Prudential

Important Notice About Your Application for Reinstatement

The Prudential Insurance Company of America
Pruco Life Insurance Company of New Jersey

Thank you for choosing to reinstate your policy. Before we will reinstate the policy we must review and approve your application. To do this, we need to collect and evaluate personal information about you.
The words "you" and "your" refer to the primary insured and policyowner, if other than the insured.
This notice tells you about the information practices we will employ in evaluating your application for reinstatement.

Collecting Information for Underwriting

We review information about you to decide if you are eligible for reinstatement of coverage. In addition to the application, we may get information about you from the following sources: any required medical examination; the MIB, Inc., formerly known as Medical Information Bureau; and doctors, hospitals, health care providers, pharmacy benefit management organizations, 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; for actuarial or research studies; or as otherwise permitted or required, with or without your authorization, by applicable law. 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. Information about MIB may be obtained on its website at www.mib.com. 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.

We will not disclose information we have collected to affiliates for insurance marketing purposes or to companies in our corporate family or to non-Prudential companies to allow them to tell you about other products and services.

Your Right to Information

If we do not reinstate 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 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734, 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

Prudential

APPLICATION FOR REINSTATEMENT

The Prudential Insurance Company of America
Pruco Life Insurance Company of New Jersey

INSTRUCTIONS

The policy(ies) may only be reinstated during the reinstatement period described in your policy. This period will vary by policy type.

This application may be used to apply for reinstatement of more than one policy. However, each policy included in the application must have the same primary insured and must have the same ownership arrangement. Please use separate applications if you wish to apply for reinstatement of policies with different insureds or different policyowners. For survivorship policies, each insured must complete a separate application.

The policyowner and the insured (if different people) must apply for reinstatement. If the insured is under age 14 years 6 months, the policyowner will complete any statements requiring completion by the insured -- for the insured. Questions about the spouse or other family members should be completed ONLY if you are applying for coverage on them to be reinstated.

The policy(ies) will not be reinstated until the Company is paid the full amount necessary to reinstate and until we approve this application. Checks should be made payable to Prudential. The full amount needed to reinstate the policy(ies) must be included with this application. If you want to use any policy values, if available, to pay the reinstatement amount, you must include the appropriate disbursement form with this application.

Your application for reinstatement will be considered only if the check or any other form of payment of the full amount received is good and can be collected. In the case of using policy values to pay the required amount, the amount must be available for use.

If we approve the reinstatement, the contestability clause will begin as of the date of the reinstatement of the policy.

If we do not approve the reinstatement, the reinstatement payment will be refunded or returned to its source (put back into the policy values from where it came). Making a reinstatement payment does not reinstate the policy or create any liability under the policy.

Reinstating the policy(ies) will not restore or create any coverage for any person(s) previously covered who is not living at the time of reinstatement. Also, reinstatement will not provide insurance for any person who would not have been covered under the policy on the date of this application had there been no default in premiums.

Unless otherwise provided, we will also reinstate the ownership, beneficiary and assignee arrangements.

In completing Part 2 Section D, the insured's current state of residence should be considered when answering state-specified medical questions.

On these pages, *I, you,* and *your* refer to the policyowner or any covered person. *We, us, our,* and *the Company* refer to the Prudential Financial company that issued the policy.

Prudential

AUTHORIZATION TO RELEASE INFORMATION

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

POLICY NUMBER: _____

INSURED NAME: _____

THE SIGNATURE(S) BELOW APPLY ONLY TO THIS AUTHORIZATION.

THE ISSUING COMPANY IS REFERENCED HEREAFTER AS "COMPANY", "WE", "US", OR "OUR".

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 or producer, financial or legal advisor, government agency, MIB, Inc, consumer reporting agency, or other organization or person as referenced in the Important Notice 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 Reinstatement and/or benefit payment, and/or to contest coverage and/or to conduct legally permissible actuarial, audit and research activities. 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, the revocation does not effect our legal rights under the policy to contest a claim or the policy itself. Revocation or alteration of this Authorization may mean that we will not be able to complete the Reinstatement 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. Information related to alcohol and drug abuse that has been disclosed to the Company may be protected by Federal Regulations 42 CFR part 2.
- This Authorization also applies to any member of my family proposed for reinstatement of coverage in the application & is valid for 2 years after the date below for the purposes stated above. When used for claim purposes, it is valid for 2 years after the date below or for the duration of the claim.
- A copy of this Authorization will be provided to me or my authorized representative 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.

SIGNATURE(S)

- I acknowledge that I have received the **Important Notice About Your Application for Reinstatement**.
- 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.

SIGN & DATE HERE Primary insured *(policyowner's signature if insured is less than age 18)* **X** _____ Date ____/____/_____

SIGN & DATE HERE Insured spouse *(if coverage on this person is to be reinstated)* **X** _____ Date ____/____/_____

SIGN & DATE HERE Applicant *(if Applicant's Waiver of Premium Benefit is to be reinstated)* **X** _____ Date ____/____/_____

Prudential

AUTHORIZATION TO RELEASE INFORMATION

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

POLICY NUMBER: _____

INSURED NAME: _____

THE SIGNATURE(S) BELOW APPLY ONLY TO THIS AUTHORIZATION.

THE ISSUING COMPANY IS REFERENCED HEREAFTER AS "COMPANY", "WE", "US", OR "OUR".

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 or producer, financial or legal advisor, government agency, MIB, Inc, consumer reporting agency, or other organization or person as referenced in the Important Notice 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 Reinstatement and/or benefit payment, and/or to contest coverage and/or to conduct legally permissible actuarial, audit and research activities. 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, the revocation does not effect our legal rights under the policy to contest a claim or the policy itself. Revocation or alteration of this Authorization may mean that we will not be able to complete the Reinstatement 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. Information related to alcohol and drug abuse that has been disclosed to the Company may be protected by Federal Regulations 42 CFR part 2.
- This Authorization also applies to any member of my family proposed for reinstatement of coverage in the application & is valid for 2 years after the date below for the purposes stated above. When used for claim purposes, it is valid for 2 years after the date below or for the duration of the claim.
- A copy of this Authorization will be provided to me or my authorized representative 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.

SIGNATURE(S)

- I acknowledge that I have received the **Important Notice About Your Application for Reinstatement**.
- 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.

SIGN & DATE HERE Primary insured *(policyowner's signature if insured is less than age 18)* **X** _____ Date ____/____/_____

SIGN & DATE HERE Insured spouse *(if coverage on this person is to be reinstated)* **X** _____ Date ____/____/_____

SIGN & DATE HERE Applicant *(if Applicant's Waiver of Premium Benefit is to be reinstated)* **X** _____ Date ____/____/_____

COMB 6641B-2010 NEW YORK

Prudential keeps this copy

Prudential

APPLICATION FOR REINSTATEMENT

PART 1

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

PLEASE PRINT USING BLUE OR BLACK INK.

A. POLICY INFORMATION (TO BE COMPLETED BY POLICYOWNER.)

Policy number(s)

_____ _____

Type of owner: ☐ Individual ☐ Multiple ☐ Business ☐ Trust

Name of policyowner *(First/MI/Last)* Enter "same" if same as insured.

_____

Name of joint owner, if any *(First/MI/Last)*

_____

Policyowner's current mailing address *(Street, Apt., City, State, ZIP)*

_____

_____

Policyowner's telephone numbers:

Daytime _____ Evening _____

Is the policyowner 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 :

_____

_____

B. PRIMARY INSURED'S INFORMATION (TO BE COMPLETED BY PRIMARY INSURED.)

1. Name of primary insured *(First/MI/Last)* _____

2. Current employer name _____ Telephone number _____

3. Business address: Street _____ Suite _____

City _____ State _____ ZIP _____

4. Occupation _____ Duties _____

5. If the primary insured or any covered person has changed his or her last name in the last five years, give:

Current name _____ Previous name _____

This will not change the name on the policy. If you want to change the name, please contact our Customer Service Office.

6. Are you applying for or reinstating life insurance with any company? ☐ Yes ☐ No
If Yes, give company name, amount applied for and/or reinstating, including this application :

_____

_____

7. Has any person for whom you are applying for coverage to be reinstated 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 :

_____

_____

(CONTINUED)

C. OTHER INSUREDS (TO BE COMPLETED BY POLICYOWNER.)

Use this section to provide information on the primary insured's spouse and children. **The following information must be provided for each person for whom you are applying for coverage to be reinstated.**

1. Name *(First/MI/Last)*	Age	Date of birth	Place of birth	Relationship to Primary Insured	Sex
					☐ M ☐ F
					☐ M ☐ F
					☐ M ☐ F
					☐ M ☐ F
					☐ M ☐ F

2. Has any covered family member died since the first missed premium due date or the date of the default? ☐ Yes ☐ No
If Yes, please give the person's name and date of the death below.

Name _____ Date (MM/DD/YYYY)_____

3. Are any children named above:
a. foster children or children whose legal adoption has not been made final? ☐ Yes ☐ No
b. not living in the primary insured's household? ☐ Yes ☐ No
c. dependent on someone other than the primary insured? ☐ Yes ☐ No

4. If Applicant's Waiver of Premium (AWP) benefit is to be reinstated, please list the name of the applicant under AWP.

_____

D. GENERAL INFORMATION (TO BE COMPLETED BY PRIMARY INSURED.)

1. In the past five years, has any person for whom you are applying for coverage to be reinstated flown as a pilot, student pilot or crew member or do they intend to become a pilot? ☐ Yes ☐ No

2. In the past five years, has any person for whom you are applying for coverage to be reinstated 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 they intend to? ☐ Yes ☐ No

3. Has either the primary insured or covered spouse (if any) ever used tobacco or any other nicotine products such as cigarettes, cigars, pipe, chewing tobacco, snuff, nicotine gum or nicotine patch? ☐ Yes ☐ No
***If Yes, provide details*:**

	Product Type(s)	Date Last Used	Frequency of Use
Primary insured			
Covered spouse			

4. In the past five years, has any person for whom you are applying for coverage to be reinstated:
a. had a 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, has any person for whom you are applying for coverage to be reinstated been convicted for any crime and/or is currently awaiting trial for any crime? ☐ Yes ☐ No

6. Will any person for whom you are applying for coverage to be reinstated 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.

(CONTINUED)

D. GENERAL INFORMATION (TO BE COMPLETED BY PRIMARY INSURED.) CONTINUED

7. Give complete details of any "Yes" answers for questions 1, 2, 4 – 6, including question number, name, and appropriate details:
Question # Name of Person Details

FOR ADDITIONAL DETAILS, USE A BLANK SHEET OF PAPER

PART 2 (THIS INFORMATION MUST BE PROVIDED FOR EACH PERSON FOR WHOM YOU ARE APPLYING FOR COVERAGE TO BE REINSTATED.)

A. PERSONAL PHYSICIAN INFORMATION (TO BE COMPLETED BY PRIMARY INSURED.)

PRIMARY INSURED

Name _____

Address: Street _____ Suite _____

City _____ State _____ ZIP _____

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

Reason last seen: _____

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

COVERED SPOUSE OR APPLICANT FOR APPLICANT'S WAIVER OF PREMIUM

Name _____

Address: Street _____ Suite _____

City _____ State _____ ZIP _____

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

Reason last seen: _____

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

B. PHYSICAL MEASUREMENTS (TO BE COMPLETED BY PRIMARY INSURED.)

1a. Height: _____ feet _____ inches Weight: _____ pounds (Primary Insured)

b. Height: _____ feet _____ inches Weight: _____ pounds (Covered Spouse or Applicant for Applicant's Waiver of Premium)

2. Within the last 12 months, has any person for whom you are applying for coverage to be reinstated had a change of weight (gain or loss) of more than 10 pounds? ☐ Yes ☐ No

If Yes, provide details: _____

(CONTINUED)

C. FAMILY HISTORY (TO BE COMPLETED BY PRIMARY INSURED.)

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 _____

D. MEDICAL INFORMATION (TO BE COMPLETED BY PRIMARY INSURED.)

1. Has any person for whom you are applying for coverage to be reinstated ever been treated by a member of the medical profession for, or been diagnosed 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. Has any person for whom you are applying for coverage to be reinstated 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. Has any person for whom you are applying for coverage to be reinstated 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, has any person for whom you are applying for coverage to be reinstated:

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. Is any person for whom you are applying for coverage to be reinstated 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, name, diagnosis, date of onset and recovery, medication/treatment prescribed and the name, address and telephone number of all attending physicians and hospitals**.

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

FOR ADDITIONAL MEDICAL DETAILS, USE A BLANK SHEET OF PAPER.

(CONTINUED)

ATTESTATIONS AND SIGNATURES

By signing this form, I affirm, understand, and agree to the following:

- To the best of my knowledge and belief, the statements in this application are complete, true and correctly recorded.
- The Company will not contest this reinstatement request after the end of two years from the date of reinstatement, subject to the conditions and exceptions stated in the policy.
- I will inform the Company of any changes to any answers on this application, prior to reinstatement of this policy.
- I have received and read the **Instructions** and the **Important Notice About Your Application for Reinstatement**.
- I understand that this application, if approved, will automatically restore all supplementary benefits and policy riders, unless I specify otherwise.

Signed at *(City, State)* _____

SIGN & DATE HERE Primary insured *(if age 14 years 6 months or over)* **X** _____ Date ____/____/_____

SIGN & DATE HERE Policyowner *(if other than the insured)* **X** _____ Date ____/____/_____

SIGN & DATE HERE Joint owner *(if applicable)* **X** _____ Date ____/____/_____

SIGN & DATE HERE Insured spouse *(if coverage on this person is to be reinstated)* **X** _____ Date ____/____/_____

SIGN & DATE HERE Applicant *(if Applicant's Waiver of Premium Benefit is to be reinstated)* **X** _____ Date ____/____/_____

Any covered children *(age 14 years 6 months or over - multiple signatures allowed per line)* :

SIGN & DATE HERE **X** _____ Date ____/____/_____

X _____ Date ____/____/_____

- For **corporations,** an authorized officer must sign. Be sure to include the title of the officer and the company name.
  - If **president** – no additional requirements
  - If **vice president** – for policies over $1,000,000, provide a Corporate Secretary's statement reflecting the vice president's authority to sign
  - If **any other officer** – provide a corporate resolution
- For **limited liability companies**, the individual(s) authorized to act, along with title and company name. Also provide the document (e.g., operating agreement or articles of organization) that defines who is authorized to act for the company.
- 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** for the policyowner (if other than the insured) 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 in whose favor the rights have been limited must also sign.

SUPPLEMENTARY INFORMATION AND RECEIPT

A. CONSUMER REPORT

If a consumer report is required, does the primary proposed insured want to be interviewed? ☐ Yes ☐ No

B. REMARKS

_____

_____

_____

_____

_____

C. PRODUCER'S CERTIFICATION

By signing this form, I certify that:

- I saw the insured(s) on the date shown below who made and signed the statements on this application;
- I am not related to any person having an interest in the policy;
- I am not aware of any information, other than what is stated in this application, including **Remarks**, that would adversely affect any insured's insurability.

SIGN & DATE HERE Writing representative **X** _____ Date ____/____/_____

FOR PRUDENTIAL USE ONLY

Contract number_____ Prudential representative_____

Amount remitted_____ Paid Report Date_____ Related Code_____ Staff_____ Debit_____

Policy issued by:

☐ The Prudential Insurance Company of America ☐ Pruco Life Insurance Company of New Jersey ☐ Pruco Life Insurance Company

CUT HERE AND KEEP RECEIPT FOR YOUR RECORDS

Prudential

The company received $_____ from_____

_____. This amount was collected when, on this date, a reinstatement application was signed in which _____ is (are) named as the insured(s) on policy number(s) _____.

This receipt is issued on the condition that any order for the payment of money is good and can be collected. **All checks must be payable only to Prudential and not to any other party.**

If we do not approve the reinstatement, the amount shown above will be returned to you. This receipt does not reinstate the policy or create any liability under the policy. It does not mean that the sum shown is the full amount needed to reinstate the policy.

No change may be made in the terms and conditions of this form. No statement which claims to make such a change will bind the Company.

SIGN & DATE HERE Writing representative **X** _____ Date ____/____/_____

We, us, our, and *the Company* refer to the Prudential Financial company that issued the policy.