

**THIS WORKSHEET PACKET IS FOR USE FOR THE FOLLOWING PRODUCTS, IN ALL STATES EXCEPT:**

**Florida, Kansas, Massachusetts, Minnesota, Missouri, New Jersey, New Mexico, New York, North Carolina & Vermont (Use appropriate state specific packet)**

**PruLife Custom Premier (VUL)  
Term Essential**

**PruLife Universal Protector  
Term Elite**

**PruLife Universal Plus**

Please be sure to read the following instructions to help you expedite the completion of the Prudential Xpress QuickForm.

**EXCLUSIONS:**

The **Prudential Xpress QuickForm** is designed to provide an efficient means of recording basic client information to submit a case for underwriting. The QuickForm should not be used for certain situations such as juvenile applications and Pru to Pru replacements. **Please call 1-800-286-7745 for instructions if the QuickForm cannot be used.**

**CONTACT INFORMATION: FAX QuickForm to : 888-271-6661**

**General Inquiries: 800-286-7745**

**INSTRUCTIONS**

**THIS IS NOT AN APPLICATION**

Step 1: Please provide your client with the *What to Expect Next* brochure and *Important Notice About Your Application for Insurance* **before** completing the QuickForm.

Step 2: Have the client read and sign the *Authorization to Release Information, Limited Insurance Agreement and Variable Contract Acknowledgement*, plus any other required state or Pruco Life pre-issue forms as listed below.

Step 3: Complete the QuickForm.

For special requests or more complete information, provide on a separate cover sheet. **The cover sheet should also be used to indicate if the client's health, mental or physical condition has changed from a Prudential or Pruco Life policy received within the last three months.**

**PruLife Custom Premier**

**CA:** Elder Disclosure Statement (PPI or owner is  $\geq$  age 65)  
Replacement Forms (*if applicable*)  
Request for Auto-Rebalancing (*if applicable*)  
Request for Dollar Cost Averaging (*if applicable*)

**PruLife Universal Protector & Plus**

**CA:** Elder Disclosure Statement (PPI or owner is  $\geq$  age 65)  
**PA:** Pennsylvania Disclosure  
**MD:** PruLife Universal Protector MD Disclosure  
Replacement Forms (*if applicable*)  
Illustration or Illustration Certification as appropriate

**Term Essential**

**CA:** Elder Disclosure Statement (PPI or owner is  $\geq$  age 65)  
**PA:** Pennsylvania Disclosure  
**TX:** Illustration Certification  
**ME:** Prelim. Statement of Policy Cost  
**MT & TX:** Premium Provisions of Indeterminate Premium Contracts  
Replacement Forms (*if applicable*)

**Term Elite**

**CA:** Elder Disclosure Statement (PPI or owner is  $\geq$  age 65)  
**PA:** Pennsylvania Disclosure  
**TX:** Illustration Certification  
**ME:** Prelim. Statement of Policy Cost  
Replacement Forms (*if applicable*)

Step 4: Please fax the completed QuickForm, *Authorization to Release Information, Limited Insurance Agreement and Variable Contract Acknowledgement* and any applicable replacement forms to **888-271-6661**.

Step 5: Please mail the QuickForm, the original signature *Authorization to Release Information, Limited Insurance Agreement and Variable Contract Acknowledgement*, plus any other necessary forms (see above) to:

**Prudential Financial  
ATTN: Life New Business  
Suite DTY, 2101 Welsh Road  
Dresher, PA 19025**

Name \_\_\_\_\_ Policy number \_\_\_\_\_

**Authorization to Release Information Acknowledgment.** I have received the **Important Notice About Your Application for Insurance.**

I authorize any licensed physician, medical practitioner, hospital, clinic, other health care provider, pharmacy benefit manager, insurance company, government agency, or the Medical Information Bureau 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. The information authorized for release includes my entire medical record, excluding psychotherapy notes, but includes 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). It also includes motor vehicle records.

**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 any of the Service Offices 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.

The Company may retain and disclose information to the Medical Information Bureau, 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.

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 and is valid for two 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.

**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 Health Certification:** A premium can be collected and insurance can take effect under this agreement only if the following statement is true:

I certify and affirm that no person proposed for coverage has:

- (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).

Amount of insurance requested \$ \_\_\_\_\_ Amount of prepayment \$ \_\_\_\_\_ Person(s) proposed for coverage \_\_\_\_\_

**All premium checks must be made payable to the Insurance Company - do not make check payable to the agent or leave the payee blank. This agreement is valid only if the check or other form of payment is good and can be collected, and if the Company received this payment, Limited Insurance Agreement and the request for coverage on the same date.**

Upon payment of the full initial premium, the Company agrees to provide limited life insurance coverage under the following terms and conditions:

- Limited insurance starts on the latest of the following dates: the date of this agreement or the date all required initial medical exams and tests are completed on all proposed insureds. However, if any proposed insured dies from accidental bodily injury within 30 days of the date of this agreement and before any exam and tests are completed, a death benefit will be paid under the terms of this agreement.
- If any proposed insured dies, (or if survivorship coverage is requested and both proposed insureds die), the total death benefit under this Limited Insurance Agreement is the amount requested, up to a maximum of \$1,000,000.
- This agreement does not include any supplemental benefits including Waiver of Premium, Applicant's Waiver of Premium and Accidental Death (and Dismemberment) benefits you have requested from the Company.
- The 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.

Limited insurance ends when any 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. If you do not accept the policy, the prepayment will be refunded.
  3. We mail you a letter notifying you that we have declined to issue you a policy or that we will not provide life insurance coverage on a prepaid basis.
  4. 60 days have passed since the date of this agreement, and the limited insurance provided under this agreement has not ended for any of the reasons listed above.
- If this is a request for a policy change or conversion, the amount of insurance provided by this limited insurance agreement is the amount requested minus the amount of insurance being discontinued as part of this request, up to a maximum of \$1,000,000.

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

No Company representative has any right to accept risks, waive or change policies, give up any of our rights or requirements, or change the provisions of this agreement.

**There is no coverage under this Limited Insurance Agreement if the Health Certification is materially mis-represented or fraudulent. If death is due to suicide or intentionally self-inflicted injury, payment will be limited to the return of the amount paid.**

If you have not received a policy or your money back after 60 days have passed, please tell the Company the amount and date paid, and the name of the writing representative who accepted the payment.

Customer Service Office 2101 Welsh Road Dresher, PA 19025

I have read and agreed to all the applicable terms of this form. I also understand this form in its entirety will be provided to any of the individuals listed in the Authorization above in order to request medical information to determine eligibility for coverage.

**PENNSYLVANIA ONLY:** The writing representative certifies that the Disclosure Statement as required by the Commonwealth of Pennsylvania Insurance Department was delivered to the applicant.

**CALIFORNIA ONLY:** 1) A copy of any consumer investigative report conducted will be provided to you; 2) the writing representative certifies that the CA Disclosure Statement was provided to the policyowner in accordance with CA Insurance Code section 789.8.

Signature of primary proposed insured  \_\_\_\_\_ Date \_\_\_\_\_

*If age 15 or over, otherwise applicant (In Pennsylvania: If age 18 or over, otherwise applicant)*

Signature of spouse, if proposed for coverage  \_\_\_\_\_

Signature of policyowner, if different from primary proposed insured or applicant  \_\_\_\_\_

Name of company, if owner is a business or corporation \_\_\_\_\_

Officer of company (Must sign here and give his or her title)  \_\_\_\_\_

Writing representative  \_\_\_\_\_ Contract number \_\_\_\_\_ Field Office \_\_\_\_\_



General Information

General Agency Name: General Agency Contract Number:
General Agency Phone Number: Fax Number:
Agency Contact Name: e-mail address:

Ordering of Requirements Prudential should Order the Following Req's (check all that apply):
List other requirements submitted:

Delivery State: Date "Authorization, Acknowledgement and Limited Insurance Agreement" was signed:
Requested Policy Date? Backdate to Save Age
Proposed Insured
Name (F/M/L): Birth Date (M/D/Y): SSN: Sex: Male Female
Resident Address (No PO Boxes): Street City State ZIP
Client Interview: (Phone Interviews conducted M-F 9am - 9pm Local Time) Best time to call: Morning Afternoon Evening
Preferred contact number: Home Work Alternate Special Needs:

Do you plan on submitting, or have you recently submitted any other worksheets that are related to this one?
If YES: Provide names:

Earned Annual Income: \$ Unearned Annual Income: \$
Driver's License State and Number: Spouse/Domestic Partner's Annual Income: \$

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)?

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)?

If either of the above two questions are answered "YES", do not collect prepayment.

Is this 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?

Product Information

Please select product: Term Essential: 10 15 20 30 Term Elite: 10 15 20
PruLife Universal: Plus Protector PruLife Custom Premier (VUL):
Level Variable Return of Premium
Death Benefit Option (choose one, if applicable):
Definition of Life Insurance test (choose one, if applicable): Cash Value Accumulation Test (CVAT) Guideline Premium Test (GPT)

NEW YORK ONLY - SUBMIT FORM ORD 99767 FOR UL AND VUL II CASES.

Face Amount: \$ If applicable to plan: Billed premium amount \$
Rating/Category Quoted: Were Smoker Rates Quoted? Yes No

Requested Optional Benefits:
Acceleration of Death Benefit (Living Needs Benefit [NOT AVAILABLE IN MASSACHUSETTS])
Waiver of Premium/Enhanced Disability Benefit (if applicable) Accidental Death Benefit: Amount \$ (if applicable)
Target Term Rider: Amount \$ (if applicable) Child Protection Rider: Amount \$ (if applicable)
Is the Owner a US Citizen or resident alien? Yes No If NO - A completed W-8 is required
Is the Owner subject to back-up withholding? Yes No

Existing Insurance

List all existing life insurance and/or annuities in all companies (Use REMARKS to list additional contracts): Check here if None:
Table with columns: Company, Policy Number, Amount, Year Issued, Type of Insurance (Group, Individual)

For each proposed insured: (a) would this insurance replace or cause a change in an existing insurance/ annuity in any company?
(b) do you (the producer) have any information, other than what is stated on this worksheet, that any
current life insurance or annuity in any company may be replaced or changed?

If YES to (a), Additional details required for each policy/contract to be replaced (Use REMARKS to list additional contract details to be replaced):
Policy Number: PI's Role in Existing Contract 1035 Exchange Plan
Primary Insured Spouse Child Yes No Life Annuity
Primary Insured Spouse Child Yes No Life Annuity

Is the policy to be replaced a Term policy (required for new Term plans only)?
Have you discussed the advantages and any disadvantages of the replacement with the applicant?
Have you determined that the replacement transaction is appropriate for the applicant?

Beneficiaries (Use REMARKS to list additional Beneficiary information)

Beneficiary Name: Class: Relationship: Age:
Beneficiary Name: Class: Relationship: Age:

Payment

Prepayment Amount: \$ Check Date: Payment Mode: Annual Semiannual Quarterly EFT
If EFT: Name of Financial Institution: Routing No.:
Account Number: Checking Savings Withdrawal Date: 1st 7th 15th 23rd 28th
Account Owner: Same as Policy Owner Other: Name & Address:

Are policy values of any kind being used to fund this sale? Yes No
What is the source of initial premiums? Current income or savings account Other:
What is the source of future premiums? Current income or savings account Other:

Purpose of Insurance (Check all that apply.)

- Personal: Death benefit, Estate conservation, Retirement income needs, Deferred compensation, Executive bonus (section 162), Basic last expenses, Charitable giving, Buy/Sell, Business continuation, Income replacement, Potential cash accumulation (permanent insurance only), Other, Key person, Loan indemnification, Split dollar, Other

Owner Information - This section to be completed only when the policy owner is other than the Primary Proposed Insured

If Owner is a TRUST, provide the following: Name of Trust & Address, Tax ID of Trust, Trustee Name(s), Date of Trust, Trust is: Irrevocable, Revocable (If Revocable, Grantor's Name)

If Owner is other than a Trust and different from Proposed Insured, provide the following: If there are joint policyowners, provide details for the policyowner who assumes tax reporting liability below, listing additional policyowners in REMARKS

Owner Name (F/M/L), Birth Date (M/D/Y), SSN, Resident Address (No PO Boxes): Street, City, State, ZIP, Current annual income of Owner, Current net worth of Owner, How much insurance does the Owner currently have: inforce, pending, Relationship to PI, Why will this person own the contract? Business Insurance, Estate Tax, Support for Insured, Final Expenses, Other

Business Information: This section to be completed when the application is for Business Insurance

Type of firm: corporation, partnership, sole proprietorship, Has the business been established for less than two (2) years?, What is the net worth of the business?, Is this a split dollar arrangement?, Is the primary proposed Insured?, Are there any additional owners of this business?, Other owner names, Insurance in force, Amount applied for, Percent ownership

Complete if face amount of policy is \$5,000,000 or greater (submission of a cover sheet is recommended):

Assets, Liabilities, Fair Market Value, Gross Annual Sales, Net Profit After Taxes

Variable Contract Information

Telephone Reallocations/Transfer Privileges (If more than one owner, telephone reallocations/transfer privileges are NOT allowed.) The applicant does not wish to authorize telephone reallocations/transfers. He/She understands that by not taking this option any future request for this option must be submitted in writing.

Investment Options and Allocations (Use REMARKS to list additional fund details): THE TOTAL ALLOCATION MUST EQUAL 100%

Table with columns: Investment Option, Code, Allocation Percentage, Investment Option, Code, Allocation Percentage

Allocated Charges (Must be in whole percentages, Fixed Rate Option may not be chosen, Max 2):

Investment Option: Percentage: Investment Option: Percentage:

Auto Rebalancing: (check if requested) - if requested, please submit a completed, unsigned form with this worksheet

Dollar Cost Averaging: (check if requested) - if requested, please submit a completed, unsigned form with this worksheet

Suitability Checklist:

- 1. This application is submitted in the belief that the purchase of this policy is suitable for the applicant based on the information furnished.
2. Reasonable inquiry has been made of the applicant concerning the applicant's insurance and investment objectives, financial situation and needs.
3. The applicant is considering the purchase of this variable life insurance product primarily as a vehicle to provide for long term insurance needs and not primarily as an investment.
4. I provided the applicant with the brochure "What every consumer should know about life insurance" and answered any questions they had about the purchase.

Producer Information - For splits greater than two, use an additional page with all details

PRODUCER #1 Split Commission %, Non-variable commissions to be paid? Directly to me, To my Firm or Broker Dealer, Producer Name, National Account

GA EIN, Producer Contract No., Producer SS#

COMPLETE ONLY IF PAYING FIRM:

Firm Paying Contract No., Firm Name, Firm EIN

PRODUCER #2 Split Commission %, Non-variable commissions to be paid? Directly to me, To my Firm or Broker Dealer, Producer Name, National Account

GA EIN, Producer Contract No., Producer SS#

COMPLETE ONLY IF PAYING FIRM:

Firm Paying Contract No., Firm Name, Firm EIN



CALLBACK APPOINTMENT TIME: \_\_\_\_\_

### Informational and Underwriting Callback

You will be telephoned so that we may obtain important information necessary to issue a policy and to evaluate your eligibility. Depending on your product purchase and medical history, the call should take about 30 minutes. In order to help reduce any inconvenience during the call, please be prepared to have the following information available:

- Beneficiaries' information such as social security numbers and dates of birth
- Policyowner(s) information (if policyowner(s) is someone other than yourself) such as social security number and date of birth
- Your physician's name, address and phone number
- Date of your most recent visit to your Primary Care Physician (if it wasn't with your Primary Care Physician, we will still need your Primary Care Physician's information), plus:
  - Reason for that visit
  - Your height and weight
  - Current prescriptions
  - Your driver's license number
  - Diagnosis and treatment
  - Any hospitalization/surgeries/medical tests
  - Occupation, hobbies and background

To ensure that you have a full understanding of what you are buying, an underwriter will also verify:

- If out-of-pocket funds will pay policy premiums or if policy dividends, cash value, loans or withdrawals from other policies will pay future premiums on this policy
- If this policy replaces any existing life insurance and/or annuity policies

Prior to the scheduled call, consult with your licensed financial professional if you do not understand any of the above items, or if you are unsure if they apply to you

### Medical Exam

Based upon your age and the amount of life insurance you are applying for, an exam and/or some medical tests may be required. These additional tests will provide us with the information that we need to fairly assess your eligibility for life insurance. The medical exam will include a few or all of the following:

- Blood Pressure and Pulse Readings
- A Blood Test and Urinalysis
- A Chest X-Ray
- Height and Weight Measurements
- An Electrocardiogram (ECG)

### Policy Issue

Upon completion of the underwriting process, Prudential will either approve you for coverage (with or without changes and/or exclusions) or decline coverage. If approved, your policy will be issued and delivered to you by your licensed financial professional.

The words "you" and "your" refer to the primary proposed insured and policyowner or applicant, if other than the primary proposed insured.

This notice tells you about the information practices we will employ in evaluating your application for insurance. Information about Prudential's information policies and practices relating to its customers and former customers is provided in our publication "Your Financial Security, Your Satisfaction and Your Privacy."

**Collecting Information for Underwriting**

We review information about you to decide if you're eligible for coverage. In addition to the application, we may get information about you from the following sources: any required medical examination; the Medical Information Bureau (MIB); and doctors, hospitals, health care providers, pharmacy benefit managers, publicly accessible sources, or any other organizations or persons who have information about you or your mental or physical health. We may obtain information, either directly or through an investigative consumer report, by means of interviews with your neighbors, friends, or others with whom you are acquainted. This inquiry includes information about your character, general reputation, personal characteristics, and mode of living. You may ask to be interviewed as well.

**Disclosing Information**

We will treat any information we obtain or have obtained about you as confidential. We may disclose information we have collected as follows: to affiliates or third parties that perform services for us, or on our behalf, or that are providing service to you; to your doctor; to insurance regulators; to law enforcement or other governmental authorities under limited circumstances; to affiliates for insurance marketing purposes (except for medical information); to companies in our corporate family and to non-Prudential companies to allow them to tell you about other products and services when permitted to do so by applicable law; for actuarial or research studies; or as otherwise permitted or required, with or without your authorization, by applicable law. If you do not want information disclosed to affiliates or non-affiliated third parties so that they may tell you about other products or services, you may write to us and tell us not to disclose information for this purpose. The address is: Prudential - Customer Privacy, P.O. Box 9047, Millville, New Jersey 08332-9047. Prudential or its reinsurers may make a brief report to the MIB, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the MIB, upon request, will supply such company with the information in its file. Prudential, or its reinsurers, may also release information in its file to other life insurance companies to which you may apply for life or health insurance or to which a claim for benefits may be submitted. A consumer reporting agency that prepares a consumer report may keep the information it has gathered and disclose it to others.

**Your Right to Information**

If we do not issue the contract you requested, we will tell you and explain the reasons for our decision in writing. You have the right to make a written request within a reasonable period of time to receive additional, detailed information about the nature and scope of any investigative consumer report we request. You also have the right to request a written summary of your rights as a consumer from the consumer reporting agency that prepared the report. Upon your request to the address below, we will provide you with our notice of information practices. If you write to us at the address shown below, we will describe the information we have relating to this insurance transaction, describe how you may get access to it, tell you about certain disclosures that may have been made, and tell you how you may request correction, amendment or deletion of information that you dispute. If you request one, a copy of any consumer report we obtained about you will be provided to you.

Upon receipt of a request from you, the MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of the information in the MIB's file, you may contact the MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the MIB's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, toll-free telephone number (866-692-6901) [TTY # 866-346-3642 for the hearing impaired].

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

I, \_\_\_\_\_,  
(Print name of proposed Insured)

hereby authorize Prudential Insurance Company of America, Pruco Life Insurance Company and/or Pruco Life Insurance Company of New Jersey, their employees, officers, affiliates, (collectively, "Prudential") to disclose any and all medical information ("Information"), which has been collected by Prudential in connection with my current request for life insurance to the General Agent and Broker submitting that life insurance request. Information includes but is not limited to the results of any physical examination or tests, electrocardiogram, chest X-ray and Attending Physician Statements.

It is my understanding that the purpose of this authorization is to facilitate submission of this Information by the General Agent or Broker or their authorized representatives to other insurers to evaluate an application for insurance on my life. I understand that Prudential assumes no liability with respect to any application for insurance to other companies and makes no representation as to the completeness or accuracy of the Information. I also understand that Prudential will only provide disclosures as permitted by law, and, in its sole discretion, may not provide all Information in its possession. It is my responsibility to disclose any and all requested medical information to any insurance carrier to which I apply for insurance coverage.

I further understand that Prudential's privacy policy does not extend to the copy of the Information provided to the General Agent and/or Broker.

This authorization is effective as of the date it is signed and shall continue for six (6) months unless otherwise provided by law. I also understand that I may revoke this authorization by providing written notification to Prudential at Prudential Brokerage, PO Box 7426, Philadelphia, Pennsylvania 19176, which revocation shall be subject to the rights of Prudential to the extent Prudential has acted in reliance on the authorization prior to notice of revocation.

A copy of this authorization shall be as valid as the original.

**I acknowledge that I have received a copy of this authorization from the General Agent or Broker.**

\_\_\_\_\_  
Signature of Proposed Insured

\_\_\_\_\_  
Date



Prudential Insurance Company of America  
Corporate Offices  
Newark, New Jersey 07102  
973-802-6000

**The Prudential Insurance Company of America**  
**Pruco Life Insurance Company,**  
*both are Prudential companies*

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**REPLACING YOUR LIFE INSURANCE POLICY OR ANNUITY?**

Are you thinking about buying a new life insurance policy or annuity and discontinuing or changing an existing one? If you are, your decision could be a good one -- or a mistake. You will not know for sure unless you make a careful comparison of your existing benefits and the proposed benefits.

Make sure you understand the facts. You should ask the company or agent that sold you your existing policy to give you information about it. You are urged not to take action to terminate, assign or alter your existing policy until your new policy has been issued and you have examined it and found it acceptable.

Hear both sides before you decide. This way you can be sure you are making a decision that is in your best interest.

We are required by law to notify your existing company that you may be replacing your policy.

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Applicant's Signature

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Date

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Agent's Signature



Prudential Insurance Company of America  
Corporate Offices  
Newark, New Jersey 07102  
973-802-6000

**The Prudential Insurance Company of America**  
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Applicant's Signature

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Date

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Agent's Signature

Prudential Insurance Company of America  
Corporate Offices  
Newark, New Jersey 07102  
973-802-6000

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Date

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Agent's Signature