Prudential

PART 2 OF APPLICATION FOR LIFE INSURANCE

POLICY NUMBER (IF KNOWN):_____

ON THE LIFE OF
PROPOSED INSURED:_____

This form contains confidential information about the person you have examined. Do not give this form or any copy of it to anyone outside Prudential.

INSTRUCTIONS TO THE EXAMINER

Important

After this form has been completed, mail it directly to the Home Office at once. Do so regardless of the findings on the person examined and even if you are unable to fully complete the form.

NOTE: Verify identification by photo ID.

Mail the urine specimen to the laboratory if <u>any</u> of the following conditions are present:

1. Medical Examination Appointment Slip indicates a urine specimen requirement in either the Examination Information or the Additional Remarks section.
2. Albumin or sugar is indicated on the dipstick analysis of the urine specimen.
3. Systolic blood pressure of more than 140 mm. Hg., or diastolic of more than 90.
4. History of :
    a. Hypertension.
    b. Abnormal urinary findings or disease of genito-urinary system.

Always record three blood pressure readings.

In addition to signing the Examiner's Report (Page 4), the signature of the examiner is also required for the collection of the medical declarations (Pages 2 & 3) as the witness at the bottom of Page 3 .

VOUCHER

It is important that this voucher be fully and properly completed.

1. Name of person examined: _____
2. Date of birth: ____/____/____ 3. Social Security number: _____
4. Name of examiner: _____
5. Tax number: _____
6. Address of examiner: Street _____ Apt _____
   City _____ State _____ ZIP _____
7. Date of examination: ____/____/____
8. Amount of insurance: $_____
9. Name of writing representative: _____ 10. Field office_____

TO BE COMPLETED BY EXAMINING PHYSICIAN

Fee – Please indicate your fee for the service(s) provided.

Exam $_____ ECG $_____ Lab $_____ X-Ray $_____

Total $_____

FOR PRUDENTIAL USE ONLY

Fee – Please indicate your fee for the service(s) provided.

☐ A400 ☐ A470 ☐ A852 ☐ A892 ☐ _____

E004

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):_____

NAME OF PERSON TO BE EXAMINED:_____

PERSONAL PHYSICIAN INFORMATION

Name _____

Address: Street _____ Suite _____

City _____ State _____ ZIP _____

Telephone number: (____) _____ Date last seen: _____

Reason last seen: _____

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 _____ or Age at death: _____ **Mother:** Current age _____ 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

SIGNATURE

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

➔ Signature of Witness **X** _____ Date _____

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

Name of person examined (please print) _____

POLICY NUMBER (IF KNOWN): _____

PROPOSED INSURED: _____

EXAMINER'S CONFIDENTIAL REPORT

A. Examination was done at:
☐ Home ☐ Business ☐ My office

B. Time of day examined: _____AM _____PM.

C. Height: _____ft. ____in. Did you measure? ☐ Yes ☐ No

D. Weight (in clothes): _____ lbs. Did you weigh? ☐ Yes ☐ No

E. Has there been any change of weight (gain or loss) of more than 10 pounds within the last year? ☐ Yes ☐ No

F. Blood pressure:

	Systolic	Diastolic	Arm	Time Taken (Include AM/PM)
1st reading:	_____	_____	☐ Left ☐ Right	_____
2nd reading:	_____	_____	☐ Left ☐ Right	_____
3rd reading:	_____	_____	☐ Left ☐ Right	_____

Always record three blood pressure readings taken at intervals. Mail us a urine specimen if systolic is over 140 or diastolic is over 90.

G. Pulse: At rest (seated)

Pulse rate per minute	Premature contractions No. per minute

1. If lowest rate exceeds 100, repeat observations later in examination.
2. Any irregularities other than premature contractions? ***(If yes, describe below.)*** ☐ Yes ☐ No

H. Are there any abnormalities of: *(Record all details below)*
1. Eyes (*retinopathy, retinal changes)?* ☐ Yes ☐ No
2. Blood vessels (pedal pulses, bruits)? ☐ Yes ☐ No
3. Respiratory organs (including nose, throat and mouth)? ☐ Yes ☐ No
4. Abdominal organs (including tenderness, scars, organomegaly, bruits)? ☐ Yes ☐ No
5. Nervous system? ☐ Yes ☐ No

Note: Examine heart in upright, recumbent and left lateral recumbent positions.

I. Heart – any murmur present? ☐ Yes ☐ No
(If yes, give details below.)

1. Murmur details
☐ Apical ☐ Basal ☐ Other
☐ Systolic ☐ Diastolic
☐ Barely heard-Gr.1 ☐ Faint-Gr.2 ☐ Mod-Gr.3
☐ Loud-Gr.4 ☐ Very loud-Gr.5 ☐ Loudest possible-Gr.6
☐ Transmitted ☐ Localized

2. Effect of body position: _____

3a. Is heart enlarged? ☐ Yes ☐ No
b. Any other abnormal cardiac findings? ☐ Yes ☐ No
(If either is yes, describe below.)

4. What is your diagnosis or opinion?

_____

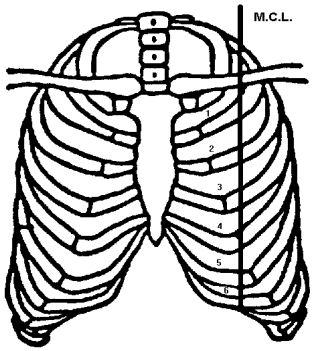
5. Mark position of apex; location of murmur(s) and transmission on diagram.

Position of apex beat **X**

Area of distribution of murmur

Point of maximum intensity of murmur

Direction of transmission of murmur →



J. Analysis of urine:
Are you mailing us a urine specimen? ☐ Yes ☐ No
Mail a specimen, if required by instructions on cover.)
Albumin ☐ Yes ☐ No
Sugar ☐ Yes ☐ No
(*If either is yes, mail us a portion of the urine examined.)*

K. Female only: Current menses? ☐ Yes ☐ No

L. Is the person examined your patient? ☐ Yes ☐ No
(If yes, and if any information was not disclosed, submit office records.)

M. Have you any information about this person not recorded elsewhere on this form relating to physical or mental impairment? ☐ Yes ☐ No

Give details of all yes answers to Questions E, G(2), H, I 3a-b, and M.

_____

_____

_____

_____

_____

_____

I secured the required picture identification of the person examined. ☐ **Yes** ☐ **No**
I certify that on the date below, I examined the person named above. ☐ **Yes** ☐ **No**

SIGNATURE

➔ Signature of examiner **X** _____ Date of examination _____

Street, city, state, ZIP _____

Prudential

Pruco Life Insurance Company
The Prudential Insurance Company of America
Corporate Offices, Newark, New Jersey

Notice and Consent for AIDS virus (HIV) Antibody/Antigen Testing

Policy Number: _____

To evaluate your insurability, the Insurer named above has requested that you provide a sample of your blood, oral fluid extracted from cheek and gum tissue, or urine for testing and analysis to determine the presence of human immunodeficiency virus (HIV) antibodies. By signing and dating this form you agree that this test may be done and that underwriting decisions will be based on the test result. A series of three tests will be performed by a licensed laboratory through a medically accepted procedure.

Pre-Testing Considerations
Many public health organizations have recommended that before taking an HIV-related test a person seek counseling to become informed concerning the implications of such a test. You may wish to consider counseling, at your expense, prior to being tested.

Meaning of Positive Test Result
The test is not a test for AIDS. It is a test for antibodies to the HIV virus, the causative agent for AIDS, and shows whether you have been exposed to the virus. A positive test result does not mean that you have AIDS but that you are at significantly increased risk of developing problems with your immune system. The test for HIV antibodies is very sensitive. Errors are rare, but they do occur. Your private physician, a public health clinic, or an AIDS information organization in your city might provide you with further information on the medical implications of a positive test.

Positive HIV antibody test results will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged, or that other policy changes may be necessary.

Confidentiality of Test Results
All test results are required to be treated confidentially. They will be reported by the laboratory to the Insurer. The test results may be disclosed as required by law or may be disclosed to employees of the Insurer who have the responsibility to make underwriting decisions on behalf of the Insurer or to outside legal counsel who needs such information to effectively represent the Insurer in regard to your application. The results may be disclosed to a reinsurer, if the reinsurer is involved in the underwriting process. The test may be released to an insurance medical information exchange under procedures that are designed to assure confidentiality, including the use of general codes that also cover results of tests for other diseases or conditions not related to AIDS, or for the preparation of statistical reports that do not disclose the identify of any particular person.

Notification of Test Result
If your test results are negative, no routine notification will be sent to you. If your test results are reported by the laboratory to the Insurer as being positive, you will receive written notification of such results from a physician you have designated or, in the absence of such designation, from the Texas Department of Health. Because a trained person should deliver that information so that you can understand clearly what the test result means, please list your private physician so that the Insurer can have him or her tell you the test result and explain its meaning.

Name of physician for reporting a possible positive test result: _____

Address: _____

In the event the test is positive and you are denied coverage because of that fact and you request the reason for the denial, the insurer may require you to name a physician at that time in order to receive the information.

If the test indicates a positive result, but you do not designate a private physician, the test results will be provided to you by a representative of the Texas Department of Health.

Consent for Testing and Disclosure of Test Results
I have read and understand the Notice and Consent for AIDS virus (HIV) Antibody/Antigen Testing set forth above. I voluntarily consent to the withdrawal of my bodily fluid(s), the testing of the specimen(s) provided and the disclosure of the test results as described above. I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

Name of Proposed Insured	Signature of Proposed Insured or Parent/Guardian	Date signed

Address

Prudential

AUTHORIZATION TO RELEASE INFORMATION

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

POLICY NUMBER (IF KNOWN): _____

PROPOSED INSURED NAME (PRINT): _____

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.

SIGNATURES

- I acknowledge that I have received the **Important Notice About Your Application for Insurance.**
- I authorize the Company to retain and disclose information to the MIB, 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.

➔ Signature of proposed insured X _____ Date: _____
(Parent/Guardian when proposed insured age is less than 18)