?
   Make: _____ Model: _____
3. Flight time in hours: Last 24 months: _____ Last 12 months: _____ Total time: _____ Next 12 months: _____

C. FUTURE FLIGHT PLANS (ALWAYS COMPLETE)

1. Do you plan to fly a different aircraft within the next 24 months? ☐ Yes ☑ No
   If Yes, provide details. What are the make(s) and model(s) of the aircraft you plan to fly?
   Make: _____ Model: _____ Anticipated date: _____
   Make: _____ Model: _____ Anticipated date: _____
2. Within the next 24 months, do you plan that your future flying will be of a different nature, including aerobatic flight, stunt flying or racing? ***If Yes, provide details in section D.*** ☐ Yes ☑ No

D. DETAILS

_____
_____
_____
_____

E. SIGNATURES

To the best of my knowledge and belief, the above statements are complete, true and correctly recorded.

➔ X *John Doe* Date 2 / 1 / 2007
Signature of proposed insured

X *Richard Roe* Date 2 / 1 / 2007
Signature of producer

Prudential

General Avocation Supplement

Supplementary Declarations Forming a Part of the Application For Insurance

Pruco Life Insurance Company
The Prudential Insurance Company of America
Both are Prudential Financial companies.
Policy is issued by the company named at the beginning of this application.

POLICY NUMBER (IF KNOWN): XX XXX XXX

PROPOSED INSURED: John Doe

A. BACKGROUND DETAILS (LIST EACH AVOCATION YOU PARTICIPATE IN. USE ADDITIONAL SUPPLEMENTS AS NECESSARY.)

A. Avocation: Bungee Jumping

1. Description of activity: Bungee Jumping
2. Frequency of activity: 1 times per year Date of last activity: 6/2008
3. Experience: ☑ Less than one year ☐ One to three years ☐ More than three years
4. Certificate or license required? ☐ Yes ☑ No
   If Yes, describe :
5. Are you a member of any related club or associations? ☐ Yes ☑ No
   If Yes, describe :
6. Is safety equipment used or required? ☑ Yes ☐ No
   If Yes, describe : Standard equipment at location
7. Have you engaged in: ☐ exhibitions ☐ stunting ☐ exploration ☐ rescue ☐ dare-devil ☐ record-setting activities
8. Do you have any future plans to engage in:
   ☐ exhibitions ☐ stunting ☐ exploration ☐ rescue ☐ dare-devil ☐ record-setting activities
9. Do you participate or plan to participate in any avocation outside the United States? ☐ Yes ☑ No
   If Yes, describe :
10. For aerial avocations only: a. Average height for participation: _____ ft. and duration: _____
    b. Maximum height for participation: _____ ft. and duration: _____

B. Avocation:

1. Description of activity:
2. Frequency of activity: _____ times per year Date of last activity: _____
3. Experience: ☐ Less than one year ☐ One to three years ☐ More than three years
4. Certificate or license required? ☐ Yes ☐ No
   If Yes, describe :
5. Are you a member of any related club or associations? ☐ Yes ☐ No
   If Yes, describe :
6. Is safety equipment used or required? ☐ Yes ☐ No
   If Yes, describe :
7. Have you engaged in: ☐ exhibitions ☐ stunting ☐ exploration ☐ rescue ☐ dare-devil ☐ record-setting activities
8. Do you have any future plans to engage in:
   ☐ exhibitions ☐ stunting ☐ exploration ☐ rescue ☐ dare-devil ☐ record-setting activities
9. Do you participate or plan to participate in any avocation outside the United States? ☐ Yes ☐ No
   If Yes, describe :
10. For aerial avocations only: a. Average height for participation: _____ ft. and duration: _____
    b. Maximum height for participation: _____ ft. and duration: _____

B. ADDITIONAL INFORMATION

C. SIGNATURES

To the best of my knowledge and belief, the above statements are complete, true and correctly recorded.

X *John Doe* Date 2 / 1 / 2007
Signature of proposed insured

X *Richard Roe* Date 2 / 1 / 2007
Signature of producer

Prudential

BUSINESS SUPPLEMENT

Supplementary Declarations Forming a Part of the Application for Insurance

Pruco Life Insurance Company
The Prudential Insurance Company of America
Both are Prudential Financial companies.
Policy is issued by the company named at the beginning of this application.

POLICY NUMBER (IF KNOWN): XX XXX XXX

PROPOSED INSURED: John Doe

INSTRUCTIONS

[Required for all insurance where the purpose of the insurance is for business purposes such as buy-sell, key person coverage or as collateral for a business loan. Submit copies of material that supplements the information requested, such as loan commitments, written buy-sell arrangements, audited financial statements or letters.]

A. BUSINESS INFORMATION

1. Source of Financial Information. (Check all that apply.)
   [☑ Proposed Insured ☐ Accountant/CPA ☐ Banker ☐ Attorney ☐ Producer] ☐ Other (specify)_____
2. Who determined the amount of insurance applied for? (Check all that apply.)
   [☑ Proposed Insured ☐ Accountant/CPA ☐ Banker ☐ Attorney ☐ Producer] ☐ Other (specify)_____
3. Name of company: _____
4. When was the business established? (mo/yr) 4 / 2000
5. The Proposed Insured is an: ☐ Employee ☐ Owner If owner, percentage of ownership: 100 %
6. List amount of business insurance in force and applied for in all companies on each officer or member of the business.

Name	Age	Ownership %	In force Amount	Amount Applied For
John Doe	57	100 %	$ 750,000	$ 500,000
		%	$	$
		%	$	$
		%	$	$
		%	$	$

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

   a. ☐ **Buy-Sell Arrangement**
      1. Is there a written buy-sell agreement? ☐ Yes ☐ No
      2. Are all other parties to agreement already covered by or applying for comparable amounts of insurance? ☐ Yes ☐ No
         If No, explain : _____

   b. ☐ **Key Person**
      1. Are all other key persons covered by or applying for comparable amounts of insurance? ☐ Yes ☐ No
         If No, explain : _____
      2. Why is the Proposed Insured considered "Key"? (Detail special skills/knowledge/ability.)
         _____
         _____

   c. ☐ **Business Loan Collateral**
      1. Is the insurance required by the creditor? ☐ Yes ☐ No
      2. Is the Proposed Insured personally responsible for the loan? ☐ Yes ☐ No
      3. Name of creditor/lending institution: _____
      4. What is the purpose of the loan? _____
      5. What is the amount of the loan? $_____
      6. What is the repayment schedule? _____
      7. Date loan was committed: ____/____ If not yet committed, please explain: _____

A. BUSINESS INFORMATION (CONTINUED)

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

9. Business values:
   a. Assets: $ 850,000
   b. Liabilities: $ 400,000
   c. Gross annual sales and/or revenue: $ 800,000
   d. Net profit after taxes: $ 450,000

10. Additional Comments:_____

B. SIGNATURES

[If this proposed policy will be an "employer-owned contract" under Internal Revenue Code Section 101(j), I (the owner) acknowledge and understand:

- that the policy death benefit may be income taxable unless I have satisfied the conditions of Section 101(j) **before policy issue**;
- that it remains my responsibility to ensure compliance with the requirements of Sections 101(j) and 6039I; and
- that The Prudential Insurance Company of America, its affiliates and producers are not authorized to provide tax or legal advice and that I must look to my legal and tax advisors for information concerning this law.

By signing in the Signature section, I acknowledge my understanding of this information, and that I have or will obtain from my tax or legal advisors whatever advice I deem necessary concerning the taxation of this proposed policy. See Employer-Owned Notice and Consent Form for more information.]

To the best of my knowledge and belief, the above statements are complete, true and correctly recorded.

➔ *Signature of policyowner* X John Doe Date 2 / 1 / 2007

➔ *Signature of producer* X Richard Roe Date 2 / 1 / 2007

Prudential

Corporate Offices, Newark, New Jersey

CHILD RIDER SUPPLEMENT

Supplementary Declarations Forming a Part of the Application For Insurance

Pruco Life Insurance Company
The Prudential Insurance Company of America
Both are Prudential Financial companies.
Policy is issued by the company named at the beginning of this application.

PRIMARY PROPOSED INSURED: John Doe

POLICY NUMBER (IF KNOWN): XX XXX XXX **AMOUNT OF RIDER (PER CHILD):** $ 50,000

A. COMPLETE FOR ALL CHILDREN PROPOSED FOR COVERAGE UNDER THE RIDER

Name *(first, middle initial, last)*	Date of birth	Place of birth	Sex
1. Mary J. Doe	1/1/98	New Jersey	☐ Male ☑ Female
2. Robert A. Doe	10/20/93	New Jersey	☑ Male ☐ Female
3.			☐ Male ☐ Female
4.			☐ Male ☐ Female

[List additional children details in Section E.]

B. GENERAL INFORMATION

1. Is any child listed above:
   a. a foster child or child whose legal adoption is not final? ☐ Yes ☑ No
   b. living elsewhere than in the household of primary proposed insured? ☐ Yes ☑ No
   c. dependent on someone other than the primary proposed insured? ☐ Yes ☑ No
2. Does the primary proposed insured have other children under age 18 who are not proposed for coverage? ☐ Yes ☑ No
3. Will any child live or travel outside the United States within the next 12 months? ☐ Yes ☑ No

[***If Yes to any of the above, provide full details in Section E.***]

C. MEDICAL INFORMATION

1. Has a member of the medical profession ever treated any child for or diagnosed any child with:
   a. a heart murmur, a heart valve disorder or any other disorder of the heart or blood vessels? ☐ Yes ☑ No
   b. anemia or other abnormality of the blood (other than HIV)? ☐ Yes ☑ No
   c. a tumor, cancer, leukemia or lymphoma? ☐ Yes ☑ No
   d. diabetes, high blood sugar, glucose intolerance or other endocrine disorder? ☐ Yes ☑ No
   e. anxiety, depression, or any mental or psychiatric illness such as an eating disorder, Attention Deficit Hyperactivity Disorder (ADHD) or autism? ☐ Yes ☑ No
   f. asthma, apnea or any other disorder of the lungs or respiratory system? ☐ Yes ☑ No
   g. a seizure, cerebral palsy, mental retardation, developmental delay, or any other disorder of the brain or nervous system? ☐ Yes ☑ No
   h. any disorder of the liver, stomach or intestines? ☐ Yes ☑ No
   i. any disorder of the kidneys, urinary tract or genital systems? ☐ Yes ☑ No
   j. arthritis or any other disorder of the joints, muscles or bones? ☐ Yes ☑ No
2. Other than what has already been disclosed, within the past 5 years, has any child:
   a. been a patient in a hospital or other medical facility, other than for normal childbirth? ☐ Yes ☑ No
   b. had any other disease, disorder, condition or birth defect? ☐ Yes ☑ No
   c. been advised to have surgery, medical treatments or diagnostic procedures (other than for HIV)? ☐ Yes ☑ No
3. Has any child ever had life or health insurance declined, postponed or issued with an increased premium? ☐ Yes ☑ No
4. Have disability benefits ever been requested for any child? ☐ Yes ☑ No
5. Is any child currently receiving medical treatment or taking any medication or herbal supplement that has not already been disclosed? ☐ Yes ☑ No

D. ADDITIONAL INFORMATION (COMPLETE FOR AGES 15 - 17)

1. In the past five years, has any child:
   a. flown as a pilot, student pilot or crew member or plan to become a pilot? ☐ Yes ☑ No
      [***If Yes, complete the appropriate supplement.***]
   b. participated in any activities such as motorized vehicle racing, SCUBA diving, mountain climbing, skydiving, extreme sports such as BASE jumping, bungee jumping or cave exploration, or intends to do so? ☐ Yes ☑ No
      [***If Yes, complete the appropriate supplement.***]
2. Has any child:
   a. had his/her driver's license denied, suspended or revoked? ☐ Yes ☑ No
   b. been convicted of or pled guilty to driving under the influence of alcohol and/or drugs? ☐ Yes ☑ No
   c. been convicted of or pled guilty to any moving violations? ☐ Yes ☑ No

   If Yes to 2a, b or c, provide details **:**

   Driver's license issuing state: _____ Number: _____ Expiration date: _____
3. Has any child been arrested, convicted, or imprisoned for any crime and/or are they awaiting trial for any crime? ☐ Yes ☑ No
4. Has a member of the medical profession ever treated any child for or diagnosed any child with an infection caused by the Human Immunodeficiency Virus (HIV) [(**Not applicable in CA. In WI:** AIDS virus, HIV antibody testing is limited to FDA-licensed enzyme immunoassay and confirmatory HIV antibody tests. Any test performed at an anonymous counseling and testing site or home testing is confidential and need not be revealed on this application.),] Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), or any other sexually transmitted disease? ☐ Yes ☑ No
5. Has any child ever:
   a. used cocaine, crack, marijuana, heroin, Ecstasy, PCP, LSD, methamphetamine, any other hallucinogenic drug or controlled substance? ☐ Yes ☑ No
   b. used amphetamines, barbiturates, sedatives, opiates or methadone, or controlled substance, except as prescribed by a physician? ☐ Yes ☑ No
   c. had or been advised to have treatment or counseling for alcohol or drug use, or been asked to reduce or eliminate their use? ☐ Yes ☑ No

E. DETAILS

- [Include details for any child to be covered that are not listed in Section A.]
- Give details of any "Yes" answer for sections B, C and/or D 2–5 above. Details should include, but are not limited to: section & question number, name of child, date, duration and name of illness, hospitalization, reason for checkup, medication and any advice or treatment given by a medical professional, name and address of physician seen.

_____

_____

_____

_____

_____

_____

_____

_____

F. TERMS AND CONDITIONS

The Company will pay the beneficiary named in the application any applicable insurance benefit either at the death of the primary proposed insured or at the death of an insured child after the death of the primary insured.

The policyowner is the primary proposed insured unless a different policyowner is named in the application. This is subject to any provisions for the automatic transfer of ownership stated in the policy.

To the best of my knowledge and belief, the above statements are complete, true and correctly recorded.

➔ *Signature of primary proposed insured* X John Doe Date 2 / 1 / 2007

➔ *Signature of producer* X Richard Roe Date 2 / 1 / 2007

Prudential

DIVING SUPPLEMENT

Supplementary Declarations Forming a Part of the Application For Insurance

Pruco Life Insurance Company
The Prudential Insurance Company of America
Both are Prudential Financial companies.
Policy is issued by the company named at the beginning of this application.

POLICY NUMBER (IF KNOWN): XX XXX XXX

PROPOSED INSURED: John Doe

A. BACKGROUND DETAILS

1. Date of last dive: 11/2008
2. Diving history:

Depth Attained	Last 12 Months # of Dives	Last 12 Months Average Time	Next 12 Months # of Dives	Next 12 Months Average Time
Less than 50 feet	1	30 min.	1	30 min.
50 – 100 feet				
101 – 150 feet				
Greater than 150 feet				

3. Do you plan any future dives? ☐ Yes ☑ No
   If Yes, please provide information about your diving experience and qualifications **:**
   a. When did you learn to dive? _____
   b. Are you an active member of a diving club? ☐ Yes ☐ No
   If Yes, name of club **:** _____
   c. Are you a certified diver? ☐ Yes ☐ No
   If Yes, level and issuer of certification **:** _____
   d. Have you suffered any illness or injury due to diving? ☐ Yes ☐ No
   If Yes, provide details **:** _____
   e. Do you use mixed gas equipment? ☐ Yes ☐ No
   If Yes, what types and frequency of use **:** _____
   f. What is the maximum depth you have dived to, and reason for that dive?
   _____
   g. Do you dive alone? ☐ Yes ☐ No
   If Yes, how often and under what conditions **:** _____
   h. Where do you dive?
   1. Environment type (Check all that apply.):
   ☐ Open ocean ☐ Deep sea ☐ Coastal waters ☐ Lakes ☐ Rivers
   ☐ Quarries ☐ Other: _____
   2. Location (State/Country): _____
   i. Do you participate in any of the following? (Check all that apply.)
   ☐ Wreck diving (observation, salvage, photography or exploration) ☐ Treasure diving ☐ Depth record attempts
   ☐ Diving at high altitudes (i.e. mountain lakes) ☐ Ice diving ☐ Rescue attempts ☐ Cave or sink hole diving
   If you checked any of the above, provide full details including how often:
   _____

B. ADDITIONAL INFORMATION

_____

C. SIGNATURES

To the best of my knowledge and belief, the above statements are complete, true and correctly recorded.

➔ X *John Doe* Date 1 / 1 / 2007 X *Richard Roe* Date 1 / 1 / 2007

Signature of proposed insured *Signature of producer*

Prudential

FINANCIAL SUPPLEMENT

Supplementary Declarations Forming a Part of the Application for Insurance

Pruco Life Insurance Company
The Prudential Insurance Company of America
Both are Prudential Financial companies.
Policy is issued by the company named at the beginning of this application.

POLICY NUMBER (IF KNOWN): XX XXX XXX

PROPOSED INSURED(S): John Doe

INSTRUCTIONS [(REQUIRED FOR APPLICATIONS WITH A FACE AMOUNT OF $5,000,000 OR MORE)]

[• Financial information prepared by an independent third party is required for applications with a face amount of $10,000,000 or more.

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

A. FINANCIAL INFORMATION

1. Source of Financial Information (Check all that apply.)
   [☑ Proposed Insured ☐ Accountant/CPA ☐ Banker ☐ Attorney ☐ Producer] ☐ Other (specify):

2. Who determined the amount of insurance applied for? (Check all that apply.)
   [☐ Proposed Insured ☐ Accountant/CPA ☐ Banker ☐ Attorney ☑ Producer] ☐ Other (specify):

	1st Proposed Insured	2ND Proposed Insured (Survivorship Applications only)
3. Current Annual Household Income		
a. Gross Compensation (e.g., Salary, Commissions, Bonuses, etc.):	$ 300,000	$
b. Other Income (e.g., Dividends, Interest, Net Real Estate Income, etc.):	$ 100,000	$
c. Total Annual Cash Income before taxes:	$ 400,000	$
4. Net Worth (excluding any business interest)		
a. Liquid Assets (assets that can be easily changed to cash):	$ 3,000,000	$
b. Other Assets:	$ 5,000,000	$
c. Liabilities:	$ 500,000	$
d. Net Worth (excluding business):	$ 7,500,000	$
5. Business Related Assets:	$ Ø	$

6. Have either the proposed insured(s) or owner filed for bankruptcy within the past five years? ☐ Yes ☑ No
   [***If Yes, please provide details including whether bankruptcy was dismissed or discharged; type of bankruptcy (chapter); whether it was personal or business related; current status; single or multiple occurrences; any outstanding judgments, liens or garnishments, etc.***]

7. Additional Comments:

B. SIGNATURES

To the best of my knowledge and belief, the above statements are complete, true and correctly recorded.

➔ *Signature of proposed insured(s)* X *John Doe* Date 2 / 1 / 2007

➔ *Signature of policyowner (if different)* X Date / /

➔ *Signature of producer* X *Richard Roe* Date 2 / 1 / 2007

Prudential

MOUNTAIN CLIMBING SUPPLEMENT

Supplementary Declarations Forming a Part of the Application for Insurance

Pruco Life Insurance Company
The Prudential Insurance Company of America
Both are Prudential Financial companies.
Policy is issued by the company named at the beginning of this application.

POLICY NUMBER (IF KNOWN): XX XXX XXX

PROPOSED INSURED: John Doe

A. BACKGROUND DETAILS

1. How long have you been mountain climbing? 5 Years
2. Date of your last climb: 7/2008
3. Total number of climbs: 7
4. Average height climbed: 10,000 feet
5. Are you a member of a climbing club? ☑ Yes ☐ No
   If Yes, name of club : Colorado Mountain Club
6. Do you ever climb solo or free (without use of climbing aids)? ☐ Yes ☑ No
   If Yes, provide details :

7a. Countries outside the U.S. where you have climbed or intend to climb:
None

7b. Geographic regions you have climbed in:
☐ Arctic ☐ Himalayan
☐ Antarctica ☐ Other

8. Type(s) of terrain involved in climbing:
☑ Rock ☐ Artificial Climbing Walls
☐ Snow/Ice ☐ Other (Describe):

9. Do you have any plans to climb in other/different regions or terrains in the future? ☐ Yes ☑ No
   If Yes, provide details (including each location planned, increase in altitude, time of year, climbing style, etc.) :

10. Season(s) of the year when you climb:
☐ Winter ☑ Spring
☑ Summer ☐ Fall

11. Any climbs above 13,000 feet (4,000 meters)? ☐ Yes ☑ No
   If Yes, provide details including total number of climbs, heights attained, frequency and safety equipment used :

B. ADDITIONAL INFORMATION

C. SIGNATURES

To the best of my knowledge and belief, the above statements are complete, true and correctly recorded.

➔ *Signature of proposed insured* X John Doe Date 2 / 1 / 2007

➔ *Signature of producer* X Richard Roe Date 2 / 1 / 2007

Prudential

MOTORIZED VEHICLE RACING SUPPLEMENT

Supplementary Declarations Forming a Part of the Application for Insurance

Pruco Life Insurance Company
The Prudential Insurance Company of America
Both are Prudential Financial companies.
Policy is issued by the company named at the beginning of this application.

POLICY NUMBER (IF KNOWN): XX XXX XXX

PROPOSED INSURED: John Doe

A. BACKGROUND DETAILS

1. How long have you been racing? 5 Years
2. Date of your last race: 9/2008
3. Total number of races: 15
4. What type of vehicle is being driven?
   ☑ Automobile ☐ Motorcycle ☐ Boat ☐ Snowmobile ☐ Other: _____
5. What kind of track do you race on?
   ☐ Automobile: ☐ Permanent/Paved Road Course ☐ Temporary/Paved Road Course ☐ Hill Climb ☑ Drag Strip
   ☐ Permanent/Paved Oval ☐ Temporary Oval ☐ Off-Road ☐ Other: _____
   ☐ Motorcycle: ☐ Permanent/Paved Road Course ☐ Temporary/Paved Road Course ☐ Hill Climb ☐ Motocross
   ☐ Permanent/Paved Oval ☐ Temporary Oval ☐ Off-Road ☐ Supercross
   ☐ Drag Strip ☐ Other: _____
   ☐ Boat: ☐ Closed Course (Inland) ☐ Closed Course (Ocean) ☐ Open Ocean
   ☐ Snowmobile (explain): _____
   ☐ Other (explain): _____
6. Are the events you participate in sanctioned by any regulatory body? ☑ Yes ☐ No
   ***If Yes, provide name of sanctioning body*:** NHRA
   What specific safety requirements are mandated by the sanctioning body?
   ☐ Roll Cages ☐ Head and Neck Restraints
   ☐ On-site Medical Personnel ☑ Other: fire resistant suit
7. Have you had any formalized training? ☑ Yes ☐ No
   ***If Yes, please list racing schools*:** Skip Barber Racing School
8. Is participation in the above racing your: ☐ Occupation ☑ Avocation (not primary source of income)
9. Have you been involved in any accidents that required hospitalization as a result of your racing? ☐ Yes ☑ No
   ***If Yes, please describe*:** _____

B. VEHICLE DETAILS

1. Generic type (e.g., drag racer, stock, hydrofoil): Drag Racing
2. Make: Chevy
3. Model: Camaro
4. Engine Displacement (cc): 5 Liters
5. Horsepower: 475
6. Average Speed (mph): 100 MPH
7. Maximum Speed (mph): 120 MPH

C. ADDITIONAL INFORMATION

_____

D. SIGNATURES

To the best of my knowledge and belief, the above statements are complete, true and correctly recorded.

➔ *Signature of proposed insured* X *John Doe* Date 1 / 1 / 2007

➔ *Signature of producer* X *Richard Roe* Date 1 / 1 / 2007

Prudential

POLICYOWNER STATEMENT SUPPLEMENT

Supplementary Declarations Forming a Part of the Application For Insurance

Corporate Offices, Newark, New Jersey

Pruco Life Insurance Company
The Prudential Insurance Company of America
Both are Prudential Financial companies.
Telephone: 973-802-6000

POLICY NUMBER (IF KNOWN): XX XXX XXX

PROPOSED INSURED(S): Mary Doe

POLICYOWNER: John Doe

Prudential will not knowingly participate in a life insurance sale where the sale of the policy in a secondary market or the participation of investors in the policy death benefits is being considered. Accordingly, the Policyowner is asked to answer the following questions:

1. Have you or the proposed insured been offered "free insurance" or any inducement such as a cash payment, gifts, loan proceeds in excess of the amount necessary to fund the policy, or anything else of value as an encouragement to apply for this life insurance policy? ☐ Yes ☑ No
2. Have you or the proposed insured been solicited to sell or transfer, or had any discussions about selling any of the following to a life settlement company or group of investors in the next five years: the proposed life insurance policy; any other life insurance policy on the life of the proposed insured; or, a trust, limited liability company or other entity that has been or will be established to own the policy? ☐ Yes ☑ No
3. Have you or the proposed insured entered into or been offered a financing arrangement where a lender or other third party, other than your employer or family member, will receive any portion of the death benefit of the policy applied for in excess of repayment of the principal and interest? ☐ Yes ☑ No

Provide details to any Yes answers to Questions 1 – 3:

SIGNATURES

To the best of my knowledge and belief, the above statements are complete, true and correctly recorded.

➔ Signature of policyowner X *John Doe* Date: 1 / 1 / 2007

Producer's statement:

1. I represent that all answers to the above questions are correct, true and complete, to the best of my knowledge and belief.
2. I have no knowledge of any plans for the policy being applied for to be sold to a life settlement or viatical company.

➔ Signature of producer X *Richard Roe* Date: 1 / 1 / 2007

Prudential

REQUEST FOR POLICY CHANGE

Supplementary Declarations Forming a Part of the Application for Insurance

Pruco Life Insurance Company
The Prudential Insurance Company of America
Both are Prudential Financial companies.
Corporate Offices, Newark, New Jersey

☐ PLACED CHANGE REQUIRING EVIDENCE OF INSURABILITY
☑ TERM CONVERSION

POLICY NUMBER: XX XXX XXX

INSURED'S NAME: John Doe

This supplement page must be accompanied by a completed ORD 96200 Application for Life Insurance.

If more than one policy number is being converted and combined into one policy, list the other policy numbers in Section A.

A. POLICY CHANGE REQUESTED

Please describe requested change in detail:

Please convert the Level Term Rider to a PruLife Universal Plus contract as detailed in this application.

For policy changes, the existing policyowner and beneficiary designation will be used unless a new policyowner or beneficiary designation is provided in the Application for Life Insurance.

B. SIGNATURE(S)

For policy changes, the owner of the existing policy must sign below and must also sign in the signature section of the application. Signature of insured is not required on this supplement page if they are not also the policyowner.

➔ X _____
*Signature of policyowner(s) (if different from insured) on existing policy**

➔ X John Doe
*Signature of insured (only if same as policyowner) on existing policy**

➔ X _____
*Signature of joint owner(s) (if different from insured) on existing policy**

➔ X _____
Signature of beneficiary (required if rights are limited)

➔ X _____
Signature of collateral assignee

Title of officer for corporation or trust _____ Company name _____

[*For **corporations**, please show the company's name and submit the signature and title of the authorized officer.

- If **president** – no additional requirements apply.
- If **vice president** – and the amount is more than $1,000,000, provide a Corporate Secretary statement that the vice president has the authority to sign.
- If **any other officer** – and the amount is more than $1,000,000, provide a corporate resolution authorizing the change. If the amount is $1,000,000 or less, provide a corporate seal or the corporate resolution.

*For **partnerships** with at least two general partners, two authorized general partners must sign with the title "general partner" after each name (if only one, use "sole general partner") and include the name of the partnership.

*For **sole proprietorships**, submit the signature of the owner, followed by "doing business as (company name), a sole proprietorship."

*For **trusts**, each trustee must sign unless the trust itself or state law provides otherwise. Trustee must include trustee designation (for example, "John Doe, Trustee under Trust Agreement dated 1/1/1998").

*A **holder of power of attorney** must provide a copy of the power of attorney and include, following his or her signature, the words "Attorney-in-fact for (owner's name)."

*For a policy containing a **limitation of rights**, the person or entity on whose favor the rights have been limited must also sign.

*For **limited liability company**, submit the signature of the manager, who is authorized to act if the LLC is managed by managers. If the LLC is member-managed, any manager can sign.]

[New policy number (for term conversions only) _____]

Prudential

VARIABLE SUPPLEMENT

Supplementary Declarations Forming a Part of the Application for Insurance

Pruco Life Insurance Company
The Prudential Insurance Company of America
Both are Prudential Financial companies.
Policy is issued by the company named at the beginning of this application.

PROPOSED INSURED: John Doe

POLICY NUMBER (IF KNOWN): XX XXX XXX

1. INVESTMENT OPTIONS AND ALLOCATIONS

[I request that net premium payments be allocated to the investment options selected below. **Investment allocations must be made in whole numbers and the total allocation must equal 100%.**

Investment Option	Code	Allocation	Investment Option	Code	Allocation
Equity	CSTK	50 %	Fixed Rate Option	FXRT	50 %
		%			%
		%			%
		%			%
		%			%
		%			%
		%			%
		%			%
		%			%
		%			%]
				Total	100 %

2. ALLOCATED CHARGES

[You may select up to two variable investment options from which your monthly charges will be deducted.

- Allocations must be in whole percentages.
- The Fixed Rate Option can not be chosen.
- If you do not specify an allocation of monthly charges or if there is not enough money to deduct from the selected investment options, charges will be deducted from the remaining investment options on a pro-rata basis.
- The sum of all percentages must equal 100 percent.

Investment Option	Code	Allocation	Investment Option	Code	Allocation
		%			%
				Total	100 %]

3. TELEPHONE REALLOCATIONS / TRANSFER PRIVILEGES

[If more than one owner, telephone reallocations/transfer privileges are **not** allowed.

☐ I do not wish to authorize telephone reallocations/transfers. I understand that by not taking this option any future request for this option must be submitted in writing.]

4. SIGNATURE

I believe this contract meets my insurance needs and financial objectives. I acknowledge receipt of a current prospectus for the contract. I understand that the contract's value and death benefit may vary depending on the contract's investment experience. ☑ Yes ☐ No

An illustration of values is available upon request.

➔ *Signature of policyowner* X *John Doe* 2 / 1 / 2007

Prudential

OVERFLOW DETAILS SUPPLEMENT

Supplementary Declarations Forming a Part of the Application For Insurance

Pruco Life Insurance Company
The Prudential Insurance Company of America
Both are Prudential Financial companies.
Policy is issued by the company named at the beginning of this application

POLICY NUMBER (IF KNOWN): XX XXX XXX

PRIMARY PROPOSED INSURED: John Doe

Give complete details of any answers from Parts 1 or 2 where details did not fit within allocated space on the application. Include within the information below the application part, section and question number as well as all applicable information related to that question.

Part 1, Section G, Question #6 - Sapporo, Japan, once per year, 1 week, vacation; Innsbruck, Austria, once per year, 1 week, vacation;

Calgary, Canada, once per year, 1 week, vacation.

Part 2, Section D, Question #4b - broken leg, Calgary General hospital, March 3-6, 2005, fully recovered.

SIGNATURES

To the best of my knowledge and belief, the above statements are complete, true and correctly recorded.

➔ *Signature of proposed insured* X *John Doe* Date ___/___/___

➔ *Signature of policy owner (if different)* X _____ Date ___/___/___

➔ *Signature of producer* X *Richard Roe* Date ___/___/___

Prudential

GOOD HEALTH STATEMENT

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

POLICY NUMBER: XX XXX XXX

PROPOSED INSURED: _____

I acknowledge, that I have reviewed the application and all supplements included with this contract and that to the best of my knowledge and belief, all statements made in the application and/or any supplements (including statements relating to my health, medical condition or treatment) remain complete, true and accurate and have not changed.

Signature of Proposed Insured X *John Doe* Date 2 / 1 / 2007

Prudential

GOOD HEALTH STATEMENT

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

POLICY NUMBER: XX XXX XXX

PROPOSED INSURED: _____

I acknowledge, that I have reviewed the application and all supplements included with this contract and that to the best of my knowledge and belief, all statements made in the application and/or any supplements (including statements relating to the proposed insured's health, medical condition or treatment) remain complete, true and accurate and have not changed.

Signature of Parent/Guardian X *John Doe* Date 2 / 1 / 2007

Prudential

GOOD HEALTH STATEMENT

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

POLICY NUMBER: XX XXX XXX

PROPOSED INSURED: _____

We acknowledge, that we have reviewed the application and all supplements included with this contract and that to the best of our knowledge and belief, all statements made in the application and/or any supplements (including statements relating to our health, medical condition or treatment) remain complete, true and accurate and have not changed.

➔ Signature of 1st Proposed Insured X *Mary Doe* Date 2 / 1 / 2007

➔ Signature of 2nd Proposed Insured X *John Doe* Date 2 / 1 / 2007

Prudential

AMENDMENTS

TO THE PRODUCER: APPLICATION AMENDED - SIGNATURES REQUIRED

1. Have the same people who signed the application, sign both copies of this form.
2. Return this copy with all other delivery forms.

Number
XX XXX XXX

The Company is authorized to change the application for this contract, so the contract is issued:

The undersigned agree(s) that this form is a part of the application and is to be put in the contract.

Date
2/1/2007

Signature of Proposed Insured
John Doe

Signature of Producer
Richard Roe

Signature of Policyowner (If other than proposed Insured)

(If policyowner is a firm or corporation, show that company's name)

By

(Signature and title of officer signing for that company)

Prudential

AMENDMENTS

Number
XX XXX XXX

The Company is authorized to change the application for this contract, so the contract is issued:

The undersigned agree(s) that this form is a part of the application and is to be put in the contract.

Date
2/1/2007

Signature of Proposed Insured
John Doe

Signature of Producer
Richard Roe

This copy to stay in the Contract.

Signature of Policyowner (If other than proposed Insured)

(If policyowner is a firm or corporation, show that company's name)

By

(Signature and title of officer signing for that company)

Prudential

PART 2 OF APPLICATION FOR LIFE INSURANCE

Pruco Life Insurance Company
The Prudential Insurance Company of America
Both are Prudential Financial companies.
Policy is issued by the company named at the beginning of this application.

POLICY NUMBER (IF KNOWN): XX XXX XXX

NAME OF PERSON TO BE EXAMINED: John Doe

PERSONAL PHYSICIAN INFORMATION

Name John Doe

Address: Street 123 Main Street Suite

City Any City State Any State ZIP XXXXX

Telephone number: (XXX) XXX-XXXX Date last seen: 5 / 1 / 2008

Reason last seen: Cold

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

FAMILY HISTORY

1. Have any immediate family members (mother, father, brother, sister) been diagnosed with or died from coronary artery disease, cerebrovascular disease, diabetes or cancer before age 70? ☐ Yes ☑ No
   If Yes, provide details including which member and medical condition, age at diagnosis, and age at death (if applicable) :

2. **Father:** Current age 65 or Age at death: _____ **Mother:** Current age 65 or Age at death: _____

MEDICAL INFORMATION

1. Has a member of the medical profession ever treated you for or diagnosed you with:
   a. high blood pressure, chest pain, a heart attack, coronary artery disease, a heart valve disorder, a heart murmur, an irregular heart beat, cerebrovascular disease, a stroke, circulatory disease, an aneurysm or any disease of the heart or blood vessels? ☐ Yes ☑ No
   b. anemia or other abnormality of the blood (other than HIV)? ☐ Yes ☑ No
   c. a polyp, cyst, tumor, cancer, leukemia, melanoma, lymphoma or Hodgkin's disease? ☐ Yes ☑ No
   d. diabetes, high blood sugar, glucose intolerance or other endocrine disorder? ☐ Yes ☑ No
   e. anxiety, depression, or any other mental or psychiatric illness? ☐ Yes ☑ No
   f. an infection caused by the Human Immunodeficiency Virus (HIV) (**Not applicable in CA. In WI:** AIDS virus, HIV antibody testing is limited to FDA-licensed enzyme immunoassay and confirmatory HIV antibody tests. Any test performed at an anonymous counseling and testing site or home testing is confidential and need not be revealed on this application.), Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), or any other sexually transmitted disease? ☐ Yes ☑ No
   g. asthma, emphysema, cystic fibrosis, sleep apnea, sarcoidosis, tuberculosis or any other disorder of the lungs or respiratory system? ☑ Yes ☐ No
   h. a seizure, epilepsy, multiple sclerosis, Parkinson's disease, muscular dystrophy, cerebral palsy, paralysis, Alzheimer's disease or any other disorder of the brain or nervous system? ☐ Yes ☑ No
   i. an ulcer, hepatitis, cirrhosis, pancreatitis, ulcerative colitis, Crohn's disease or any other disorder of the esophagus, liver, stomach or intestines? ☐ Yes ☑ No
   j. nephritis, polycystic kidney disease or any other disorder of the bladder, kidney, urinary tract or prostate? ☐ Yes ☑ No
   k. arthritis, gout, back trouble, or any disease or disorder of the joints, muscles or bones? ☐ Yes ☑ No
   l. lupus, rheumatoid arthritis, chronic fatigue syndrome, fibromyalgia, or any other disease or disorder of the autoimmune system? ☐ Yes ☑ No
2. Have you ever used:
   a. cocaine, crack, marijuana, heroin, Ecstasy, PCP, LSD, methamphetamine, any other hallucinogenic drug or controlled substance? ☐ Yes ☑ No
   b. amphetamines, barbiturates, sedatives, opiates or methadone, or controlled substance except as prescribed by a physician? ☐ Yes ☑ No
3. Have you had or been advised to have treatment or counseling for alcohol or drug use or been asked to reduce or eliminate their usage? ☐ Yes ☑ No

(CONTINUED)

MEDICAL INFORMATION (CONTINUED)

4. Other than what has already been disclosed, within the past 5 years, have you:
   a. requested or received disability or compensation benefits? ☐ Yes ☑ No
   b. been a patient in a hospital or other medical facility, other than for normal childbirth? ☐ Yes ☑ No
   c. had any other disease, disorder or condition? ☐ Yes ☑ No
   d. been advised to have surgery, medical tests or diagnostic procedures (other than for HIV)? ☐ Yes ☑ No
5. Are you currently receiving medical treatment or taking any other medication or herbal supplement that has not already been disclosed? ☐ Yes ☑ No
6. Give complete details of any "Yes" answers for questions 1-5, including: **Question number, diagnosis, date of onset and recovery, medication/treatment prescribed and the name, address and telephone number of all attending physicians and hospitals.**

Question #	Diagnosis	Date of Onset	Date of Recovery	Medication/ Treatment Prescribed	Physician/Hospital Name, Address & Phone Number
1g	Cold	4/25/08	5/1/08		Dr. William Smith 23 Main Street Any City, Any State XXXXX

SIGNATURE

All answers are, to the best of my knowledge and belief, complete, true and correctly recorded.

➔ Signature of Witness X *Jane Smith* Date 5 / 1 / 2008

➔ Signature of person examined (if age 18 or over) otherwise, parent/guardian X *John Doe*

Name of person examined (please print) John Doe

Prudential

Part 2 of Application for Life Insurance
Additional Details

Pruco Life Insurance Company
The Prudential Insurance Company of America
Both are Prudential Financial companies.
Policy is issued by the company named at the beginning of this application

POLICY NUMBER (IF KNOWN): XX XXX XXX

PRIMARY PROPOSED INSURED: John Doe

Provide any additional details of any "Yes" answers for questions 1-5 that did not fit within ORD 84379, including:

Question number, diagnosis, date of onset and recovery, medication/treatment prescribed and the name, address and telephone number of all attending physicians and hospitals.

Part 2, Section D, Question #4b - broken leg, Calgary General hospital, March 3-6, 2005, fully recovered.

SIGNATURES

All answers are, to the best of my knowledge and belief, complete, true and correctly recorded.

➔ *Signature of person examined (if age 18 or over) otherwise, parent/guardian* X John Doe Date ___/___/___

Name of person examined (please print): _____

➔ *Signature of witness* X Richard Roe Date ___/___/___

Supporting Document Schedules

Item Status: **Status Date:**

Satisfied - Item: Flesch Certification

Comments:

Attachments:

Arkansas Readability Flesch Certification (Prud.).pdf

Arkansas Certification of Compliance (Prud.).pdf

Item Status: **Status Date:**

Satisfied - Item: Application

Comments:

The Application Forms are located under the Form Schedule tab.

Item Status: **Status Date:**

Satisfied - Item: Statement of Variability

Comments:

Attachment:

Statement of Variability_ 8-19-09.pdf

Item Status: **Status Date:**

Satisfied - Item: ORD 96200A-2010 Limited Insurance Agreement and ORD 96200F-2010 Authorization, Acknowledgement and Limited Insurance Agreement.

Comments:

For informational puposes, we have enclosed copies pf form ORD 96200A-2010, ORD 96200F-2010 which are administrative forms that will be used with application form ORD 96200-2010, ORD 96200JUV-2010 and ORD 96200SURV-2010.

Attachments:

ORD_96200A-2010_040109_PRU_Prefilled.pdf
ORD_96200F-2010_042409_AUTH_VCA_PRU_Prefilled.pdf

Item Status: **Status Date:**

Satisfied - Item: Filing Grids

Comments:

Attachement A, B, F, G, & H.

Attachments:

2010 App Filing Grid - GENERIC.pdf
2010 Exam Filing Grid - GENERIC.pdf
2010 Supp Filing Grid - GENERIC.pdf
2010 Variable Supp Filing Grid - GENERIC.pdf
2010 Amendment Filing Grid - GENERIC.pdf

Item Status: **Status Date:**

Satisfied - Item: List of Replaced Forms-Attachment I.

Comments:

Attachment:

ATTACHMENT I_ List of Replaced Forms (Prudential).pdf

Item Status: **Status Date:**

Satisfied - Item: Copies of Replaced Forms

Comments:

Attach Copies of Replaced Forms

Attachments:

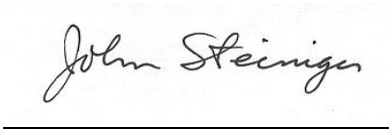
ORD_96200-98.pdf
ORD 9098-98.pdf
ORD 9098A-98.pdf
COMB_84379-98_.pdf
COMB 10164-82.pdf
ORD 86218-90.pdf

STATE OF ARKANSAS
READABILITY CERTIFICATION

COMPANY NAME: The Prudential Insurance Company of America

This is to certify that the forms referenced below have achieved a Flesch Reading Ease Score as indicated below and complies with the requirements of Ark. Stat. Ann. Section 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

Form Number	Score
ORD 96200-2010	50.3
ORD 96200JUV-2010	52.7
ORD 96200SURV-2010	53.6
ORD 96200-2010 Aviation	74.8
ORD 96200-2010 Avocation	47.1
ORD 96200-2010 Business	50.9
ORD 96200-2010 Child Rider	54.5
ORD 96200-2010 Diving	76.6
ORD 96200-2010 Financial	36.2*
ORD 96200-2010 Mountain Climbing	69.9
ORD 96200-2010 Racing	55.9
ORD 96200-2010 Owner Statement	50.2
ORD96200CHG-2010	34.3*
ORD 96200-2010 Variable	44.9
ORD 96200-2010 Overflow Details	49.8
ORD 112730-2010 Individual	44.9
ORD 112730-2010 Juvenile	40.5
ORD 112730-2010 Survivorship	52.4
COMB 10164-2010	62.7
ORD 84379- 2010	40.4
ORD 84379- 2010 Additional Details	39.4*



Name: John Steiniger
Title: Second Vice President
Date August 24, 2009

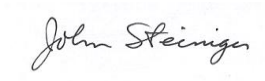
* Although the forms do not meet the required flesch scores by themselves, when they are used in conjunction with form, ORD 96200-2010, they achieve a score of 53.1.

Certificate of Compliance with
Arkansas Rule and Regulation 19

Insurer: The Prudential Insurance Company of America

Form Number(s): *ORD 96200-2010 et. al. (*see attached list below for remaining forms.)

I hereby certify that the filings above meet all applicable Arkansas requirements including the requirements of Rule and Regulation 19.



Signature of Company Officer

John Steiniger

Name

Second Vice President

Title

August 24, 2009

Date

FORM NUMBER	TITLE
ORD 96200JUV-2010	Application For Life Insurance on a Juvenile (Age 0-17)
ORD 96200SURV-2010	Application For Life Insurance Survivorship Life
ORD 96200-2010 Aviation	Aviation Supplement
ORD 96200-2010 Avocation	General Avocation Supplement
ORD 96200-2010 Business	Business Supplement
ORD 96200-2010 Child Rider	Child Rider Supplement
ORD 96200-2010 Diving	Diving Supplement
ORD 96200-2010 Financial	Financial Statement Supplement
ORD 96200-2010 Mountain Climbing	Mountain Climbing Supplement
ORD 96200-2010 Racing	Motorized Vehicle Racing Supplement
ORD 96200-2010 Overflow Details	Overflow Details Supplement
ORD 96200-2010 Owner Statement	Policyowner Statement Supplement
ORD 96200CHG-2010	Request For Policy Change
ORD 96200-2010 Variable	Variable Supplement
ORD 112730-2010 Individual	Individual Good Health Statement
ORD 112730-2010 Juvenile	Juvenile Good Health Statement
ORD 112730-2010 Survivorship	Survivorship Good Health Statement
COMB 10164-2010	Amendment
ORD 84379-2010	Part 2 of Application For Life Insurance
ORD 84379-2010 Additional Details	Part 2 of Application For Life Insurance Additional Details

STATEMENT OF VARIABILITY
Forms ORD 96200-2010, et al
August 19, 2009

1. The listed products are bracketed as variable information in the Plan of Insurance section in the application forms. The listed products may vary in the future based on changes to our individual life product portfolio.

The current list of products includes:

Term Essential (10, 15, 20, or 30 year level-premium plans)
Term Elite (10, 15, or 20 year level-premium plans)
ROP Term (15, 20, or 30 year level-premium plans)
PruLife Custom Premier II (VUL II)
PruLife Universal Life Plus (UL Plus)
PruLife Universal Life Protector (UL Protector)
VUL Protector (VULP)

For the juvenile application, the current list of products includes:

PruLife Universal Life Plus (UL Plus)
PruLife Universal Life Protector (UL Protector)
PruLife Custom Premier II (VUL II)
VUL Protector (VULP)

For the survivorship application, the current list of products includes:

PruLife SUL Protector

In each of the application forms, this section includes a check-off for Other, which can be used to write-in other available products.

2. The listed optional benefits are bracketed as variable information in the Plan of Insurance section in the application forms. The listed optional benefits may vary in the future based on changes to our individual life product portfolio.

The current list of optional benefits includes:

Waiver of Premium/Enhanced Disability Benefit
Acceleration of Death Benefit (Living Needs Benefit)
Accidental Death Benefit
Overloan Protection Rider
Child Rider
Automatic Premium Loan
Enhanced Cash Value Rider

For the juvenile application, the current list of optional benefits includes:

Waiver of Premium/Enhanced Disability Benefit
Acceleration of Death Benefit (Living Needs Benefit)
Overloan Protection Rider
Enhanced Cash Value Rider
Accidental Death Benefit

For the survivorship application, the current list of optional benefits includes:

Estate Protection Rider

In each of the application forms, this section includes a check-off for Other Riders/Benefits, which can be used to write-in other available optional riders or benefits.

3. The instructions are bracketed as variable information in the Plan of Insurance section in the application forms. The instructions may vary in the future based on changes to our individual life product portfolio and/or changes to our current procedures.

If the amount of insurance applied for is $5,000,000 or more, the current instructions indicate to complete the Financial Supplement.

If the product applied for is a variable life policy, the current instructions indicate to complete the Variable Supplement.

The instructions list the current applicable products for a requested death benefit type. The current available death benefit types are Type A (Level), Type B (Variable) or Type C (Return of Premium).

The instructions list the current applicable products for a requested definition of life insurance selection.

If child rider is requested, the current instructions indicate to complete the Child Rider Supplement.

4. The listed premium payment modes and instructions for billed premium are bracketed as variable information in the Premium section in the application forms. The premium payment mode and instructions may vary in the future based on changes to our current rules and procedures. The current listed premium payment modes include annual, semi-annual, quarterly, and monthly – electronic funds transfer.

5. The listed trust and business owner types and instructions are bracketed as variable information in the Owner section in the application forms. The listed owner types and instructions may vary in the future based on changes to our current rules and procedures. The current listed trust owner types include revocable, irrevocable, qualified retirement plan trust, and welfare benefit trust. The current listed business owner types include corporation,

partnership, sole proprietorship, S corporation, LLC, Tax exempt, or other. The current instructions indicate to provide details in the Special Requests section for multiple owners and to complete the Trustee Statement and Agreement for trust owners and the Business Supplement for business owners. The references to business owner are not applicable for the juvenile application.

6. The instructions are bracketed as variable information in the Beneficiary section in the application forms. The instructions may vary in the future based on changes to our current rules and procedures.

7. The instructions are bracketed as variable information in the General Information section in the application forms. The instructions may vary in the future based on changes to our current rules and procedures. The current instructions indicate to complete the appropriate Supplement for a 'Yes' answer to the question asking about aviation or avocation activities.

8. The state-specific instructions and state-required text are bracketed as variable information in the Medical Information section in the application forms. The instructions may vary in the future based on changes to these or other state-specific requirements.

9. The state-specific instructions and state-required text are bracketed as variable information in the Fraud Warning section in the application forms. The instructions may vary in the future based on changes to these or other state-specific requirements.

10. The IRS certification and instructions are bracketed as variable information in the Signatures section. The IRS Certification and instructions may vary in the future based on changes to the IRS requirements.

11. The number of lines for additional details in the application forms may vary based on the amount of space needed for the additional details provided by the applicant and the capabilities of our systems to support this need.

12. The page numbers and included supplement forms are bracketed as variable information in the application forms. The page numbering and included supplements may vary based on the answers provided in the application, which require that a supplement(s) be completed.

13. The instructions and listed check-offs in Section A and the instructions in the Signatures section of the Business Supplement are bracketed as variable information. The current listed source of financial information and source for determining the amount of insurance applied include the proposed insured, accountant/CPA, banker, attorney, producer or other. The instructions and listed check-offs in Section A may vary in the future based on changes to our current rules and procedures. The instructions in the Signatures section of the Business Supplement may vary in the future based on changes to the IRC requirements.

14. The general and state-specific instructions and state-required text are bracketed as variable information in the Child Rider Supplement. The instructions and state-required text may vary in

the future based on changes to our current procedures or changes to these or other state-specific requirements.

15. The instructions and listed check-offs in Section A of the Financial Supplement are bracketed as variable information. The current listed source of financial information and source for determining the amount of insurance applied include the proposed insured, accountant/CPA, banker, attorney, producer or other. The instructions and listed check-offs in Section A may vary in the future based on changes to our current rules and procedures.

16. The administrative sections of the Variable Supplement are bracketed as variable information. The instructions, investment options, codes and allocation percentages in the Investment Options and Allocations section and Allocated Charges section may vary based on the available investment options and our current rules and procedures. The instructions in the Telephone Reallocation/Transfer section may also vary based on our current rules and procedures.

17. The instructions in the Request for Policy Change form are marked as variable information and may vary in the future based on changes to our current rules and procedures.

18. The general instruction and the state-specific instructions and state-required text in the Fraud Warning section are bracketed as variable information in the Application for Reinstatement form. The instructions and state-required text may vary in the future based on changes to our current procedures or changes to these or other state-specific requirements.

Prudential

LIMITED INSURANCE AGREEMENT

Corporate Offices, Newark, New Jersey

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

THANK YOU FOR CHOOSING PRUDENTIAL FOR YOUR INSURANCE NEEDS

POLICY NUMBER: XX XXX XXX

PART 1 – HEALTH CERTIFICATE

A premium can be collected and insurance can take effect under this Limited Insurance Agreement (the "Agreement") only if the following statement is true: I certify and affirm that the proposed insured has not:

(1) Within the past 90 days been hospitalized or been advised by a member of the medical profession that he or she needs hospitalization for any reason (other than for normal pregnancy or well-baby care).

(2) Within the past 12 months received treatment or advice from a member of the medical profession for heart disease, chest pain, stroke or cancer (except skin).

Person proposed for coverage: John Doe

Amount of insurance requested: $ 100,000 Amount of prepayment: $ XXX.XX

All premium checks must be made payable to the Company – do not make check payable to the producer or leave the payee blank. This agreement is valid only if the form of payment submitted is honored. If payment is made by credit card or automatic bank draft, no premium is considered to be honored until the Company actually receives the funds unless otherwise provided by applicable law.

PART 2 – TERMS AND CONDITIONS

The Company agrees to provide limited life insurance coverage under the following terms and conditions:

A. EFFECTIVE DATE OF COVERAGE

Limited insurance starts on the date all of the following requirements have been met:

1. A payment equal to the full first required premium is received at our Administrative Office within the lifetime of the person proposed for coverage under this Agreement. A payment will be considered to be received only if one of the following valid items is received at our Administrative Office: (i) A check in the amount of the full first required premium; (ii) A completed and signed payment form for the first full premium; or (iii) Any other form of payment acceptable to the Company.
2. The form of payment submitted is honored. If payment is made by credit card or automatic bank draft, no premium is considered to be honored until the Company actually receives the funds unless otherwise provided by applicable law.
3. All application information (including, but not limited to, all information necessary to complete parts 1 & 2 of the application and any questionnaires and supplements to the application) is provided and received at our Administrative Office and any medical examinations and tests required by the Company are completed and received at our Administrative Office.
4. This Agreement has been fully completed, signed and dated by the policyowner, proposed insured (if different than the policyowner) and producer.

However, if the proposed insured dies as a direct result of, independent from all other causes, accidental bodily injury within 30 days of the date payment is honored but before any exam and tests are completed, a death benefit will be paid under the terms of this Agreement. We will not pay a benefit under the preceding sentence for death caused or contributed to by: (1) infirmity or disease of mind or body or treatment for it or (2) any infection other than one caused by an accidental cut or wound.

B. END DATE OF COVERAGE

Limited insurance ends when the first of the following occurs:

1. We issue a policy as applied for and the application has been signed.
2. We deliver a policy other than as applied for. The limited insurance will end on delivery of the policy regardless of whether the policy is accepted.
3. We mail you a letter notifying you that we have declined to issue you a policy or that we will not provide limited insurance coverage on a prepaid basis.
4. Sixty days have passed since the Effective Date of Coverage under this Agreement, and the limited insurance provided under this Agreement has not ended for any of the reasons listed above.

If the limited insurance ends and is not replaced by a policy, we will refund the amount you paid.

C. AMOUNT OF COVERAGE

If the proposed insured dies, the total death benefit under this Agreement is the amount requested, up to a maximum aggregate amount of death benefit payable under this Agreement and any other Limited Insurance Agreement issued by the Company on the proposed insured of $1,000,000. The total maximum aggregate amount of death benefit payable under this Agreement and any other Limited Insurance Agreement issued by the Company on any proposed insured cannot exceed $1,000,000.

E. SIGNATURES

I have read this Limited Insurance Agreement including the Special Limitations in section D on page 2. The terms, conditions and limitations of this Agreement have been fully explained to me by the producer, and I understand and agree to them.

➔ Signature of proposed insured: X *John Doe* Date: 2 / 1 / 2007
(Parent/Guardian when proposed insured age is less than 18)

➔ Signature of policyowner(s): X _____ Date: / /
(If different from proposed insured [Parent/Guardian when proposed insured age is less than 18])

I have no personal knowledge of any factors which may have a negative effect on the proposed insured's insurability:

➔ Signature of producer: X *Richard Roe* Date: 2 / 1 / 2007

D. SPECIAL LIMITATIONS (CONTINUED FROM PAGE 1)

- This Agreement does not provide coverage for any riders or additional supplemental benefits which you have requested from the Company.
- The limited insurance is subject to the terms, limitations and exclusions of the policy you have requested from the Company. We will pay the death benefit under this Agreement to the beneficiary you designated to the Company.
- If benefits are payable under this Agreement, then no benefit relating to that death will be payable under any policy that is subsequently issued.
- No producer, medical examiner, or any other Company representative is authorized to accept risks or determine insurability, or to alter or waive any of the terms or conditions of this Agreement, or to waive any of the Company's rights or requirements.
- The total amount of insurance requested in all applications on the proposed insured (or if survivorship coverage is requested, both proposed insureds combined) cannot exceed $5,000,000.
- **There is no coverage under this Limited Insurance Agreement if the Health Certification is materially misrepresented or fraudulent. If death is due to suicide or intentionally self-inflicted injury, while sane or insane, payment will be limited to the return of the amount paid.**

Definitions: The term "Company" refers to the company named at the beginning of the Application for Life Insurance.

My original signature has been affixed to this Agreement. The original will be retained by the Company and I will receive a copy identical in form and substance.

Prudential

Authorization, Acknowledgement and Limited Insurance Agreement

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

PROPOSED INSURED NAME (PRINT): _____

POLICY NUMBER (IF KNOWN): XX XXX XXX

AUTHORIZATION TO RELEASE INFORMATION (THIS AUTHORIZATION WAS INTENDED TO COMPLY WITH THE HIPAA PRIVACY RULE)

[• I authorize any licensed physician, medical practitioner, hospital, clinic, other health care provider, pharmacy benefit manager, insurance company, government agency, or MIB Inc., or other organization or person to give any information about me, or my mental or physical health to the Company and/or its authorized agents to determine my eligibility for insurance and/or benefit payment. It also includes motor vehicle records

- The information authorized for release includes:
  My entire medical record, including any information regarding medications used, drug and alcohol treatment, and communicable or venereal diseases, such as hepatitis, syphilis, gonorrhea, the human immunodeficiency virus (HIV), and Acquired Immune Deficiency Syndrome (AIDS), excluding psychotherapy notes.
- **For purposes of this Authorization, I hereby revoke any prior restriction on disclosure of my medical records, and authorize the release of my entire medical record to the Company, excluding psychotherapy notes.**
- This Authorization may be revoked at any time by writing us at the Customer Service Office address provided in the Important Notice. The revocation will not be valid to the extent we relied on the authorization prior to the notice of revocation. In addition, we may continue to use the Authorization to contest coverage. Revocation or alteration of this Authorization may mean that we will not be able to complete the application process and may deny a claim for insurance.
- Once disclosed to the Company, the information will no longer be protected by the Health Insurance Portability and Accountability Act, but will be protected by other applicable federal and state laws relating to the protection of personal information.
- This Authorization also applies to any member of my family proposed for coverage in the application & is valid for 2 years after the date below.
- A copy of this Authorization will be provided to me by my insurance representative or the Company, either at the time of execution or shortly thereafter. I understand my representative can tell me how and when I will receive a copy. A photocopy of this Authorization is as valid as the original.
- Treatment, payment, enrollment in a health plan, or eligibility for health benefits may not be conditioned on signing this authorization.]

ORD 96200C 2010

VARIABLE CONTRACT ACKNOWLEDGEMENT (IF APPLICABLE)

[I believe this contract meets my insurance needs and financial objectives. I acknowledge receipt of a current prospectus for the contract. I understand that the contract's values and death benefit may vary depending on the contract 's investment experience. An illustration of values is available upon request.]

LIMITED INSURANCE AGREEMENT (PART 1 – HEALTH CERTIFICATE)

A premium can be collected and insurance can take effect under this Limited Insurance Agreement (the "Agreement") only if the following statement is true:
I certify and affirm that the proposed insured has not:

(1) Within the past 90 days been hospitalized or been advised by a member of the medical profession that he or she needs hospitalization for any reason (other than for normal pregnancy or well-baby care).
(2) Within the past 12 months received treatment or advice from a member of the medical profession for heart disease, chest pain, stroke or cancer (except skin).

Person proposed for coverage: John Doe

Amount of insurance requested: $ 100,000 Amount of prepayment: $ XXX.XX

All premium checks must be made payable to the Company – do not make check payable to the producer or leave the payee blank. This agreement is valid only if the form of payment submitted is honored. If payment is made by credit card or automatic bank draft, no premium is considered to be honored until the Company actually receives the funds unless otherwise provided by applicable law.

SIGNATURES

Acknowledgments and Authorizations:

- I have received the **Important Notice About Your Application for Insurance**.

[• The Company may retain and disclose information to MIB Inc., reinsurers, or for insurance underwriting, policyholder service or claim handling, to others who perform services for us, or as otherwise allowed by law. Any revocation of this authorization will not impact these rights of disclosure.]

- I have read this Limited Insurance Agreement including the Special Limitations in section D and all other relevant information on Page 2. The terms, conditions and limitations of this Agreement have been fully explained to me by the producer, and I understand and agree to them.

[• **I AUTHORIZE THIS ENTIRE FORM TO BE PROVIDED TO ANY OF THE INDIVIDUALS LISTED IN THE AUTHORIZATION ABOVE IN ORDER TO REQUEST MEDICAL INFORMATION TO DETERMINE ELIGIBILITY FOR COVERAGE**.]

➔ Signature of proposed insured X John Doe Date: 2 / 1 / 07
(Parent/Guardian when proposed insured age is less than 18)

➔ Signature of policyowner(s) X John Doe Date: 2 / 1 / 07
(If different from proposed insured [Parent/Guardian when proposed insured age is less than 18])

I have no personal knowledge of any factors which may have a negative effect on the proposed insured's insurability:

➔ Signature of producer X Richard Roe Date: 2 / 1 / 07

ORD 96200F 2010

(CONTINUED)

PART 2 – TERMS AND CONDITIONS

The Company agrees to provide limited life insurance coverage under the following terms and conditions:

A. EFFECTIVE DATE OF COVERAGE

Limited insurance starts on the date all of the following requirements have been met:

1. A payment equal to the full first required premium is received at our Administrative Office within the lifetime of the person proposed for coverage under this Agreement. A payment will be considered to be received only if one of the following valid items is received at our Administrative Office:
   i. A check in the amount of the full first required premium;
   ii. A completed and signed payment form for the first full premium; or
   iii. Any other form of payment acceptable to the Company.
2. The form of payment submitted is honored. If payment is made by credit card or automatic bank draft, no premium is considered to be honored until the Company actually receives the funds unless otherwise provided by applicable law.
3. All application information (including, but not limited to, all information necessary to complete parts 1 & 2 of the application and any questionnaires and supplements to the application) is provided and received at our Administrative Office and any medical examinations and tests required by the Company are completed and received at our Administrative Office.
4. This Agreement has been fully completed, signed and dated by the policyowner, proposed insured (if different than the policyowner) and producer.

However, if the proposed insured dies as a direct result of, independent from all other causes, accidental bodily injury within 30 days of the date payment is honored but before any exam and tests are completed, a death benefit will be paid under the terms of this Agreement. We will not pay a benefit under the preceding sentence for death caused or contributed to by:

1. infirmity or disease of mind or body or treatment for it or
2. any infection other than one caused by an accidental cut or wound.

B. END DATE OF COVERAGE

Limited insurance ends when the first of the following occurs:

1. We issue a policy as applied for and the application has been signed.
2. We deliver a policy other than as applied for. The limited insurance will end on delivery of the policy regardless of whether the policy is accepted.
3. We mail you a letter notifying you that we have declined to issue you a policy or that we will not provide limited insurance coverage on a prepaid basis.
4. Sixty days have passed since the Effective Date of Coverage under this Agreement, and the limited insurance provided under this Agreement has not ended for any of the reasons listed above.

If the limited insurance ends and is not replaced by a policy, we will refund the amount you paid.

C. AMOUNT OF COVERAGE

If the proposed insured dies, the total death benefit under this Agreement is the amount requested, up to a maximum aggregate amount of death benefit payable under this Agreement and any other Limited Insurance Agreement issued by the Company on the proposed insured of $1,000,000. The total maximum aggregate amount of death benefit payable under this Agreement and any other Limited Insurance Agreement issued by the Company on any proposed insured cannot exceed $1,000,000.

D. SPECIAL LIMITATIONS

- This Agreement does not provide coverage for any riders or additional supplemental benefits which you have requested from the Company.
- The limited insurance is subject to the terms, limitations and exclusions of the policy you have requested from the Company. We will pay the death benefit under this Agreement to the beneficiary you designated to the Company.
- If benefits are payable under this Agreement, then no benefit relating to that death will be payable under any policy that is subsequently issued.
- No producer, medical examiner, or any other Company representative is authorized to accept risks or determine insurability, or to alter or waive any of the terms or conditions of this Agreement, or to waive any of the Company's rights or requirements.
- The total amount of insurance requested in all applications on the proposed insured (or if survivorship coverage is requested, both proposed insureds combined) cannot exceed $5,000,000.
- **There is no coverage under this Limited Insurance Agreement if the Health Certification is materially misrepresented or fraudulent. If death is due to suicide or intentionally self-inflicted injury, while sane or insane, payment will be limited to the return of the amount paid.**

Definitions: The term "Company" refers to the company named at the beginning of the Application for Life Insurance. My original signature has been affixed to this Agreement. The original will be retained by the Company and I will receive a copy identical in form and substance.

Attachment A

LIFE APPLICATION FORM

Current Application (96200-98)	New Application (96200-2010)	Reason for Change
Application for Life Insurance or Policy Change	**Application for Life Insurance**	Application is to be used for new business transactions only – no post issue changes
PART 1		
Section A (About the Primary Proposed Insured)	***Section A (Proposed Insured)***	
Not included on current application	Previous Name	Added for identification purposes – know your customer
Marital Status	Not included in new application	Detail not needed for risk evaluation
Age	Not included in new application	Removed from application – age to be determined by date of birth
Not included on current application	Date Policy to Save Age	Added for clarification – always submitted but request had to be written in
Not included on current application	Are you a permanent, legal US resident – If NO, country of legal residence, visa type & number, expiration date and length of residence in US required	Added for identification purposes – know your customer
	Driver's license number, issuing state and expiration date	Moved from Section H
Billing address		Moved to Section C
Home address, *if different*	Residence address	Revised for clarity
Not included on current application	e-mail address	Added for additional contact information
Not included on current application	Current employer address	Revised for identification purposes – know your customer
	Occupation and duties	Moved from Section H
Not included on current application	Earned and unearned annual income, net worth	Needed for financial underwriting
Existing Life Insurance		Moved to Section F
Section B (All Other Proposed Insureds)		Section eliminated – base application to apply only to a single proposed insured
Section C (Coverage Information)	**Section B (Plan of Insurance)**	

Current Application (96200-98)	New Application (96200-2010)	Reason for Change
Plan of Insurance	Product applied for	Reformatted for clarity
Not on previous form	Death Benefit Type	Added for clarity
Not on previous form	Definition of Life Insurance	Added for clarity – applicable to specified products
Supplementary benefits & riders	Requested optional benefits	Updated to reflect all current benefits and riders
Section E (Payment Information)	**Section C (Premium)**	
1a Within the past 90 days, has any proposed insured been hospitalized or been advised by a member of the medical profession that he or she needs hospitalization for any reason other than for normal pregnancy or well-baby care? b. Within the past 12 months, has any proposed insured received treatment or advice from a member of the medical profession for heart disease, chest pain, stroke or cancer (except skin)?		Removed from the application – statements remain on the Limited Insurance Agreement
Medical examination required?		Removed from the application. Information no longer required
Not on previous form	Send notices to who, and to where	Changed from “Billing Address”.
Payment mode	Payment mode:	Mode options reduced to those currently available.
Not on previous form	Billed Premium for non-term plans	Added for clarity
Amount of prepayment and date collected		Removed from the application
Section D (Beneficiaries & Ownership)	**Section D (Owner)**	Beneficiaries and Ownership information split into separate sections for clarity
Not on previous form	Added the following: SSN/TIN, @ email address for all Trust owner: trust date, trustee(s) and trust type Business owner: form of the business Personal: total insurance program (inforce & applied for), relationship to proposed insured, date of birth and income.	Additional details added to better know the customer:
	Section E (Beneficiaries)	
	Added primary/secondary check box options for beneficiary	Added for clarity

Current Application (96200-98)	New Application (96200-2010)	Reason for Change
	classes	
Section F (Replacement)	**Section F (Insurance History)**	
	Do you have any existing life insurance or annuities? Note: Existing coverage includes any life insurance policies that have been assigned, sold or transferred.	Moved from Section A (Proposed Insured) & reformatted for clarity.
For any proposed insured, would this insurance replace or cause a change in any existing insurance or annuity in any company?	Will this insurance replace* any existing insurance or annuity? *Replace or replaced means that the insurance being applied for may replace or cause a change in any existing insurance or annuity with any company, including the lapse or surrender of the existing policy, or the use of funds or values from the existing policy to pay for the new policy.	Replacement question reformatted for clarity
	Grid enhanced with Life/Annuity indicator as well as 1035 indicators	Added for clarity
	Are you applying for or reinstating life insurance with any company?	Moved from Section H, language simplified for clarity
	Have you had life or health insurance declined, postponed, rated or issued with an increased premium?	Moved from Section M, language simplified for clarity
Not on previous form	Is the proposed insured or proposed owner considering the transfer or sale to a life settlement company or other investor of: policy ownership; or, any interest in the policy benefits, either directly as a named beneficiary or indirectly as a beneficiary or owner of a trust or other entity?	Added to confirm insurable interest
Section G (Special Requests)		Section now located at the end of Part 1
Section H (Background on Proposed Insureds)	**Section +G (General Information)**	
Within the last two years, has any proposed insured done or does he or she plan to do the following: **a.** operate or have any duties aboard an aircraft, glider, balloon or similar device?	In the past five years, have you flown as a pilot, student pilot or crew member or do you intend to become a pilot?	Language revised for clarity
participate in hazardous sports, such as auto, motorcycle, snowmobile or powerboat competitions/exhibitions, scuba diving, mountain climbing, parachuting, skydiving or any other such	In the past five years, have you participated in any activities such as motorized vehicle racing, SCUBA diving, mountain climbing, skydiving, extreme sports such as BASE jumping, bungee jumping or cave exploration, or do you intend to?	Language revised for clarity

Current Application (96200-98)	New Application (96200-2010)	Reason for Change
sport or hobby?		
Has either the primary proposed insured or second proposed insured (if any) ever used tobacco or other nicotine products such as cigarettes, cigars, pipe, chewing tobacco, snuff, nicotine gum or nicotine patch?	Have you ever used tobacco or any other nicotine products such as cigarettes, cigars, pipe, chewing tobacco, snuff, nicotine gum or nicotine patch?	Language simplified
Occupation/duties of primary proposed insured		Question moved to Section A (Proposed Insured)
Reinstatement question		Question moved to Section F (Insurance History)
Driver's license number and issuing state		Question moved to Section A (Proposed Insured)
In the last three years, has any proposed insured **(1)** had a driver's license denied, suspended or revoked? **(2)** been convicted of or cited for **(a)** three or more moving violations? **(b)** driving under the influence of alcohol or drugs? **(3)** been involved as a driver in two or more auto accidents?	In the past five years, have you: a) had your driver's license denied, suspended or revoked? b) been convicted of or pled guilty to driving under the influence of alcohol and/or drugs? c) been convicted of or pled guilty to any moving violations?	Simplified for clarity
Has any proposed insured been convicted of, or currently charged with, the commission of any criminal offense – other than the violation of a motor vehicle law – within the last 10 years?	Within the past 10 years, have you been arrested, convicted, or imprisoned for any crime and/or are you currently awaiting trial for any crime?	Simplified for clarity
Does any proposed insured plan to live or travel outside the United States or Canada within the next 12 months?	Will you live or travel outside the United States within the next 12 months?	Canada eliminated from question. Simplified for clarity.
	Details	Common details section for Yes answers to Section G questions
Section I (Additional Coverage)		Information no longer required.
Section J (Changes)		Information no longer required.
	Section H (Special Requests)	Section relocated

Current Application (96200-98)	New Application (96200-2010)	Reason for Change

PART 2		
Current Application (96200-98)	**New Application (96200-2010)**	**Reason for Change**
Section K (Physician Information)	**Section A (Personal Physician Information)**	
Primary physician	Revised to Personal Physician	Supports risk selection
Physician last consulted	Not Included	Information will be completed as part of Section D
Section L (Physical Measurements)	**Section B (Physical Measurements)**	
	Within the last 12 months, have you had a change of weight (gain or loss) of more than 10 pounds?	Question added regarding change in weight – relevant to risk selection.
Section M – Question 1 Family record	**Section C (Family History)**	
This question requests the current age or age at death & year and cause of death for the parents and siblings of the proposed Insured	Have any immediate family members (mother, father, brother, sister) been diagnosed with or died from coronary artery disease, cerebrovascular disease, diabetes or cancer before age 70?	Relevant to risk selection.

	Section D (Medical Information)	
Question 2 Has anyone proposed for coverage been diagnosed with or treated by a member of the medical profession for:	***Question 1*** Has a member of the medical profession ever treated you for or diagnosed you with:	
a. chest pain or any disorder of the heart or blood vessels? b. high blood pressure? c. cancer, tumor, leukemia, melanoma or lymphoma? d. diabetes or high blood sugar? e. mental or psychiatric illness? f. Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC)? g. infection caused by the Human Immunodeficiency Virus (HIV)? (Not applicable in California. Wisconsin: AIDS virus HIV antibody testing is limited to FDA-licensed enzyme immunoassay and confirmatory HIV antibody tests. Any test performed at an anonymous counseling and testing site or home testing is confidential and need not be revealed on this application.) h. any sexually transmitted diseases?	a. high blood pressure, chest pain, a heart attack, coronary artery disease, a heart valve disorder, a heart murmur, an irregular heart beat, cerebrovascular disease, a stroke, circulatory disease, an aneurysm or any disease of the heart or blood vessels? b. anemia or other abnormality of the blood (other than HIV)? c. a polyp, cyst, tumor, cancer, leukemia, melanoma, lymphoma or Hodgkin's disease? d. diabetes, high blood sugar, glucose intolerance or other endocrine disorder? e. anxiety, depression, or any other mental or psychiatric illness? f. an infection caused by the Human Immunodeficiency Virus (HIV) (Not applicable in CA. In WI: AIDS virus, HIV antibody testing is limited to FDA-licensed enzyme immunoassay and confirmatory HIV antibody tests. Any test performed at an anonymous counseling and testing site or home testing is confidential and need not be revealed on this application.),	Additional medical conditions mentioned by name, question reorganized by type of condition. Revised to add clarity by including additional medical conditions, questions reorganized

i. asthma or any disorder of the lungs? j. any disorder of the brain or nervous system? k. hepatitis or any disorder of the liver, stomach or intestines? l. any disorder of the kidney or urinary tract?	Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), or any other sexually transmitted disease? g. asthma, emphysema, cystic fibrosis, sleep apnea, sarcoidosis, tuberculosis or any other disorder of the lungs or respiratory system? h. a seizure, epilepsy, multiple sclerosis, Parkinson's disease, muscular dystrophy, cerebral palsy, paralysis, Alzheimer's disease or any other disorder of the brain or nervous system? i. an ulcer, hepatitis, cirrhosis, pancreatitis, ulcerative colitis, Crohn's disease or any other disorder of the esophagus, liver, stomach or intestines? j. nephritis, polycystic kidney disease or any other disorder of the bladder, kidney, urinary tract or prostate? k. arthritis, gout, back trouble, or any disease or disorder of the joints, muscles or bones? l. lupus, rheumatoid arthritis, chronic fatigue syndrome, fibromyalgia, or any other disease or disorder of the autoimmune system?	
Question 3 – Is anyone proposed for coverage currently taking prescription medication?	***Question 5*** Are you currently receiving medical treatment or taking any other medication or herbal supplement that has not already been disclosed?	Revised for clarity
Question 5 – Has anyone proposed for coverage: a. used, or is he or she now using, cocaine, amphetamines, marijuana, heroin or other drugs, except as prescribed by a member of the medical profession? b. had or been advised to have treatment or counseling for alcohol or drug use?	***Question 2*** Have you ever used: a. cocaine, crack, marijuana, heroin, Ecstasy, PCP, LSD, methamphetamine, any other hallucinogenic drug or controlled substance? b. amphetamines, barbiturates, sedatives, opiates or methadone, or controlled substance except as prescribed by a physician?	Revisions add clarity and enhance risk selection

	Question 3 Have you had or been advised to have treatment or counseling for alcohol or drug use or been asked to reduce or eliminate their usage?	Revisions add clarity and enhance risk selection
Question 4 – Other than above, has anyone proposed for	***Question 4 –*** Other than what has already been disclosed, within the past	Questions combined and require only a 5 year look back

coverage a. been a patient in a hospital or other medical facility? b. in the last five years, had or been advised to have surgery, medical tests (other than HIV) or diagnostic procedures such as ECGs, stress tests, X-rays, blood tests, urine tests, etc.? ***Question 6 –*** Does anyone proposed for coverage have any disease, disorder or condition not previously mentioned? ***Question 9 –*** Has anyone proposed for coverage requested or received disability or compensation benefits?	5 years, have you: a. requested or received disability or compensation benefits? b. been a patient in a hospital or other medical facility, other than for normal childbirth? c. had any other disease, disorder or condition? d. been advised to have surgery, medical tests or diagnostic procedures (other than for HIV)?	
Question 7 – Has anyone proposed for coverage had life or health insurance declined, postponed or issued with an increased premium? (Missouri: this question may be answered No if an individual has been declined for coverage.)		Moved from Part 2 (Medical Information) to Part 1 Section G (General Information) for clarity.
Question 8 – Is anyone proposed for coverage currently unable to perform his or her normal daily activities or all normal occupational duties on a full-time basis at the customary place of employment?	***N/A***	Eliminated

Current Application (96200-98)	New Application (96200-2010)	Reason for Change
Terms and Conditions	**Agreements**	
The words "I" and "my" refer to the primary proposed insured and policyowner or applicant, if other than the primary proposed insured. The word "Company" refers to the company checked at the beginning of this application.	**N/A**	Entire section revised
If the Company enters any change in section J, I approve the change by accepting the policy unless the law requires written consent to changes. No Company representative can make or change a policy, or waive any of the Company's rights or requirements.	**N/A**	Section J (Changes) eliminated
The Company will pay the beneficiary named in the application (or in the policy if requesting a policy change and no beneficiary has been named in the application) any applicable insurance benefit either at the death of the primary insured or at the death of an insured child after the death of the primary insured if there is no insured spouse.	**N/A**	Stated in policy provision
For policy changes, the existing policyowner and beneficiary designation will be used unless a new policyowner or beneficiary designation is provided in this application.	**N/A**	Addressed in Policy Change Supplement
The policyowner is either the primary proposed insured or the applicant unless a different policyowner is named in the application. This is subject to any provisions for the automatic transfer of ownership stated in the policy.	**N/A**	Stated in policy provision
If joint policyowners are named, in the event of the death of one policyowner, the survivor(s) shall be the policyowner(s) unless otherwise specified.	**N/A**	Stated in policy provision
Signatures		
I certify, affirm and understand the following:	By signing this form, I have carefully reviewed the	Language simplified for clarity

	application including all supplements attached to the policy, and I agree to the following:	
To the best of my knowledge and belief, the statements in this application, as well as any forms that the Company designates to be part of the application and that are attached to the policy, are complete, true and correctly recorded.	To the best of my knowledge and belief, the statements in this application are complete, true and correctly recorded.	Language simplified for clarity
Except for failure to pay premium or fraud, the Company will not contest the validity of this policy or change request after it has been in force during the insured's lifetime for two years from the date it takes effect.	Except for failure to pay premium, the validity of this policy will not be contested after it has been in force during the insured's lifetime for two years from the date it takes effect.	Language simplified for clarity
I have received and read the Terms and Conditions shown above and the Important Notice About Your Application for Insurance.	N/A	Statement removed from application, included within the authorization to release information
If I have requested the Acceleration of Death Benefits (Living Needs Benefit), I have read the disclosures in the brochure (ORD 87246)	If I have requested the Acceleration of Death Benefits (Living Needs Benefit), I have read the disclosures in the Living Needs Benefit brochure.	Removed form number
My original signature has been affixed to this application, the original application will be retained by the Company and I will receive a copy identical in form and substance to the original, attached to my policy.	My original signature has been affixed to this application, the original will be retained by the Company named at the beginning of this application ("Company"). The copies attached to the policy issued to me are identical in form and substance.	Language simplified for clarity
Unless I have specified a policy date or special payment plan (e.g. government allotment, payroll budget) in this application, I understand that if the initial premium is not paid with this request for coverage, coverage will become effective when all of the following conditions are met: the policy is issued, delivered and I accept it, the health of all persons proposed for insurance remains as stated in the application and the first premium is paid in full and the check or other form of payment is good and can be collected.	Any policy issued on this application shall not take effect until after all of the following conditions are met: • A payment equal to the full first required premium is received by the Company within the lifetime of the proposed insured. A payment will only be considered to be received if one of the following valid items is received by the Company: (i) a check in the amount of the full first required premium; (ii) a completed and signed payment form for the first full premium; or (iii) any other form of payment acceptable to the Company. • The form of payment submitted is honored. If payment is made by credit/debit card, wire transfer or automatic	Language revised to provide clarity

I will inform the Company of any changes in my or any proposed insured's health, mental or physical condition, or of any changes to any answers on this application, prior to or upon delivery of this policy.	bank draft, no premium is considered to be honored until the Company actually receives the funds unless otherwise provided by applicable law. • A signed copy of this Application is received by the Company. • • The Owner has personally received the policy during the lifetime of and while the health of the Proposed Insured is as stated in this application.	
I believe this policy meets my insurance needs and financial objectives. For a variable product: I acknowledge receipt of a current prospectus for the policy. I understand that the policy's value and death benefit may vary depending on the policy's investment experience.	N/A	Included in the Variable Supplement, and included with, and made part of the contract.
Not on previous application	Only an officer of the Company with the rank or title of Vice President may make or alter any contract or agree not to enforce any of the rights of the Company, and then only in writing. **No producer or medical examiner is authorized to accept risks, pass on insurability, make or alter contracts, or waive any of the other rights or requirements of the Company.** Notice to or knowledge imputed to any producer or medical examiner will not be notice of or knowledge to the Company unless it is set out in writing in this application.	Language revised to provide clarity
	Fraud Warning	
Not applicable in Arizona: **Any person who knowingly and intentionally gives false or deceptive information when completing an application for insurance or filing a claim, for the purpose of defrauding an insurance company:** • **Arkansas, Hawaii, Louisiana, New Mexico, Tennessee, Virginia** and **Washington:** may be subject to fines, denial of insurance benefits, or confinement in prison. • **Colorado:** penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete,	**(**Not applicable in **AZ**.) Any person who knowingly: • **AR, HI, LA, NM, TN, VA and WA**: and intentionally gives false or deceptive information when completing an application for insurance or filing a claim, for the purpose of defrauding an insurance company may be subject to fines, denial of insurance benefits, or confinement in prison. • **CO:** and intentionally gives false or deceptive information when completing an application for insurance or filing a claim, for the purpose of defrauding an insurance company may have committed fraud, or may have violated state law. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or	Complies with various state regulations and Department of Insurance requests for fraud notice.

or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies. • **District of Columbia:** or any other person has committed a crime. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant. • • **All other states:** may have committed fraud, or may have violated state law.	misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies. • **DC**: presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. • **MD:** and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. • **OH:** and with 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 is guilty of insurance fraud. • **PA:** 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 commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. • **All other states:** and intentionally gives false or deceptive information when completing an application for insurance or filing a claim, for the purpose of defrauding an insurance company may have committed fraud, or may have violated state law.	
	Signatures	
Not on previous application	IRS Certification	Added to eliminate need for stand alone Tax Certification
Signed at City/State on Date	Signed at State on Date	Simplification of completion of application
Signature of primary proposed insured, if age 8 or over, or of currently insured person, if policy change.	Signature of proposed insured.	Application limited to ages 18 and over.

Signature of spouse (Applicable in South Carolina, if proposed for coverage)	**N/A**	Application no longer supports multiple proposed insureds
Signature of policyowner (if different from the primary proposed insured) or of existing policyowner if a policy change. If owner is a firm or corporation, give that company's name and have an officer sign below.	**If policyowner is different from the proposed insured:** For a personal policyowner(s): Signature(s) of policyowner(s) For an entity policyowner(s) (i.e., trust, business): Name of entity Signature of officer/trustee(s) **X** Title of officer/trustee(s)	Revised to add clarity
Signature and title of officer of firm or corporation	**See above for business signature requirements**	Adds clarity, ease of completion
Signature of applicant, if different from primary proposed insured or policyowner	**N/A**	Signature of applicant removed from file – no longer applicable
Signature of beneficiary, if policy change and rights are limited		Moved to Policy Change Supplement
Licensed Writing Representative's Certification		
Do you have any information, other than that stated in this application, which indicates that any proposed insured may replace or change any current insurance or annuity in any company?	N/A	Signature on application

Attachment B

MEDICAL EXAMINATION FORM

Current Form COMB 84379-98	New Form ORD 84379-2010	Reason for Change
Section 2 – Medical Information	**Personal Information Section**	
Physician last consulted	Not Included	Information will be completed as part of Medical Information Section, Question #6
Primary physician	Revised to Personal Physician	Supports risk selection
	Family History	
	Have any immediate family members (mother, father, brother, sister) been diagnosed with or died from coronary artery disease, cerebrovascular disease, diabetes or cancer before age 70?	Relevant to risk selection.
2. Has the person being examined ever used tobacco or other nicotine products such as cigarettes, cigars, pipe, chewing tobacco, snuff, nicotine gum or nicotine patch?	Removed from form	Included in Part 1 of Application
Question 3 Has the person being examined been diagnosed with or treated by a member of the medical profession for:	***Question 1*** Has a member of the medical profession ever treated you for or diagnosed you with:	
a. chest pain or any disorder of the heart or blood vessels? b. high blood pressure? c. cancer, tumor, leukemia, melanoma or lymphoma? d. diabetes or high blood sugar? e. mental or psychiatric illness? f. Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC)? g. infection caused by the Human Immunodeficiency Virus (HIV)? (Not applicable in California and Connecticut. Wisconsin: AIDS virus HIV antibody testing is limited to FDA-licensed enzyme immunoassay and confirmatory HIV antibody tests. Any test performed at an anonymous counseling and	a. high blood pressure, chest pain, a heart attack, coronary artery disease, a heart valve disorder, a heart murmur, an irregular heart beat, cerebrovascular disease, a stroke, circulatory disease, an aneurysm or any disease of the heart or blood vessels? b. anemia or other abnormality of the blood (other than HIV)? c. a polyp, cyst, tumor, cancer, leukemia, melanoma, lymphoma or Hodgkin's disease? d. diabetes, high blood sugar, glucose intolerance or other endocrine disorder? e. anxiety, depression, or any other mental or psychiatric illness? f. an infection caused by the Human Immunodeficiency Virus (HIV) (Not applicable in CA & CT. In WI: AIDS virus, HIV antibody testing is limited to FDA-licensed enzyme	Additional medical conditions mentioned by name, question reorganized by type of condition. Revised to add clarity by including additional medical conditions, questions reorganized

Current Form COMB 84379-98	New Form ORD 84379-2010	Reason for Change
testing site or home testing is confidential and need not be revealed on this application.) h. any sexually transmitted diseases? i. asthma or any disorder of the lungs? j. any disorder of the brain or nervous system? k. hepatitis or any disorder of the liver, stomach or intestines? l. any disorder of the kidney or urinary tract?	immunoassay and confirmatory HIV antibody tests. Any test performed at an anonymous counseling and testing site or home testing is confidential and need not be revealed on this application.), Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), or any other sexually transmitted disease? g. asthma, emphysema, cystic fibrosis, sleep apnea, sarcoidosis, tuberculosis or any other disorder of the lungs or respiratory system? h. a seizure, epilepsy, multiple sclerosis, Parkinson's disease, muscular dystrophy, cerebral palsy, paralysis, Alzheimer's disease or any other disorder of the brain or nervous system? i. an ulcer, hepatitis, cirrhosis, pancreatitis, ulcerative colitis, Crohn's disease or any other disorder of the esophagus, liver, stomach or intestines? j. nephritis, polycystic kidney disease or any other disorder of the bladder, kidney, urinary tract or prostate? k. arthritis, gout, back trouble, or any disease or disorder of the joints, muscles or bones? l. lupus, rheumatoid arthritis, chronic fatigue syndrome, fibromyalgia, or any other disease or disorder of the autoimmune system?	
Question 4 – Is the person being examined currently taking prescription medication?	***Question 5*** Are you currently receiving medical treatment or taking any other medication or herbal supplement that has not already been disclosed?	Revised for clarity
Question 6 – Has the person being examined: a. used, or is he or she now using, cocaine, amphetamines, marijuana, heroin or other drugs, except as prescribed by a member of the medical profession? b. had or been advised to have treatment or counseling for alcohol or drug use?	***Question 2*** Have you ever used: a. cocaine, crack, marijuana, heroin, Ecstasy, PCP, LSD, methamphetamine, any other hallucinogenic drug or controlled substance? b. amphetamines, barbiturates, sedatives, opiates or methadone, or controlled substance except as prescribed by a physician?	Revisions add clarity and enhance risk selection

Current Form COMB 84379-98	New Form ORD 84379-2010	Reason for Change
	Question 3 Have you had or been advised to have treatment or counseling for alcohol or drug use or been asked to reduce or eliminate their usage?	Revisions add clarity and enhance risk selection
Question 5 – Other than above, has the person being examined a. been a patient in a hospital or other medical facility? b. in the last five years, had or been advised to have surgery, medical tests (other than HIV) or diagnostic procedures such as ECGs, stress tests, X-rays, blood tests, urine tests, etc.? ***Question 7 –*** Does the person being examined have any disease, disorder or condition not previously mentioned? ***Question 10 –*** Has the person being examined requested or received disability or compensation benefits?	***Question 4 –*** Other than what has already been disclosed, within the past 5 years, have you: a. requested or received disability or compensation benefits? b. been a patient in a hospital or other medical facility, other than for normal childbirth? c. had any other disease, disorder or condition? d. been advised to have surgery, medical tests or diagnostic procedures (other than for HIV)?	Questions combined and require only a 5 year look back
Question 8 – Has the person being examined had life or health insurance declined, postponed or issued with an increased premium? (Missouri: this question may be answered No if an individual has been declined for coverage.)	***N/A***	Included in Part 1 of Application
Question 9 – Is the person being examined currently unable to perform his or her normal daily activities or all normal occupational duties on a full-time basis at the customary place of employment?	***N/A***	Eliminated
Signature of person examined (if age 15 or over) otherwise applicant.	Signature of person examined (if age 18 or over) otherwise, parent/guardian.	Revised to allow parent to sign through age 17

ATTACHMENT F

Aviation Supplement
GENERIC

Current Form ORD 9098-98	New Form ORD 96200-2010 Aviation	Reason for Change
Not on current form	Do you hold a valid FAA Medical Certificate?	Added to enhance risk selection
Not on current form	Do you hold a valid FAA Airman Certificate?	Added to enhance risk selection
Not on current form	What is the make and model of the primary aircraft you fly?	Added to enhance risk selection
Have you ever been in any flying accidents or been grounded for violations?	Have you ever been in any aviation accidents; received any FAA safety violations?	Revised for clarity
Flight hours chart – hours required for pilot & co-pilot, crew member and passenger categories	Flight hours chart – hours required for pilot in command, instructor, total flight time, last 12 & 24 months and next 12 months	Revised for clarity and enhanced risk selection
Type of Flights	N/A	Removed
Not on current form	Crew member only activities – duties, make/model working on, total flight time, last 12 & 24 months and next 12 months	Revised for clarity and enhanced risk selection
Do you plan that your future flying will be of a different nature? 5. Do you plan to fly in a different type of aircraft in the future?	Do you plan to fly a different aircraft within the next 24 months If Yes, provide details. What are the make(s) and model(s) of the aircraft you plan to fly? Make, Model, Anticipated date: Within the next 24 months, do you plan that your future flying will be of a different nature, including aerobatic flight, stunt flying or racing?	Revised for clarity and enhanced risk selection

Avocation Supplement
GENERIC

Current Form ORD 9098A-98	New Form ORD 96200-2010 Avocation	Reason for Change
1. Provide details of each avocation and describe safety equipment used (include exact location where each activity takes place – including starting point, if applicable). **2.** How long have you participated in each activity? **3.** Date you last participated **4.** Number of times you participate per year Last 12 months Next 12 months 1. List formal training and qualifying certificates, licenses, etc., held. 2. Are you a member of an organization with national affiliation and established safety rules? **1.** Have you engaged in, or do you intend to engage in, any exhibitions, stunting, exploration, rescue, dare-devil or record-setting activities? **2.** Describe type of competition in which you participate (If motor racing, include exact type of race, e.g., drag, enduro, against time or competition, and type of track, e.g. oval.) a. Is it amateur or professional? b. If events are supervised, name supervising organization? c. Any competition outside of U.S. or	**Avocation:** 1. Description of activity: 2. Frequency of activity: times per year Date of last activity: 3. Experience: Less than one year, One to three years, More than three years 4. Certificate or license required? 5. Are you a member of any related club or associations? 6. Is safety equipment used or required? 7. Have you engaged in: exhibitions, stunting, exploration, rescue, dare-devil, record-setting activities? 8. Do you have any future plans to engage in: exhibitions, stunting, exploration, rescue, dare-devil, record-setting activities? 9. Do you participate or plan to participate in any avocation outside the United States? 10. For aerial avocations only: a. Average height for participation: ft. and duration: b. Maximum height for participation: ft. and duration:	Revised for clarity and enhanced risk selection

Canada?		
Not in current section	**Avocation:** 1. Description of activity: 2. Frequency of activity: times per year Date of last activity: 3. Experience: Less than one year, One to three years, More than three years 4. Certificate or license required? 5. Are you a member of any related club or associations? 6. Is safety equipment used or required? 7. Have you engaged in: exhibitions, stunting, exploration, rescue, dare-devil, record-setting activities? 8. Do you have any future plans to engage in: exhibitions, stunting, exploration, rescue, dare-devil, record-setting activities? 9. Do you participate or plan to participate in any avocation outside the United States? 10. For aerial avocations only: a. Average height for participation: ft. and duration: b. Maximum height for participation: ft. and duration:	Revised for clarity
If you participate in motor sports, describe vehicle. a. Generic type (e.g., drag racer, stock, hydrofoil.) b. Make c. Model d. Horsepower e. Engine displacement (cc) f. Avg. speed (mph) g. Max. speed (mph)	Not on new form	Moved to specific new Motorized Vehicle Racing Supplement
If you participate in diving or aerial sports **1.** Estimate number of dives, jumps, flights Last 12 months Next 12 months **2.** Average depth/height ft. Maximum depth/height ft. Maximum duration min/hrs. **3.** Indicate type of equipment purchased, completely assembled, homemade, assembled from a factory kit, for experimental use.	Not on new form	Moved to specific new Diving Supplement

ATTACHMENT G

Variable Supplement
GENERIC

Current Form ORD 86218-90	New Form ORD 96200-2010 Variable	Reason for Change Form number changed to be consistent with all filed components of the application
A Supplement to the Application for a variable contract in which _____ _____is named as the proposed Insured.	Not Included	Supplement to be printed as part of the policy.

ATTACHMENT H

Amendment
GENERIC

Current Form ORD 10164-82	New Form ORD 10164-2010	Reason for Change Form number changed to be consistent with all filed components of the application
ORD 10164-82	ORD 10164-2010	Edition date updated to 2010 to match other application forms
	Prudential logo & form title	Added to enhance readability of form and customer understanding.

ATTACHMENT I
List of Replaced Forms

Arkansas

New Form Number	Replaced Form Number	Prior Approval Dates
ORD 96200-2010	ORD 96200-98	10/27/1998
ORD 96200-2010 Aviation	ORD 9098-98	10/27/1998
ORD 96200-2010 Avocation	ORD 9098A-98	10/27/1998
ORD 96200-2010 Variable	ORD 86218-90	08/28/1990
COMB 10164-2010	COMB 10164-82	05/11/1983
ORD 84379-2010	COMB 84379-98	10/27/1998

Prudential Financial

Application for Life Insurance or Policy Change

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

Part 1

Policy number _____ ☐ **Check here if policy change.**

A About the Primary Proposed Insured

1. Name of primary proposed insured *(or current insured person, if policy change)*
_____
(First name, middle initial, last name)
2. Social Security number _____
3. Sex ☐ female ☐ male
4. Marital status ☐ single ☐ married ☐ widowed ☐ separated ☐ divorced
5. Date of birth ____/____/____
month day year
6. Age _____
7. State of birth *(country if not U.S.)* _____
8. Billing address _____
(street, city, state, ZIP)
_____
9. Home address *(if different)* _____
(street, city, state, ZIP)
_____
10. Home telephone number (_____)_____
11. Business telephone number (_____)_____
12. Current employer _____
13. List all existing life insurance coverage. ☐ Check here if none.

Company	Amount	Year issued	Type of insurance	To be replaced?
	$		☐ Individual ☐ Group	☐ Yes ☐ No
	$		☐ Individual ☐ Group	☐ Yes ☐ No
	$		☐ Individual ☐ Group	☐ Yes ☐ No
	$		☐ Individual ☐ Group	☐ Yes ☐ No
	$		☐ Individual ☐ Group	☐ Yes ☐ No

B All Other Proposed Insureds

(Include applicant if requesting Applicant's Waiver of Premium [AWP] Benefit)

Name *(first, initial, last)*	relationship to primary proposed insured	sex *(F/M)*	date of birth *(M/D/Y)*	age	state of birth *(country if not U.S.)*	total life insurance in all companies

C Coverage Information

1. Plan of insurance _____
   If applicable to the plan, check one. ☐ Level Death Benefit ☐ Variable Death Benefit
2. Initial amount of insurance $_____
3. Supplementary benefits and riders
   - ☐ Waiver of Premium
   - ☐ Applicant's Waiver of Premium
   - ☐ Automatic Premium Loan
   - ☐ Acceleration of Death Benefits (Living Needs Benefit)
   - ☐ Accidental Death Benefit $ _____
   - ☐ Option to Purchase Additional Insurance (OPAI) $_____
   - ☐ Option to Purchase Paid-up Life Insurance Additions *(include details in section G, **Special Requests**)*

Other riders and benefits *(indicate amount where applicable)* _____

D Beneficiaries and Ownership

(If trust, provide name of trust, trustee and date of trust)

1. **Beneficiary information**

	Name	Relationship to primary proposed insured	Age
Primary *(Class 1)*			
Contingent *(Class 2)*			

2. Is the policyowner someone other than the primary proposed insured? ☐ Yes ☐ No
   (If Yes, provide information requested below.)
   Name _____ Date of birth ____/____/____
   (First name, middle initial, last name) *month day year*
   Address _____
   (street, city, state, ZIP)
   _____

E Payment Information

1a. Within the past 90 days, has any proposed insured been hospitalized or been advised by a member of the medical profession that he or she needs hospitalization for any reason other than for normal pregnancy or well-baby care? ☐ Yes ☐ No

b. Within the past 12 months, has any proposed insured received treatment or advice from a member of the medical profession for heart disease, chest pain, stroke or cancer (except skin)? ☐ Yes ☐ No

2. Is a medical examination required on the primary proposed insured? ☐ Yes ☐ No
second proposed insured? ☐ Yes ☐ No

3. Premium payment mode *(collect full modal premium if prepaid)*
- ☐ Annual ☐ Semiannual ☐ Quarterly ☐ Monthly
- ☐ Electronic Funds Transfer (EFT) ☐ Payroll Budget ☐ Government Allotment

4. Amount of prepayment submitted with this application $ _____ *(include any unscheduled premium payments)*
☐ None *(must be **None** if **1a** or **1b** is **Yes**, except for Gibraltar [GIB] products)*

5. Date prepayment collected, ____/____/____
month day year

F Replacement

For any proposed insured, would this insurance replace or cause a change in any existing insurance or annuity in any company? ***(If Yes, enclose all required replacement forms.)*** ☐ Yes ☐ No

G Special Requests

H Background on Proposed Insureds

1. Has either the primary proposed insured or second proposed insured (if any) ever used tobacco or other nicotine products such as cigarettes, cigars, pipe, chewing tobacco, snuff, nicotine gum or nicotine patch? ***(If Yes, provide date when last used and indicate all types of products.)*** ☐ Yes ☐ No

	Date (mo., yr.)	*Product(s)*
Primary proposed insured	_____	_____
	_____	_____
Second proposed insured	_____	_____
	_____	_____

2. What are the occupation and duties of the primary proposed insured? _____

3. Within the last two years, has any proposed insured done or does he or she plan to do the following:
   - **a.** operate or have any duties aboard an aircraft, glider, balloon or similar device? ☐ Yes ☐ No
     (If Yes, complete* Aviation Questionnaire.*)
   - **b.** participate in hazardous sports, such as auto, motorcycle, snowmobile or powerboat competitions/exhibitions, scuba diving, mountain climbing, parachuting, skydiving or any other such sport or hobby? ***(If Yes, complete* Avocation Questionnaire.*)*** ☐ Yes ☐ No

4. Is any proposed insured applying for or requesting reinstatement or policy change(s) of any other life or health insurance policy? ***(If Yes, provide insurance company, policy plan and amount.)*** ☐ Yes ☐ No

5. Has any proposed insured been convicted of, or currently charged with, the commission of any criminal offense – other than the violation of a motor vehicle law – within the last 10 years? ☐ Yes ☐ No
   (If Yes, provide details.) _____

6. **a.** Driver's license number and state of issue of primary proposed insured _____

   b. In the last three years, has any proposed insured
   - **(1)** had a driver's license denied, suspended or revoked? ☐ Yes ☐ No
   - **(2)** been convicted of or cited for
     - **(a)** three or more moving violations? ☐ Yes ☐ No
     - **(b)** driving under the influence of alcohol or drugs? ☐ Yes ☐ No
   - **(3)** been involved as a driver in two or more auto accidents? ☐ Yes ☐ No

   (If Yes to any of the above, provide details, including type of violation, accident, or reason for denial, suspension or revocation.) _____

7. Does any proposed insured plan to live or travel outside the United States or Canada within the next 12 months? ***(If Yes, list countries and purpose and duration of each trip.)*** ☐ Yes ☐ No

I Additional Coverage

Complete only if this is an application for additional coverage on a person already covered by a Prudential or Pruco policy with an application date within three months of the date of this application.

To the best of your knowledge, has the health or the mental or physical condition of any person proposed for insurance changed since the answers and statements were given in the application included in policy number _____? ☐ Yes ☐ No

(If Yes, complete the appropriate Part 2 Medical Information section.)

J Changes

Changes made by the Company **(not applicable in New Mexico or West Virginia)**

K Physician Information

Primary proposed insured

Physician last consulted

Name _____

Address _____
(street, city, state, ZIP)

_____

Telephone number (____) _____ Date last seen ____/____/____
month day year

Reason last seen _____

Primary physician

Name _____

Address _____
(street, city, state, ZIP)

_____

Telephone number (____) _____ Date last seen ____/____/____
month day year

Reason last seen _____

Second proposed insured or applicant for Applicant's Waiver of Premium (AWP)

Physician last consulted

Name _____

Address _____
(street, city, state, ZIP)

_____

Telephone number (____) _____ Date last seen ____/____/____
month day year

Reason last seen _____

Primary physician

Name _____

Address _____
(street, city, state, ZIP)

_____

Telephone number (____) _____ Date last seen ____/____/____
month day year

Reason last seen _____

L Physical Measurements

	Height	Weight
Primary proposed insured		
Second proposed insured		
AWP applicant		

M Category II Changes and Plans other than Gibraltar (GIB)

1. Family record

	Current age or age at death	Year and cause of death		Current age or age at death	Year and cause of death
Father			Mother		
Brother			Sister		
Brother			Sister		
Brother			Sister		

2. Has anyone proposed for coverage been diagnosed with or treated by a member of the medical profession for

a. chest pain or any disorder of the heart or blood vessels? ☐ Yes ☐ No

b. high blood pressure? ☐ Yes ☐ No

c. cancer, tumor, leukemia, melanoma or lymphoma? ☐ Yes ☐ No

d. diabetes or high blood sugar? ☐ Yes ☐ No

e. mental or psychiatric illness? ☐ Yes ☐ No

f. Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC)? ☐ Yes ☐ No

g. infection caused by the Human Immunodeficiency Virus (HIV)? **(Not applicable in California. Wisconsin:** AIDS virus HIV antibody testing is limited to FDA-licensed enzyme immunoassay and confirmatory HIV antibody tests. Any test performed at an anonymous counseling and testing site or home testing is confidential and need not be revealed on this application.) ☐ Yes ☐ No

h. any sexually transmitted diseases? ☐ Yes ☐ No

i. asthma or any disorder of the lungs? ☐ Yes ☐ No

j. any disorder of the brain or nervous system? ☐ Yes ☐ No

k. hepatitis or any disorder of the liver, stomach or intestines? ☐ Yes ☐ No

l. any disorder of the kidney or urinary tract? ☐ Yes ☐ No

3. Is anyone proposed for coverage currently taking prescription medication? ☐ Yes ☐ No

4. Other than above, has anyone proposed for coverage

a. been a patient in a hospital or other medical facility? ☐ Yes ☐ No

b. in the last five years, had or been advised to have surgery, medical tests (other than HIV) or diagnostic procedures such as ECGs, stress tests, X-rays, blood tests, urine tests, etc.? ☐ Yes ☐ No

5. Has anyone proposed for coverage

a. used, or is he or she now using, cocaine, amphetamines, marijuana, heroin or other drugs, except as prescribed by a member of the medical profession? ☐ Yes ☐ No

b. had or been advised to have treatment or counseling for alcohol or drug use? ☐ Yes ☐ No

6. Does anyone proposed for coverage have any disease, disorder or condition not previously mentioned? ☐ Yes ☐ No

7. Has anyone proposed for coverage had life or health insurance declined, postponed or issued with an increased premium? (**Missouri:** this question may be answered No if an individual has been declined for coverage.) ☐ Yes ☐ No

8. Is anyone proposed for coverage currently unable to perform his or her normal daily activities or all normal occupational duties on a full-time basis at the customary place of employment? ☐ Yes ☐ No

9. Has anyone proposed for coverage requested or received disability or compensation benefits? ☐ Yes ☐ No

(continued on next page)

M Category II Changes and Plans other than Gibraltar (GIB) *(continued)*

10. Details of "**Yes**" answers for questions 2-9

Question number and name of proposed insured	Indicate illness, hospitalization, reason for checkup, medication and any advice or treatment given by a medical professional	Dates and duration of illness	Name, address and telephone number of medical professionals and hospitals

For additional medical details, use another application.

Terms and Conditions

The words "I" and "my" refer to the primary proposed insured and policyowner or applicant, if other than the primary proposed insured. The word "Company" refers to the company checked at the beginning of this application.

Unless I have specified a policy date or special payment plan (e.g., government allotment, payroll budget) in this application, I understand that if the initial premium is not paid with this request for coverage, the policy will become effective when all of the following conditions are met:

- the policy is issued, delivered and I accept it,
- the health of all persons proposed for insurance remains as stated in the application and
- the first premium is paid in full and the check or other form of payment is good and can be collected.

If the Company enters any change in section J, I approve the change by accepting the policy unless the law requires written consent to changes. No Company representative can make or change a policy, or waive any of the Company's rights or requirements.

The Company will pay the beneficiary named in the application (or in the policy if requesting a policy change and no beneficiary has been named in the application) any applicable insurance benefit either at the death of the primary insured or at the death of an insured child after the death of the primary insured if there is no insured spouse.

For policy changes, the existing policyowner and beneficiary designation will be used unless a new policyowner or beneficiary designation is provided in this application.

The policyowner is either the primary proposed insured or the applicant unless a different policyowner is named in the application. This is subject to any provisions for the automatic transfer of ownership stated in the policy.

If joint policyowners are named, in the event of the death of one policyowner, the survivor(s) shall be the policyowner(s), unless otherwise specified.

Signatures

I certify, affirm and understand the following:

- To the best of my knowledge and belief, the statements in this application, as well as any forms that the Company designates to be part of the application and that are attached to the policy, are complete, true and correctly recorded.
- Except for failure to pay premium or fraud, the Company will not contest the validity of this policy or change request after it has been in force during the insured's lifetime for two years from the date it takes effect.
- I will inform the Company of any changes in my or any proposed insured's health, mental or physical condition, or of any changes to any answers on this application, prior to or upon delivery of this policy.
- If I have requested the Acceleration of Death Benefits (Living Needs Benefit), I have read the disclosures in the brochure (ORD 87246).
- I have received and read the Terms and Conditions shown above and the Important Notice About Your Application for Insurance.
- I believe this policy meets my insurance needs and financial objectives. For a variable product: I acknowledge receipt of a current prospectus for the policy. I understand that the policy's value and death benefit may vary depending on the policy's investment experience.
- My original signature has been affixed to this application, the original application will be retained by the Company and I will receive a copy identical in form and substance to the original, attached to my policy.

(continued on next page)

Signatures (continued)

- **Not applicable in Arizona:**

  Any person who knowingly and intentionally gives false or deceptive information when completing an application for insurance or filing a claim, for the purpose of defrauding an insurance company:
  - **Arkansas, Hawaii, Louisiana, New Mexico, Tennessee, Virginia** and **Washington:** may be subject to fines, denial of insurance benefits, or confinement in prison.
  - **Colorado:** penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.
  - **District of Columbia:** or any other person has committed a crime. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.
  - **All other states:** may have committed fraud, or may have violated state law.

Signed at _____ on ____/____/____
(city, state) *month day year*

Signature of primary proposed insured, if age 8 or over, or of currently insured person, if policy change **X** _____

Signature of spouse (applicable in South Carolina, if proposed for coverage.) **X** _____

Signature of policyowner (if different from the primary proposed insured) or of existing policyowner if a policy change. If the policyowner is a firm or corporation, give that company's name and have an officer sign below. **X** _____

Signature and title of officer of firm or corporation **X** _____

Signature of applicant, if different from primary proposed insured or policyowner **X** _____

Signature of beneficiary, if policy change and rights are limited **X** _____

Signature of witness (Licensed Writing Representative must witness.) **X** _____

Licensed Writing Representative's Certification

Do you have any information, other than that stated in this application, which indicates that any proposed insured may replace or change any current insurance or annuity in any company? ☐ Yes ☐ No

Signature of Writing Representative **X** _____

Prudential Financial

☐ The Prudential Insurance Company of America
☐ Pruco Life Insurance Company, *a subsidiary of The Prudential Insurance Company of America*

Aviation Questionnaire

Supplementary declarations forming a part of the application for insurance

Policy number _____

1 Name

_____
(First name, middle initial, last name)

2 Flight Hours

How many hours have you flown and do you plan to fly in each category below? (Include flight for flight pay.) If none, write "none."

	Hours flown in last 12 mos.	Hours flown in last 24 mos.	Total hours flown to date	Estimate of hours for next 12 mos.
1. Pilot and Co-pilot				
Private and Student (not flying for hire)				
Commercial (flying for hire, including pilot instruction)				
Military (including student, Reserve and National Guard)				
2. Crew member (with duties aboard aircraft, including photographer, observer, flight attendant, etc.)				
Commercial (flying for hire)				
Military (including Reserve and National Guard)				
3. Passenger, except scheduled airlines (with no duties aboard aircraft.)				

3 Type of Flights

What were the nature of the flights in section 2 and the type of aircraft flown in the last two years? (If more than one, check each appropriate box.)

1. Civil Aviation

- ☐ U.S. Certificated (comparable Canadian) passenger/cargo airline
- ☐ U.S. Certificated All-Cargo airline
- ☐ U.S. Certificated Charter airline
- ☐ Other U.S. and Canadian airline
- ☐ Foreign airline flying to U.S. and Canada
- ☐ Company or private business
- ☐ Other flying service
- ☐ Giving flight instruction number of hours per year _____
- ☐ Dusting or spraying
- ☐ Test – production line (describe in **Remarks**)
- ☐ Experimental, aerobatic or stunt flying (describe in **Remarks**)
- ☐ Pleasure
- ☐ Hang gliding, ultralite, etc.
- ☐ Student pilot
- ☐ Other (describe in **Remarks**)

2. Military Aviation

- ☐ Carrier-based aircraft
- ☐ Land-based aircraft
  - ☐ Fighters
  - ☐ Interceptors
  - ☐ Supersonic bombers
  - ☐ Fighter or attack bombers
- ☐ Other land-based aircraft, used for:
  - ☐ Observation
  - ☐ Spotting
  - ☐ Reconnaissance
  - ☐ Tactical support of combat personnel
- ☐ Non-supersonic bombers of the Air Combat Command
- ☐ Tankers and tactical airlift of the Air Mobility Command
- ☐ Other Air Mobility Command aircraft
- ☐ Patrol and reconnaissance planes of the Navy
- ☐ Search and rescue planes of the Air Force and Navy
- ☐ Test or experimental (describe in **Remarks**)
- ☐ Other (state branch of service including National Guard or Reserve)
- ☐ Student pilot

3. Type of Aircraft

☐ Single engine ☐ Multi-engine ☐ Jet ☐ Propeller ☐ Helicopter ☐ If military, identify in **Remarks** (e.g., C-5, B2, etc.)

4. Do you plan that your future flying will be of a different nature? ☐ Yes ☐ No (If yes, describe in **Remarks.**)

5. Do you plan to fly in a different type of aircraft in the future? ☐ Yes ☐ No (If yes, describe in **Remarks.**)

4 Flight Details

1. Who owns the aircraft? _____
2. What is your job aboard the aircraft? _____
3. Month and year of last flight in section 2 for all that apply: Student ____/____ Pilot or co-pilot ____/____ Crew member ____/____ Passenger ____/____

Pilots and former pilots only

4. Do you hold a valid pilot's license or certificate? ☐ Yes ☐ No (If yes, state type.) _____
5. Do you hold an instrument rating or airline transport certificate? ☐ Yes ☐ No (If yes, state type.) _____
6. Have you ever been in any flying accidents or been grounded for violations? ☐ Yes ☐ No (If yes, give details in **Remarks.**)

5 Remarks/ Additional Information

Please indicate the question number associated with your remark.

6 Signatures

To the best of my knowledge and belief, the above statements are complete, true and correctly recorded.

_____	_____	X _____	X _____
Field office	*Date*	*Witness*	*Signature of person named in section 1*

Prudential Financial

☐ The Prudential Insurance Company of America
☐ Pruco Life Insurance Company, *a subsidiary of The Prudential Insurance Company of America*

Policy number _____

Avocation Questionnaire

Supplementary declarations forming a part of the application for insurance

1 Name

_____
(First name, middle initial, last name)

2 Avocation Information

1. Provide details of each avocation and describe safety equipment used (include exact location where each activity takes place – including starting point, if applicable).

2. How long have you participated in each activity? _____

3. Date you last participated ____/____ *month year*

4. Number of times you participate per year Last 12 months _____ Next 12 months _____

3 Training and Certifications

1. List formal training and qualifying certificates, licenses, etc., held.

2. Are you a member of an organization with national affiliation and established safety rules? ☐ Yes ☐ No
If Yes, give name of organization. _____

4 Exhibitions and/or Competition Information

1. Have you engaged in, or do you intend to engage in, any exhibitions, stunting, exploration, rescue, dare-devil or record-setting activities? ☐ Yes ☐ No (If Yes, describe fully, including frequency.)

2. Describe type of competition in which you participate (If motor racing, include exact type of race, e.g., drag, enduro, against time or competition, and type of track, e.g. oval.)

(a) Is it ☐ amateur or ☐ professional?
(b) If events are supervised, name supervising organization. _____
(c) Any competition outside of U.S. or Canada? ☐ Yes ☐ No (If Yes, where) _____

5 Participation in Motor Sports

If you participate in motor sports, describe vehicle.
a. Generic type (e.g., drag racer, stock, hydrofoil.) _____
b. Make _____ c. Model _____
d. Horsepower _____ e. Engine displacement (cc) _____ f. Avg. speed (mph) _____ g. Max. speed (mph) _____

6 Participation in Diving or Aerial Sports

If you participate in diving or aerial sports
1. Estimate number of dives, jumps, flights Last 12 months _____ Next 12 months _____
2. Average depth/height _____ ft. Maximum depth/height _____ ft. Maximum duration _____ min/hrs.
3. Indicate type of equipment ☐ purchased completely assembled ☐ homemade
☐ assembled from a factory kit ☐ for experimental use

7 Signatures

To the best of my knowledge and belief, the above statements are complete, true and correctly recorded.

_____	_____	X _____	X _____
Field office	*Date*	*Witness*	*Signature of person named in section 1*

Prudential Financial

Part 2 of Application or Request for Policy Change

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

Policy number _____

1 Name of Examinee _____
(First name, middle initial, last name)

2 Medical Information

1. Physician Information

Physician last consulted

Name _____

Address _____
(street, city, state, ZIP)
_____

Telephone number (____) _____ Date last seen ____/____/____
month day year

Reason last seen _____

Primary physician

Name _____

Address _____
(street, city, state, ZIP)
_____

Telephone number (____) _____ Date last seen ____/____/____
month day year

Reason last seen _____

2. Has the person being examined ever used tobacco or other nicotine products such as cigarettes, cigars, pipe, chewing tobacco, snuff, nicotine gum or nicotine patch? ☐ Yes ☐ No
(If Yes, provide date when last used and indicate all types of products.)

____/____ *month year* Product(s) _____

3. Has the person being examined been diagnosed with or treated by a member of the medical profession for

- **a.** chest pain, or any disorder of the heart or blood vessels? ☐ Yes ☐ No
- **b.** high blood pressure? ☐ Yes ☐ No
- **c.** cancer, tumor, leukemia, melanoma, or lymphoma? ☐ Yes ☐ No
- **d.** diabetes or high blood sugar? ☐ Yes ☐ No
- **e.** mental or psychiatric illness? ☐ Yes ☐ No
- **f.** Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC)? ☐ Yes ☐ No
- **g.** infection caused by the Human Immunodeficiency Virus (HIV)? (**Not applicable in California** and **Connecticut. Wisconsin**: AIDS virus HIV antibody testing is limited to FDA-licensed enzyme immunoassay and confirmatory HIV antibody tests. Any test performed at an anonymous counseling and testing site or home testing is confidential and need not be revealed on this application.) ☐ Yes ☐ No
- **h.** any sexually transmitted diseases? ☐ Yes ☐ No
- **i.** asthma or any disorder of the lungs? ☐ Yes ☐ No
- **j.** any disorder of the brain or the nervous system? ☐ Yes ☐ No
- **k.** hepatitis or any disorder of the liver, stomach or intestines? ☐ Yes ☐ No
- **l.** any disorder of the kidney or urinary tract? ☐ Yes ☐ No

4. Is the person being examined currently taking prescription medication? ☐ Yes ☐ No

5. Other than above, has the person being examined:

- **a.** been a patient in a hospital or other medical facility? ☐ Yes ☐ No
- **b.** in the last 5 years, had or been advised to have surgery, medical tests (other than HIV) or diagnostic procedures such as ECGs, stress tests, X-rays, blood tests, urine tests, etc? ☐ Yes ☐ No

6. Has the person being examined:

a. used, or is he or she now using cocaine, amphetamines, marijuana, heroin or other drugs, except as prescribed by a member of the medical profession? ☐ Yes ☐ No

b. had or been advised to have treatment or counseling for alcohol or drug use? ☐ Yes ☐ No

7. Does the person being examined have any disease, disorder or condition not previously mentioned? ☐ Yes ☐ No

8. Has the person being examined had life or health insurance declined, postponed or issued with an increased premium? (**Missouri:** this question may be answered No if an individual has been declined for coverage.) ☐ Yes ☐ No

9. Is the person being examined currently unable to perform his or her normal daily activities or all normal occupational duties on a full-time basis at the customary place of employment? ☐ Yes ☐ No

10. Has the person being examined requested or received disability or compensation benefits? ☐ Yes ☐ No

11. Details of "Yes" answers for questions 3-10

Question number	Indicate illness, hospitalization, reason for checkup, medication and any advice or treatment given by a medical professional	Dates and duration of illness	Name, address and telephone number of medical professionals and hospitals

All the answers are, to be the best of my knowledge and belief, complete, true and correctly recorded.

Date

Witness

Signature of person examined (if age 15 or over) otherwise applicant

Printed name of person examined

THE PRUDENTIAL
INSURANCE COMPANY
OF AMERICA

Number

The Company is authorized to change the application for this contract, so that the contract is issued:

Date

By

Insurance Commissioner

The undersigned agree(s) that this form is a part of the application and is to be put in the contract.

Date

, 19

Signature of Proposed Insured or Annuitant

Signature of Applicant (If other than proposed Insured or Annuitant)

Witness to signature(s)

(If applicant is a firm or corporation, show that company's name)

By

This copy is to stay in the Contract.

(Signature and title of officer signing for that company)

COMB 10164-82

THE PRUDENTIAL
INSURANCE COMPANY
OF AMERICA

Number

The Company is authorized to change the application for this contract, so that the contract is issued:

The undersigned agree(s) that this form is a part of the application and is to be put in the contract.

Date

, 19

Signature of Proposed Insured or Annuitant

Signature of Applicant (If other than proposed Insured or Annuitant)

Witness to signature(s)

(If applicant is a firm or corporation, show that company's name)

By

This copy is to be sent back to the Issuing RHO.

(Signature and title of officer signing for that company)

COMB 10164-82

Printed in U.S.A. by PROF

Supplement to the Application

☐ The Prudential Insurance Company of America

☐ Pruco Life Insurance Company

A subsidiary of The Prudential Insurance Company of America

No. _____

A Supplement to the Application for a variable contract in which _____ _____ is named as the proposed Insured.

I BELIEVE THIS CONTRACT MEETS MY INSURANCE NEEDS AND FINANCIAL OBJECTIVES. I ACKNOWLEDGE RECEIPT OF A CURRENT PROSPECTUS FOR THE CONTRACT. I UNDERSTAND THAT THE CONTRACT'S VALUE AND DEATH BENEFIT MAY VARY DEPENDING ON THE CONTRACT'S INVESTMENT EXPERIENCE . . . . . YES ☐ NO ☐

An illustration of values is available upon request.

Date _____ Signature of Applicant _____