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 ☐ _____

Prudential

Part 2 of Application for Life Insurance

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

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. Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC)? ☐ Yes ☐ No
   g. any sexually transmitted disease? ☐ Yes ☐ No
   h. asthma, emphysema, cystic fibrosis, sleep apnea, sarcoidosis, tuberculosis or any other disorder of the lungs or respiratory system? ☐ Yes ☐ No
   i. 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
   j. an ulcer, hepatitis, cirrhosis, pancreatitis, ulcerative colitis, Crohn's disease or any other disorder of the esophagus, liver, stomach or intestines? ☐ Yes ☐ No
   k. nephritis, polycystic kidney disease or any other disorder of the bladder, kidney, urinary tract or prostate? ☐ Yes ☐ No
   l. arthritis, gout, back trouble, or any disease or disorder of the joints, muscles or bones? ☐ Yes ☐ No
   m. 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

For additional medical details, use Additional Details Supplement (ORD 84379AD-2010 NEW YORK).

SIGNATURE

All answers are, to the best of my knowledge and belief, complete, true and correctly recorded. This Part 2 will be attached to and made part of the policy when issued.

➔ 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?

_____

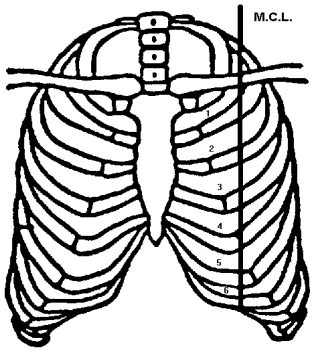
5. Mark position of apex; location of murmur(s) and transmission on diagram.

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 _____