Part 2 of Application or Request for Policy Change

On the life of

____
Primary proposed insured

____
Policy Number

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.
Please print using blue or black ink.

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 any 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

Voucher

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

Name of person examined ______________________________
(First name, middle initial, last name)

Date of birth ____/____/____ Social Security number ______________________________
month day year

Examiner ______________________________
(First name, middle initial, last name)

Tax number ______________________________

Address of examiner ______________________________
(street, city, state, ZIP)

____

Date of examination ____/____/____
month day year

Amount of insurance **$** ______________________________

Name of Writing Representative ______________________________
(First name, middle initial, last name) 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 ☐ A400 ☐ A470 ☐ A852 ☐ A892 ☐ ______

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**

<u>*Physician last consulted*</u>

Name ______________________

Address ______________________
(street, city, state, ZIP)
____

Telephone number (   ) ______________ Date last seen ___/___/___ *month day year*

Reason last seen ______________________

<u>*Primary physician*</u>

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

Continuation of Part 2 of Application for Life Insurance or Policy change

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

Primary Proposed Insured: ______________________

Policy Number: ______________________

Examiner's Confidential Report

Family Record

	Current Age or age at death	**Year and Cause of Death**
Father		
Mother		
Brothers		
Sisters		

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. 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.

F. Pulse

	Pulse rate per minute	Premature contractions No. per minute
At rest (seated)		

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

G. 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.

H. 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 →

M.C.L.

I. 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.)

J. Female Only: *Current menses?* ☐ Yes ☐ No

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

L. 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 F(2), G, H 3a-b, and L

____

____

____

____

____

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 of examiner ______________________ Date of examination

(street, city, state, ZIP)

Prudential Financial

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

Authorization to Release Information

Name ______________________

Policy number ______________________

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.

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 the individual listed in the Authorization above in order to request medical information to determine eligibility for coverage.

Signature of primary proposed insured X ______________________ ___/___/___ month day year
(If age 15 or over, otherwise applicant. [In Pennsylvania: If age 18 or over, otherwise applicant])

ORD 96200C 7/2004 CSO copy M 010