

INDIVIDUAL
APPLICATION

LONGTERM CARE

I N S U R A N C E

FL

GRP 112190
GRP 112627
GRP 112892
GRP 112432
GRP 112235
GRP 112220
GRP 112895
GRP 112911
GRP 98186
GRP 112559
GRP 98185
GRP 112215



Prudential  Financial

NOTE: You must also include:

Florida

Shoppers Guide ORD99020

Medicare Shoppers Guide (over age 65) ORD99019

HIPAA Notice GRP112891

MEDICAL HISTORY - Part 2 PERSONAL PROFILE:

Please provide the requested information about yourself.

1.

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Height Weight

2. Are you retired? Yes No
If Yes, what was your occupation?

3. Are you currently working outside your home?
 Yes No
If Yes, what occupation? _____

Is the work Full-time or Part-time?

4. Please list any activities in which you regularly participate outside your home. (For example, walking, gardening.) _____

5. Have you smoked or used tobacco products within the past three years? Yes No

5A. Do you use more than 1 (one) pack of tobacco products per day? Yes No

6. Do you drive an automobile? Yes No
If Yes, approximate number of miles driven each year? _____

7. With whom do you live? No one Spouse
 Other: _____

8. Are you living in a retirement community?
 Yes No
If Yes, please list any services you currently receive (For example, housecleaning, laundry, meals, medications.) _____

9. Are you receiving any Disability benefits:
 Yes No

Please check all that apply:

- Disability Income Insurance
- State or Federal Workers Compensation
- State Insurance Program
- Social Security
- Occupational Disease Law
- Employer's Liability Insurance

10. Have two or more years passed since you received any treatment or examination by ANY health care professional? Yes No

11. Who is your Primary Care Doctor with most of your medical records?

Name _____ Phone _____-_____-_____

Street Address _____

City _____ State _____ ZIP Code _____-_____

Date Last Seen _____

Reason Last Seen: _____

MEDICAL HISTORY - Part 3 HEALTH PROFILE:

Please answer every question in this section by indicating “Yes” or “No”

1. In the **past 12 months**, have you had an application rejected for long term care, nursing home care, or other health insurance?
 Yes No

2. Within the **past 5 years, (10 years for cancer)**, have you received any medical advice, examination, or treatment from a health care professional; taken any medications; or been medically diagnosed for:

	Yes	No	Condition
a.	<input type="checkbox"/>	<input type="checkbox"/>	Circulatory Disorder
b.	<input type="checkbox"/>	<input type="checkbox"/>	Congestive Heart Failure (CHF)
c.	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack, Chest Pain or Angina
d.	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure
e.	<input type="checkbox"/>	<input type="checkbox"/>	Irregular Heart Beat
f.	<input type="checkbox"/>	<input type="checkbox"/>	Cancer
g.	<input type="checkbox"/>	<input type="checkbox"/>	Hodgkin’s Disease, Lymphoma, Leukemia
h.	<input type="checkbox"/>	<input type="checkbox"/>	Skin Ulcers
i.	<input type="checkbox"/>	<input type="checkbox"/>	Tumor (Non-cancerous)
j.	<input type="checkbox"/>	<input type="checkbox"/>	Non-Insulin Dependent Diabetes
k.	<input type="checkbox"/>	<input type="checkbox"/>	Insulin Dependent Diabetes # of units per day _____
l.	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis
m.	<input type="checkbox"/>	<input type="checkbox"/>	Asthma, Chronic Bronchitis
n.	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Obstructive Pulmonary Disease (COPD), Emphysema, Shortness of Breath
o.	<input type="checkbox"/>	<input type="checkbox"/>	Alcoholism, Drug Addiction
p.	<input type="checkbox"/>	<input type="checkbox"/>	Brain Disorder, Convulsions, Epilepsy or Seizures
q.	<input type="checkbox"/>	<input type="checkbox"/>	Depression or Anxiety
r.	<input type="checkbox"/>	<input type="checkbox"/>	Mental, Emotional or Nervous Disorder, or Confusion, or Memory Loss
s.	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness or Balance Problems
t.	<input type="checkbox"/>	<input type="checkbox"/>	Fainting Spells or Black Outs
u.	<input type="checkbox"/>	<input type="checkbox"/>	Tremors
v.	<input type="checkbox"/>	<input type="checkbox"/>	Visual Disturbances
w.	<input type="checkbox"/>	<input type="checkbox"/>	Amputation
x.	<input type="checkbox"/>	<input type="checkbox"/>	Disabling Back or Spine Injury
y.	<input type="checkbox"/>	<input type="checkbox"/>	Fracture
z.	<input type="checkbox"/>	<input type="checkbox"/>	Numbness
aa.	<input type="checkbox"/>	<input type="checkbox"/>	Osteoarthritis
bb.	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis
cc.	<input type="checkbox"/>	<input type="checkbox"/>	Paralysis
dd.	<input type="checkbox"/>	<input type="checkbox"/>	Replacement of the Hip, Knee or other Joint
ee.	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis
ff.	<input type="checkbox"/>	<input type="checkbox"/>	Other conditions causing Crippling or Limited Motion or requiring use of an Adaptive Device

3. Within the **past three years**, have you been medically advised to enter or been confined to a hospital or other health care facility? Yes No

4. Within the **past three years**, have you:
 received home health care used adult day care
 been confined to a nursing home, assisted living facility, or long term care facility
 been medically advised to have surgery which has not been performed
 None

5. Within the **past five years**, have you received any medical advice, examination or treatment from a health care professional for any reason not previously stated? Yes No

In the space below you MUST provide details for any “Yes” answers to questions 1 through 5. If needed, complete the Additional Medical Information Page that is provided.

Refers to Number/Letter Above _____

Diagnosis Date _____

Treatment Date Last Seen _____

Reason Consulted/Treated _____

Check here if treated by Primary Care Physician (PCP). If not treated by PCP, give Name, Address, and Phone for other Treating Professional

Refers to Number/Letter Above _____

Diagnosis Date _____

Treatment Date Last Seen _____

Reason Consulted/Treated _____

Check here if treated by PCP. If not treated by PCP, give Name, Address, and Phone for other Treating Professional

Refers to Number/Letter Above _____

Diagnosis Date _____

Treatment Date Last Seen _____

Reason Consulted/Treated _____

Check here if treated by PCP. If not treated by PCP, give Name, Address, and Phone for other Treating Professional

MEDICAL HISTORY - Part 4 MEDICATIONS:

Please provide the requested information. Are you currently taking any drugs or medications? Yes No

If Yes, provide the information requested in the space below. If needed, complete the Additional Medical Information Page that is provided.

1. Drug or Medication _____ Dosage _____ How long been taking? _____

Reasons for taking _____

Check here if prescribed by Primary Care Physician (PCP) only. If not prescribed by PCP, give Name, Address and Phone No. of Treating Professional _____

2. Drug or Medication _____ Dosage _____ How long been taking? _____

Reasons for taking _____

Check here if prescribed by PCP only. If not prescribed by PCP, give Name, Address and Phone No. of Treating Professional _____

3. Drug or Medication _____ Dosage _____ How long been taking? _____

Reasons for taking _____

Check here if prescribed by PCP only. If not prescribed by PCP, give Name, Address and Phone No. of Treating Professional _____

4. Drug or Medication _____ Dosage _____ How long been taking? _____

Reasons for taking _____

Check here if prescribed by PCP only. If not prescribed by PCP, give Name, Address and Phone No. of Treating Professional _____

5. Drug or Medication _____ Dosage _____ How long been taking? _____

Reasons for taking _____

Check here if prescribed by PCP only. If not prescribed by PCP, give Name, Address and Phone No. of Treating Professional _____

6. Drug or Medication _____ Dosage _____ How long been taking? _____

Reasons for taking _____

Check here if prescribed by PCP only. If not prescribed by PCP, give Name, Address and Phone No. of Treating Professional _____

7. Drug or Medication _____ Dosage _____ How long been taking? _____

Reasons for taking _____

Check here if prescribed by PCP only. If not prescribed by PCP, give Name, Address and Phone No. of Treating Professional _____

If you are taking more than 7 medications, please list them on the "Additional Medical Information Page".

NOTIFICATION OF UNINTENTIONAL LAPSE:

You can provide Prudential with the name of a friend or relative to notify if your Policy should lapse because the premium is not paid when due. This designation does not constitute an acceptance of liability by the person named. Prudential will notify you each year of your right to designate or change the existing designation for this purpose.

Only complete the appropriate section: NAME A DESIGNEE OR WAIVER OF NOTIFICATION.

Check here ONLY to name a designee, and provide the requested information about that person:

First Name	<input type="text"/>	M. I.	<input type="text"/>	Last Name	<input type="text"/>	
Street Address	<input type="text"/>				Apt. No.	<input type="text"/>
City	<input type="text"/>	State	<input type="text"/>	ZIP Code	<input type="text"/>	

Check here ONLY IF YOU DO NOT WISH to name a person for this purpose. WAIVER OF NOTIFICATION Option: I understand that I have the right to name at least one person other than myself to receive notice of lapse or termination of my long term care insurance policy for non-payment of premium. I understand that notice will not be given until thirty-one days after the premium is due and not paid. **By my signature, I elect NOT to name any person to receive such notice.**

Applicant Signature: X <input type="text"/>
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To Residents of Indiana:

THE POLICY DOES NOT QUALIFY FOR MEDICAID ASSET PROTECTION UNDER THE INDIANA LONG TERM CARE PROGRAM. HOWEVER, THE POLICY IS AN APPROVED LONG TERM CARE POLICY UNDER STATE INSURANCE REGULATIONS. FOR INFORMATION ABOUT POLICIES AND CERTIFICATES QUALIFYING UNDER THE INDIANA LONG TERM CARE PROGRAM, CALL THE SENIOR HEALTH INSURANCE INFORMATION PROGRAM OF THE INDIANA DEPARTMENT OF INSURANCE AT: 1-800-452-4800.

To Residents of Iowa:

THE POLICY DOES NOT QUALIFY FOR MEDICAID ASSET PROTECTION UNDER THE IOWA LONG TERM CARE ASSET PRESERVATION PROGRAM. HOWEVER, THE POLICY IS AN APPROVED LONG TERM CARE POLICY UNDER STATE INSURANCE REGULATIONS. FOR INFORMATION ABOUT POLICIES AND CERTIFICATES QUALIFYING UNDER THE IOWA LONG TERM CARE ASSET PRESERVATION PROGRAM, CALL THE SENIOR HEALTH INSURANCE INFORMATION PROGRAM OF THE IOWA DIVISION OF INSURANCE AT: 1-800-281-5705.

LTC BY DESIGNSM

PLAN DESIGN SELECTION: A SELECTION MUST BE MADE FOR EVERY OPTION LISTED BELOW.

Maximum Daily Benefit:
 (\$10 increments)

\$

Home & Community-Based Care Factor MDB: 50%
 (HCBC MDB) 75%
 (Choose one option only) 100%

Lifetime Maximum:

(Choose one option only) 3 Years
 4 Years
 5 Years
 Unlimited

Elimination Period: A. Service (Standard)
 (Choose one option only) Calendar Day Elimination
 Period Rider

(Choose one option only) B. 0 Days (If checked, Service Day
 Elimination Period applies.)
 30 Days
 60 Days
 90 Days
 180 Days

Inflation Riders:

(Choose only one option where available) None (Standard)
 Periodic Inflation Rider
 5% Simple Inflation Rider
 5% Automatic Compound
 Inflation Rider - 2X Maximum
 5% Automatic Compound
 Inflation Rider - No Maximum

If 5% Automatic Compound Inflation Rider-No Maximum is not selected, please check box below:

I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of these policies. I reject the 5% Automatic Compound Inflation Rider (No Maximum).

Optional Shortened Benefit Period Rider

Nonforfeiture Benefit: I have reviewed the explanation of the Optional Nonforfeiture Benefit in the Outline of Coverage, and I make the following selection: Yes, include Nonforfeiture Benefit Rider
 No, do not include the Nonforfeiture Benefit Rider

HCBC Benefit Payment Options: Daily Benefit (Standard)
 (Choose one option only) Monthly Benefit Rider
 Cash Benefit Rider (If checked, calendar day elimination period applies)

Waiver of Premium Option: Standard (Default)
 Joint Waiver of Premium Rider
 Survivor Benefit Rider
 Joint Waiver of Premium Rider and Survivor Benefit Rider

Optional Rider: Restoration of Benefits Rider
 (Choose one option only) None

Premium Payment Mode:
 (Choose one option only)

Annual
 Semi-annual
 Quarterly
 Monthly (EFT)
 (Electronic Funds Transfer Authorization must be completed)

Full Modal Premium: \$.

Cash Submitted With Application: \$.

Spousal Discount: None Single Joint

Qualified Adult Discount: Yes No

Affiliation Discount: Yes No
 (Only where available) (If yes, please complete the Affiliation Code and Affiliation Name fields below)

Affiliation Code:

Affiliation Name:

Applicant's Name: _____

Applicant's SS#: - -

NOTE: PLEASE COMPLETE AND SUBMIT WITH APPLICATION.

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Authorization for Release of Health-Related Information

This authorization is intended to comply with the HIPAA Privacy Rule

Name of proposed insured/patient (please print)

____/____/_____
Date of birth

Social Security No.: _____

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf ("My Providers"), and any other medical or insurance organization, institution or professional, to disclose my entire medical record and any other health information concerning me, without restriction, to The Prudential Insurance Company of America and its agents, employees and representatives ("Prudential"). This includes medical records and information on diagnoses and/or treatment relating to Human Immunodeficiency Virus (HIV) infection or Acquired Immunodeficiency Syndrome (AIDS), sexually transmitted disease, mental illness, and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I terminate any agreements I have made with My Providers to restrict my protected health information and, for purposes of this authorization, I instruct My Providers to release and disclose my entire medical record without restriction to Prudential.

This information is to be disclosed under this Authorization so that Prudential may do the following, with respect to long term care insurance I have or am applying for: underwrite or make rating determinations, evaluate and determine my eligibility for long term care insurance, administer claims and other related policy provisions, obtain reinsurance, or conduct other legally permissible activities related to my application or coverage.

This authorization shall remain in force for 24 months following the date of my signature below, except to the extent that state law imposes a shorter duration. A copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to: The Prudential Insurance Company of America, Long Term Care Customer Service Center, P. O. Box 8519, Philadelphia, PA 19101, ATTN: Privacy Contact. I understand that a revocation is not effective if any of My Providers has relied on this authorization or to the extent that Prudential has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information disclosed pursuant to this authorization may be re-disclosed, to the extent allowable under federal law and no longer covered by certain federal rules governing privacy and confidentiality of health information.

I understand that if I refuse to sign this authorization, Prudential may not be able to process my application or, if coverage has been issued, may not be able to make any benefit payments. I understand that Prudential will provide me with a copy of this authorization.

Signature of Proposed Insured/Patient or Personal Representative

____/____/_____
Date

Description of Personal Representative's Authority or Relationship to Patient

PLEASE SIGN AND RETURN THIS COPY WITH YOUR APPLICATION

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Authorization for Release of Health-Related Information

This authorization is intended to comply with the HIPAA Privacy Rule

Name of proposed insured/patient (please print)

____/____/_____
Date of birth

Social Security No.: _____

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf ("My Providers"), and any other medical or insurance organization, institution or professional, to disclose my entire medical record and any other health information concerning me, without restriction, to The Prudential Insurance Company of America and its agents, employees and representatives ("Prudential"). This includes medical records and information on diagnoses and/or treatment relating to Human Immunodeficiency Virus (HIV) infection or Acquired Immunodeficiency Syndrome (AIDS), sexually transmitted disease, mental illness, and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

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This information is to be disclosed under this Authorization so that Prudential may do the following, with respect to long term care insurance I have or am applying for: underwrite or make rating determinations, evaluate and determine my eligibility for long term care insurance, administer claims and other related policy provisions, obtain reinsurance, or conduct other legally permissible activities related to my application or coverage.

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Signature of Proposed Insured/Patient or Personal Representative

____/____/_____
Date

Description of Personal Representative's Authority or Relationship to Patient

RETAIN THIS COPY FOR YOUR RECORDS

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AGENT'S STATEMENT

Please print all information except where signatures are required. Use black ink. Read all questions carefully.

Please provide complete details to avoid delays in processing.

APPLICANT'S NAME _____

1. Did you personally interview the Applicant face-to-face and witness his or her signature? Yes No
2. Does the Applicant appear to be in good health? Yes No
3. Did you observe any physical or mental impairments with regard to walking, talking, or any form of tremor? *If yes, please describe:* Yes No

4. Did you review the entire Application for corrections or omissions? Yes No
5. Do you have any knowledge or reason to believe the replacement of existing insurance may be involved, but did not have the replacement form signed? Yes No
6. Has the Applicant purchased any other health insurance policy from you during **the past 5 years**? *If Yes, provide the following information:* Yes No

COMPANY

POLICY NUMBER

7. Using the criteria on Side 2, did the Applicant qualify for Select Class I rates? Yes No
8. I received the initial, modal premium, in full where permitted by law, with the Application and provided to the Applicant as receipt of \$_____, a Premium Receipt. Yes No

9. Special requests, remarks and instructions: _____

By my signature on this form:

- I have reviewed the current health insurance coverage of the Applicant and find that additional coverage of the type and amount applied for is appropriate for the Applicant's needs.
- I certify the premium submitted reflects a Select Class I or Select Class II rate. The Preferred Health Discount must be approved by Medical Underwriting.
- I certify I have personally seen the Applicant and have accurately recorded information supplied to me by the Applicant at the time application was made.
- I certify that I am in compliance with the long term care insurance education requirements in the state of residence of the applicant as shown on his/her application.
- I certify I have delivered the Outline of Coverage to the Applicant at the first time of solicitation.

Agent's Signature **X** _____ Date _____

Print Name _____ Contract Number _____

State of Licensure _____ License Number _____

Full Address _____ Phone Number _____

PREMIUM CLASSIFICATIONS:

Prudential offers two underwriting classifications or rating categories: Select Class I and Select Class II.

To be eligible for Select Class I rating, the Applicant must exhibit the following characteristics:

- Height and weight within the acceptable ranges according to the Prudential's Height and Weight Guide below.
- Smokes less than one pack of cigarettes per day or the equivalent use of another tobacco product and does not have a cardiac, respiratory or vascular/circulatory condition
- Does not have Hodgkin's Disease, Leukemia or Lymphoma
- Does not have any of the following medical conditions requiring daily prescription medication: Congestive Heart Failure, Diabetes, Chronic Obstructive Pulmonary Disease (COPD), or Emphysema

Applicants who do not qualify for Select Class I as outlined above, but are otherwise insurable according to Prudential's Underwriting Guidelines, should be quoted Select Class II.

HEIGHT AND WEIGHT GUIDE:

Below is a height and weight table that applies to both men and women. Obesity can introduce problems when treating other conditions such as functional or mobility deficiencies, diabetes, cardiac insufficiencies, etc. Any applicant possessing a functional or physical impairment complicated with the build configuration listed below is considered a high risk LTC service user. **This applies to overweight as well as underweight.**

Height	Lowest Acceptable	Highest Acceptable	Height	Lowest Acceptable	Highest Acceptable
4' 11"	85 LBS	175 LBS	5' 9"	118 LBS	242 LBS
5' 0"	90 LBS	190 LBS	5' 10"	121 LBS	253 LBS
5' 1"	93 LBS	194 LBS	5' 11"	124 LBS	266 LBS
5' 2"	97 LBS	204 LBS	6' 0"	128 LBS	275 LBS
5' 3"	99 LBS	213 LBS	6' 1"	131 LBS	286 LBS
5' 4"	102 LBS	218 LBS	6' 2"	136 LBS	291 LBS
5' 5"	105 LBS	222 LBS	6' 3"	139 LBS	297 LBS
5' 6"	107 LBS	227 LBS	6' 4"	142 LBS	300 LBS
5' 7"	110 LBS	232 LBS	6' 5"	146 LBS	305 LBS
5' 8"	114 LBS	238 LBS			

IMPORTANT NOTICE ABOUT PRUDENTIAL'S INFORMATION PRACTICES

Thank you for choosing The Prudential Insurance Company of America (Prudential) for your insurance needs. Before we can issue coverage we must review your application/enrollment form. To do this, we need to collect and evaluate personal information about you. This notice tells you about Prudential's information practices.

Collecting Information for Underwriting

Prudential will review information about you to decide if you are eligible for coverage. In addition to your application/enrollment form, Prudential may obtain information about you from the following sources: a medical examination which we may ask you to take; an in-person health interview; the Medical Information Bureau (MIB); and doctors, hospitals, health care providers who have information about you or your mental or physical health.

Disclosing Information

We will treat any information we obtain or have obtained about you as confidential. However, we may disclose it to: your doctor, if we find a serious health problem you do not know about; the MIB; anyone conducting mortality or morbidity studies; and Company affiliates for insurance marketing, underwriting, policyholder service or claims handling. We may also disclose information to Company affiliates for non-insurance marketing purposes unless you write to us at our Long Term Care Customer Service Center and direct us not to make such a disclosure.* The Company 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. Similarly, the Company or its reinsurers may 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.

Your Right to Information

If we do not issue the policy you requested, we will tell you and explain the reasons for our decision. If you write to us, we will describe the information we have relating to this insurance transaction, describe how you may access it, and tell you how you may request correction, amendment or deletion of information that you dispute. Please note that requested information from your medical records will only be released to a medical professional designated by 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, telephone number (617) 426-3660.

**This sentence does not apply to residents of Minnesota.*

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THINGS YOU SHOULD KNOW BEFORE YOU BUY LONG TERM CARE INSURANCE

Long Term Care Insurance

- A long term care insurance policy may pay most of the costs for your care in a nursing home. Many policies also pay for care at home or other community settings. Since policies can vary in coverage, you should read this Policy and make sure you understand what it covers before you buy it.
- You should not buy this insurance policy unless you can afford to pay the premiums every year. Remember that Prudential can increase premiums in the future.
- The Personal Worksheet includes questions designed to help you and the company determine whether this Policy is suitable for your needs.

Medicare

- Medicare does **not** pay for most long term care.

Medicaid

- Medicaid will generally pay for long term care if you have very little income and few assets. You probably should **not** buy this Policy if you are now eligible for Medicaid.
- Many people become eligible for Medicaid after they have used up their own financial resources by paying for long term care services.
- When Medicaid pays your spouse's nursing home bills, you are allowed to keep your house and furniture, a living allowance and some of your joint assets.
- Your choice of long term care services may be limited if you are receiving Medicaid. To learn more about Medicaid, contact your local or state Medicaid agency.

Shopper's Guide

- Make sure the insurance company or agent gives you a copy of a book called the National Association of Insurance Commissioners' *Shopper's Guide to Long Term Care Insurance*. Read it carefully. If you have decided to apply for long term care insurance, you have the right to return the policy within 30 days and get back any premium you have paid if you are dissatisfied for any reason or choose not to purchase the Policy.

Counseling

- Free counseling and additional information about long term care insurance are available your state's insurance counseling program. Contact your state insurance department or department on aging for more information about the senior health insurance counseling program in your state.

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Long Term Care Insurance Personal Worksheet

People buy long-term care insurance for many reasons. Some don't want to use their own assets to pay for long-term care. Some buy insurance to make sure they can choose the type of care they get. Others don't want their family to have to pay for care or don't want to go on Medicaid or Medi-Cal. But long term care insurance may be expensive, and may not be right for everyone.

By state law, The Prudential Insurance Company of America (Prudential) must fill out part of the information on this worksheet and **ask** you to fill out the rest to help you and Prudential decide if you should buy this policy.

Premium Information

Policy Form Number GRP 112553:

Policy Form Number GRP 112762:

The premium for the coverage you are considering will be \$_____ per_____

Type of Policy Guaranteed Renewable

Prudential's Right to Increase Premiums

Prudential has a right to increase premiums on this policy form in the future, provided it raises rates for all policies in the same class in this state. Prudential will notify you at least 45 days in advance of any rate increase.

Rate Increase History

Prudential has sold long-term care insurance since 1986 and has sold this policy form since 2003. Prudential has never raised its rates for any long term care policy it has sold in this state or any other state.

Questions Related to Your Income

How will you pay each year's premium?

From My Income From My Savings/Investments My Family Will Pay

Have you considered whether you could afford to keep this Coverage if the premiums went up, for example, by 20%?

YES NO

What is your annual income? (Check one)

Under \$10,000 \$10,000-\$20,000 \$20,000-\$30,000
 \$30,000-\$50,000 Over \$50,000

How do you expect your income to change over the next 10 years? (Check one)

No change Increase Decrease

If you will be paying premiums with money received only from your own income, a rule of thumb is that you may not be able to afford this coverage if the premiums will be more than 7% of your income.

Will the premium be more than 7% of your income? Yes No

Will you buy inflation protection? (check one) Yes No

If not, have you considered how you will pay for the difference between future costs and your daily benefit amount?

From My Income From My Savings/Investments My Family Will Pay

The national average annual cost of care in 2000 was \$55,000 for Nursing Home Care, but this figure varies across the country. In ten years, the national average annual cost would be about \$89,650 if costs increase 5% annually.

What elimination period are you considering?

Number of days _____ Approximate cost \$_____ for that period of care.

How are you planning to pay for your care during the elimination period? (check one)

From My Income From My Savings/Investments My Family Will Pay

Questions Related to Your Savings and Investments

Not counting your home, about how much are all of your assets (your savings and investments) worth? (Check one)

Under \$20,000 \$20,000-\$30,000 \$30,000-\$50,000 Over \$50,000

How do you expect your assets to change over the next ten years? (check one)

Stay about the same Increase Decrease

If you are buying this coverage to protect your assets and your assets are less than \$30,000, you may wish to consider other options for financing your long term care.

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**Long Term Care Insurance
Potential Rate Increase Disclosure Form**

- 1. Premium Rate:** The premium rate that is applicable to you and that will be in effect until a request is made and filed for an increase is \$ _____.
- 2. The premium for this policy will be shown on the Schedule of Benefits Page of your policy.**
- 3. Rate Schedule Adjustments:** The company will provide a description of when premium rate or rate schedule adjustments will be effective (e.g., next anniversary date, next billing date, etc.): No premium rate or rate schedule adjustments are scheduled for this Policy. However, if there were a rate increase, it would be effective in your next billing date and you would be notified at least 45 days in advance.
- 4. Potential Rate Revisions:** This policy is Guaranteed Renewable. This means that the rates for this policy may be increased in the future. Your rates can NOT be increased due to your increasing age or declining health, but your rates may go up based on the experience of all policyholders with a policy similar to yours.

If you receive a premium rate or premium rate schedule increase in the future, you will be notified of the new premium amount and you will be able to exercise at least one of the following options:

- Pay the increased premium and continue your policy in force as is.
- Reduce your policy benefits to a level such that your premiums will not increase. (Subject to state law minimum standards.)
- Exercise your non-forfeiture option if purchased. (This option is available for purchase for an additional premium.)
- Exercise your contingent non-forfeiture rights.* (This option may be available if you do not purchase a separate non-forfeiture option.)

***Contingent Non-forfeiture**

If the premium rate for your policy goes up in the future and you didn't buy a non-forfeiture option, you may be eligible for contingent non forfeiture. Here's how to tell if you are eligible:

You will keep some long term care insurance coverage, if:

- Your premium after the increase exceeds your original premium by the percentage shown (or more) in the following table and
- You lapse (not pay more premiums) within 120 days of the increase.

The amount of coverage (i.e., new lifetime maximum benefit amount) you will keep will equal the total amount of premiums you've paid since your policy was first issued. If you have already received benefits under the policy, so that the remaining maximum benefit amount is less than the total amount of premiums you've paid, the amount of coverage will be that remaining amount.

Except for this reduced lifetime maximum benefit amount, all other policy benefits will remain at the levels attained at the time of the lapse and will not increase thereafter.

Should you choose this Contingent Non-forfeiture option your policy with this reduced maximum benefit amount will be considered paid up with no further premiums due.

Example:

You bought the policy at age 65 and paid the \$1,000 annual premium for 10 years, so you have paid a total of \$10,000 in premium.

In the eleventh year, you receive a rate increase of 50%, or \$500 for a new annual premium of \$1,500, and you decide to lapse the policy (not pay any more premiums).

Your paid-up policy benefits are \$10,000 (provided you have at least \$10,000 of benefits remaining under your policy.)

**Contingent Non-forfeiture
Cumulative Premium Increase over Initial Premium
That qualifies for Contingent Non-forfeiture**

(Percentage increase is cumulative from date of original issue. It does NOT represent a one-time increase.)

Issue Age	Percent Increase Over Initial Premium
29 and under	200%
30 – 34	190%
35 – 39	170%
40 – 44	150%
45 – 49	130%
50 – 54	110%
55 – 59	90%
60	70%
61	66%
62	62%
63	58%
64	54%
65	50%
66	48%
67	46%
68	44%
69	42%
70	40%
71	38%
72	36%
73	34%
74	32%
75	30%
76	28%
77	26%
78	24%
79	22%
80	20%
81	19%
82	18%
83	17%
84	16%
85	15%
86	14%
87	13%
88	12%
89	11%
90 and over	10%

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NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS OR LONG TERM CARE INSURANCE

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to the information you have furnished on your Application, you intend to lapse or otherwise terminate existing accident and sickness or long term care insurance and replace it with an individual long term care insurance policy to be issued by The Prudential Insurance Company of America. Your new Policy provides thirty (30) days within which you may decide, without cost, whether you desire to keep the Policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new Policy.

You should review this new coverage carefully, comparing it with all accident and sickness or long term care insurance coverage you now have and terminate your present policy only if, after due consideration, you find that purchase of this long term care coverage is a wise decision.

STATEMENT TO APPLICANT BY AGENT:

I have reviewed your current medical or health insurance coverage. I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following considerations, which I call to your attention:

1. This Policy has no exclusion for pre-existing conditions. This means that health conditions which you may presently have are fully and immediately covered under the new Policy.
2. State law provides that your replacement Policy or certificate may not contain new pre-existing conditions or probationary periods. The Policy you are applying for has no such pre-existing conditions or probationary periods.
3. If you are replacing existing long term care insurance coverage, you may wish to secure the advice of your present insurer or its agents regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
4. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the Application concerning your medical health history. Failure to include all material medical information on an Application may provide a basis for the company to deny any future claims and to refund your premium as though your Policy had never been in force. After the Application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

Signature of Agent, Broker or Other Representative

Applicant's Signature
The above "Notice to Applicant" was delivered to me on:

Date

Typed or Printed Name and Address of Agent

PLEASE SIGN AND RETURN THIS COPY WITH YOUR APPLICATION

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**NOTICE TO APPLICANT REGARDING REPLACEMENT
OF ACCIDENT AND SICKNESS OR LONG TERM CARE INSURANCE**

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You should review this new coverage carefully, comparing it with all accident and sickness or long term care insurance coverage you now have and terminate your present policy only if, after due consideration, you find that purchase of this long term care coverage is a wise decision.

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1. This Policy has no exclusion for pre-existing conditions. This means that health conditions which you may presently have are fully and immediately covered under the new Policy.
2. State law provides that your replacement Policy or certificate may not contain new pre-existing conditions or probationary periods. The Policy you are applying for has no such pre-existing conditions or probationary periods.
3. If you are replacing existing long term care insurance coverage, you may wish to secure the advice of your present insurer or its agents regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
4. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the Application concerning your medical health history. Failure to include all material medical information on an Application may provide a basis for the company to deny any future claims and to refund your premium as though your Policy had never been in force. After the Application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

Signature of Agent, Broker or Other Representative

Applicant's Signature
The above "Notice to Applicant" was
delivered to me on:

Date

Typed or Printed Name and Address of Agent

RETAIN THIS COPY FOR YOUR RECORDS

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**THE PRUDENTIAL INSURANCE COMPANY OF AMERICA
751 BROAD STREET
NEWARK, NEW JERSEY 07102
(800) 732-0416**

**LONG TERM CARE INSURANCE
OUTLINE OF COVERAGE**

Policy Number GRP 112553

The following applies to applicants who must answer medical questions in order to qualify for the Long Term Care Insurance.

Caution: *The issuance of this long term care insurance Policy is based upon your responses to the questions on your application. A copy of your application will be included with your Policy when issued. If your answers are incorrect or untrue, or you fail to include all material medical information requested, Prudential may have the right to deny benefits or rescind your Policy, subject to the Incontestability provision. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the company at this address: Prudential Long Term Care Customer Service Center, P. O. Box 931, Horsham, PA 19044.*

Notice to buyer: This Policy may not cover all of the costs associated with long term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations.

The policies described in this Outline of Coverage have been approved as “Long Term Care Insurance” policies meeting the requirements of Florida law.

1. This Policy is an individual policy of insurance.
2. **PURPOSE OF OUTLINE OF COVERAGE.** This outline of coverage provides a very brief description of the important features of the Policy. You should compare this outline of coverage to outlines of coverage for other policies available to you. This is not an insurance contract, but only a summary of coverage. Only the individual Policy contains governing contractual provisions. This means that the Policy sets forth in detail the rights and obligations of both you and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you **READ YOUR POLICY CAREFULLY!**
3. **FEDERAL TAX CONSEQUENCES. This Policy is intended to be a federally tax-qualified long term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986, as amended.**
4. **TERMS UNDER WHICH THE POLICY MAY BE CONTINUED IN FORCE OR DISCONTINUED. RENEWABILITY: THIS POLICY IS GUARANTEED RENEWABLE.** This means you have the right, subject to the terms of your Policy to continue this Policy as long as you pay your premiums on time. Prudential cannot change any of the terms of your Policy on its own, except that, in the future, **IT MAY INCREASE THE PREMIUM YOU PAY.** This Policy contains a Waiver of Premium provision. After you meet the Benefit Eligibility Criteria and satisfy the required Elimination Period, the

premiums for your Policy will be waived. These features are described in full detail in the Policy.

5. TERMS UNDER WHICH THE COMPANY MAY CHANGE PREMIUMS.
PRUDENTIAL RESERVES THE RIGHT TO CHANGE THE PREMIUM YOU PAY. ANY CHANGE WILL APPLY ON A CLASS BASIS TO ALL INSUREDS.

6. TERMS UNDER WHICH THE POLICY MAY BE RETURNED AND PREMIUM REFUNDED. If you decide you do not want this Long Term Care Policy, you may return it within 30 days of receipt. Your Policy will be canceled as of the Effective Date and any premium paid will be returned to you. Upon proper notification of your death or cancellation of this Policy at a time occurring after the 30 day free look period, Prudential will refund on a pro-rata basis any part of the premium for you which applies to the period after death or cancellation.

7. THIS IS NOT MEDICARE SUPPLEMENT COVERAGE. If you are eligible for Medicare, review the *Guide to Health Insurance for People with Medicare* available from Prudential. Neither Prudential nor its agents represent Medicare, the federal government or any state government.

8. LONG TERM CARE COVERAGE. Policies of this category are designed to provide coverage for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital, such as in a nursing home, in the community or in the home. This Policy provides coverage in the form of reimbursement benefits, according to the Plan you choose, for covered long term care expenses, subject to Elimination Period and Maximum Daily Benefits, Calendar Year and Lifetime Maximum benefits.

9. BENEFITS PROVIDED BY THIS POLICY. This Policy pays benefits for Eligible Charges incurred by you for Nursing Home Care, Adult Foster Home Care, care in an Assisted Living Facility or Residential Health Care Facility; Bed Reservation; Hospice Care; Respite Care; Home and Community-Based Care, which includes Home Health Care, Adult Day Care, Homemaker Services and Personal Care; and Independence Support; Emerging Trends; Information and Referral Services; and Private Care Consultant. Contingent Non-Forfeiture benefits are also included, if you do not purchase the optional Non-Forfeiture Benefit Rider. Benefits paid for Eligible Charges count towards fulfillment of your Lifetime Maximum, unless otherwise stated in the Policy. The actual amount paid depends on the Maximum Daily Benefit you have chosen.

Maximum Daily Benefit for Nursing Home, Adult Foster Home, Assisted Living Facility or Residential Health Care, Bed Reservation, Hospice Care and Respite Care:

\$ _____ (\$10 increments)

Home and Community-Based Care Factor of the Maximum Daily Benefit, for Home Health Care, Adult Day Care, Homemaker Services and Personal Care: 50% 75% 100%

Lifetime Maximum: 3 years 4 years 5 years Unlimited

Elimination Period: _____ Number of Days: _____

Elimination Period. The Elimination Period must be satisfied only once during your lifetime. Prudential will begin to count the Elimination Period with the first date you incur Eligible Charges for Qualified Long Term Care Services after your Chronic Illness or Disability begins.

Eligibility for Payment of Benefits. In order to receive benefits your condition must first be certified by a Licensed Health Care Practitioner as a Chronic Illness or Disability. A Chronic Illness or Disability is one that meets either definition below.

- 1) A loss of the ability to perform, without Substantial Assistance, at least two Activities of Daily Living due to a loss of functional capacity. This inability must be expected to continue for at least 90 consecutive days. This expectation is not a waiting period. Activities of Daily Living are Bathing, Continence, Dressing, Eating, Toileting, and Transferring.
- 2) A severe Cognitive Impairment that requires Substantial Supervision to protect you from threats to health and safety.

Activities of Daily Living are defined as follows.

Bathing - Washing oneself by sponge bath, or in either a tub or shower, including the task of getting into or out of the tub or shower.

Continence - The ability to maintain control of bowel and bladder function, or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).

Dressing - Putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.

Eating - Feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by feeding tube or intravenously.

Toileting - Getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.

Transferring - Moving into or out of a bed, chair or wheelchair.

Cognitive Impairment is defined as follows. A person's deficiency in any of the following items:

- 1) short-term or long term memory;
- 2) orientation as to people, place, or time;
- 3) deductive or abstract reasoning; or
- 4) judgment as it relates to safety awareness.

Prudential will arrange for a Licensed Health Care Practitioner to assess you or you may select your own Licensed Health Care Practitioner. The assessment will be based on objective standards of measurement. After your Chronic Illness or Disability is certified, Prudential will determine if you are eligible for benefits based on the other terms and conditions of the Policy. If you are eligible, you will need a Plan of Care. Your Plan of Care will be used to determine benefits based on the benefit options in your Policy.

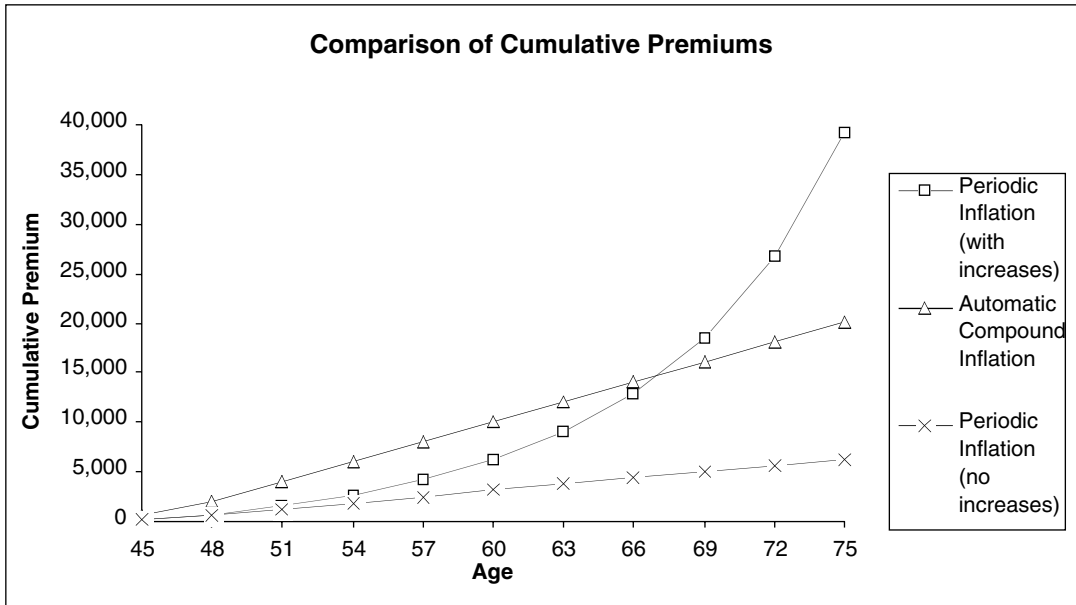
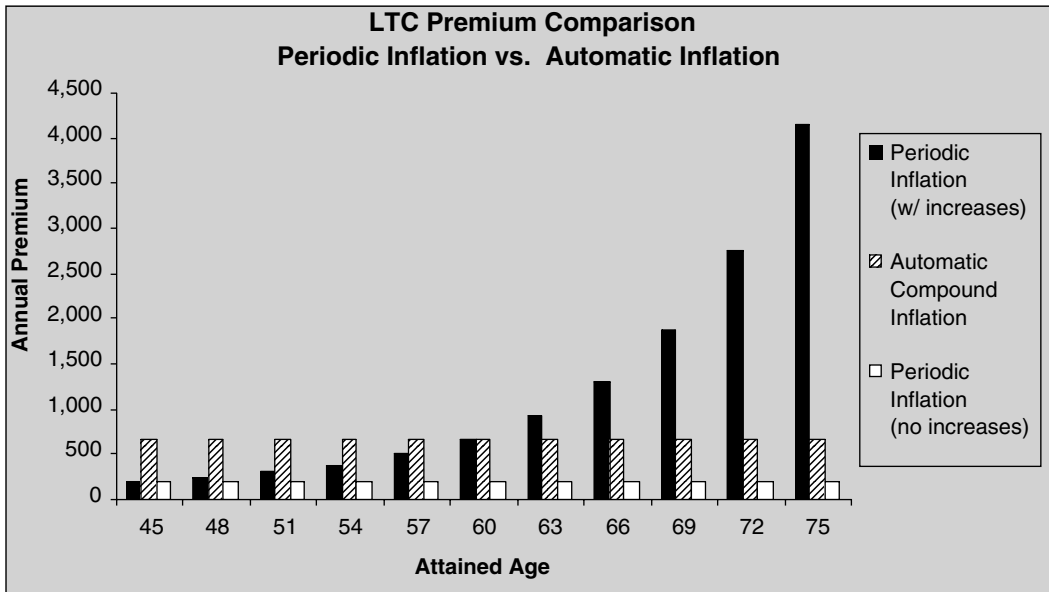
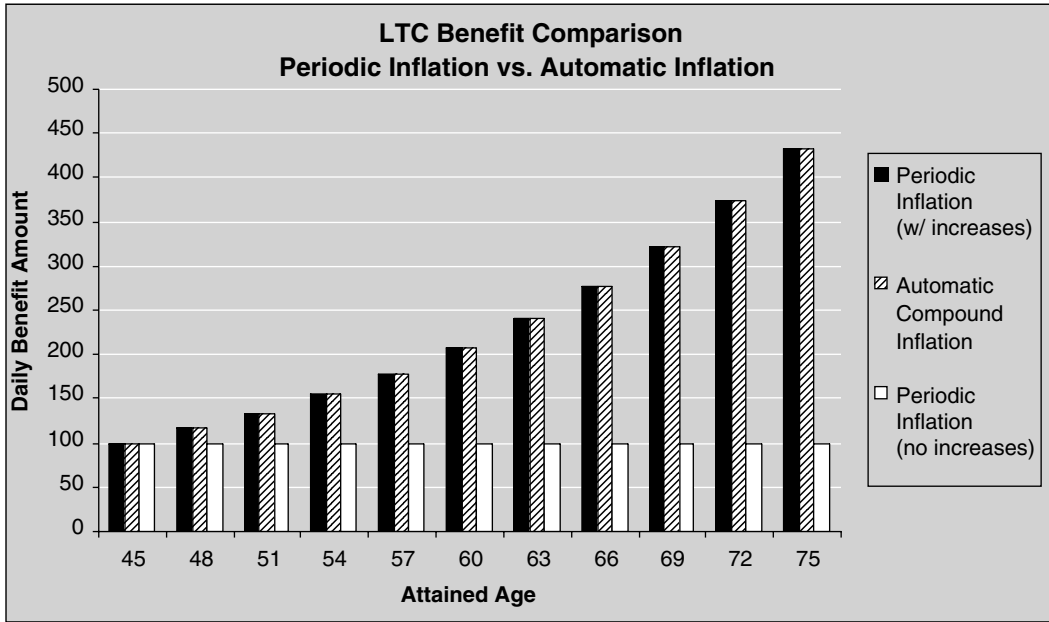
10. LIMITATIONS AND EXCLUSIONS. **Charges Not Covered.**

- a) **Government Plans.** Charges are for a service or supply you receive that is:
- 1) Furnished by or for the United States government or any other government, unless payment of the charge is required by law; or
 - 2) Provided by any law or governmental plan under which the patient is covered. This does not apply to a state plan under Medicaid or to any law or plan when, by law, its benefits are excess to those of any private insurance program or other non-governmental program.
- b) **War, Felony, Riot or Insurrection.** Charges for a condition due to war or an act of war while you are insured or due to your participation in an act of felony, riot or insurrection. "War" means declared or undeclared war and includes resistance to armed aggression. "Riot" means a wild, violent, public disturbance of the peace.
- c) **Services and Supplies Outside the United States.** Charges for services or supplies outside the United States and its possessions.
- d) **Services or Supplies Normally Furnished Without Charge.** Services or supplies for which no charge would be made in the absence of insurance.
- e) **Treatment of Chronic Alcoholism or Drug or Chemical Dependency.** Charges in connection with treatment of chronic alcoholism or drug or chemical dependency.

THIS POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LONG TERM CARE NEEDS.

11. RELATIONSHIP OF COST OF CARE AND BENEFITS. Because the costs of long term care services will likely increase over time, you should consider whether and how the benefits of this Policy may be adjusted. Benefit levels will not increase over time under the Policy, unless you purchase an optional Inflation Rider.

The following is a hypothetical graphic comparison of the benefit and premium levels of a Policy that increases benefits over the period of coverage with a Policy that does not increase benefits. The graphic comparison shows benefit and premium levels over a thirty year period. The example is based on a \$100 Maximum Daily Benefit purchased by a 45 year old.



12. **ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS.** The Policy provides coverage for insureds clinically diagnosed as having Alzheimer's disease or related degenerative and dementing illnesses.
13. **PREMIUM.** The total annual premium for the Policy and options you have selected will be \$_____. Please see the last page of this Outline of Coverage for a complete listing of the features and premium for the options you have selected.
14. **ADDITIONAL FEATURES.**

Medical Underwriting. Medical underwriting is used to determine your eligibility for the Policy. To apply for coverage under the Policy, you must complete an Application. Satisfactory evidence of good health is required for all applicants in order to be eligible for this Policy. Individuals over the age of 84 are not eligible.

Third Party Lapse Designee. Unless you decline to do so in your Application, you have the right to name a third party as your authorized designee to be notified when the lapse of your Policy is imminent. It is our responsibility to notify you and this designee prior to canceling your Policy due to lack of premium payment. Notice will not be given until 30 days after a premium is due and unpaid. You may change your designee at any time by notifying Prudential in writing.

Reinstatement. If your premium is not paid before the Grace Period ends, your Policy will lapse. Later acceptance of the past due and unpaid premium by Prudential or its agent, without an application for reinstatement, will reinstate your Policy. If Prudential or its agent requires an application, you will be given a conditional receipt for the premium. If the application for reinstatement is approved, your Policy will be reinstated as of the approval date. Lacking such approval, the Policy will be reinstated on the 30th day after the date of the conditional receipt unless Prudential has previously written you of its disapproval.

If, due to your Chronic Illness or Disability, you fail to pay your premium and your Policy lapses; you may be eligible to reinstate your Policy. You or your representative may request reinstatement within five months of the date premiums were due.

15. **CONTACT THE STATE SENIOR HEALTH INSURANCE ASSISTANCE PROGRAM IF YOU HAVE GENERAL QUESTIONS REGARDING LONG TERM CARE INSURANCE. CONTACT THE INSURANCE COMPANY IF YOU HAVE SPECIFIC QUESTIONS REGARDING YOUR LONG TERM CARE INSURANCE POLICY.**
16. **SENIOR COUNSELING PROGRAMS.** Please refer to *A Shopper's Guide To Long Term Care Insurance* contained in your enrollment material for the telephone number of the Senior Counseling Program in your state.

PREMIUM RECEIPT

**All premium checks must be made payable to The Prudential Insurance Company of America
Do not make your check payable to the Agent, or leave the payee blank.**

Received from _____ the sum of \$_____ with Application for The Prudential Insurance Company of America's Long Term Care Insurance Policy. This payment is the premium required for the first _____ months of coverage.

If for any reason the coverage is not issued, this payment will be refunded. No liability is created or assumed by The Prudential Insurance Company of America, except for refund of this payment, unless and until the insurance applied for becomes effective. The insurance applied for will become valid and effective only if:

1. Your application is approved by the Company.
2. The first premium is paid.
3. An Effective Date is established by the Company.
4. No answer given to any question on your Application changes materially after the date your Application is signed, but prior to the date your Application is approved by the Company.

Signature of Agent **X** _____

Printed Name of Agent _____

Agent Contract Number _____

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ELECTRONIC FUNDS TRANSFER AUTHORIZATION

INSTRUCTIONS:

To enroll in Prudential's monthly electronic funds transfer (EFT) payment service, please provide us with the following information. **If you wish to use your checking account, enclose your blank, voided check for that account. If you wish to use your savings account, you must confirm that your financial institution permits electronic fund withdrawals from savings accounts, and obtain your financial institution's transit routing number.** Please note that we cannot obtain acceptable banking information from deposit slips. If you have any questions, please call our Long Term Care Customer Service Center, toll free, at 1-800-732-0416. Please print except where signatures are required. Use blue or black ink.

APPLICANT/INSURED INFORMATION: (COMPLETE INFORMATION FOR EACH APPLICANT FOR WHOM THIS EFT AUTHORIZATION WILL BE USED).

First Name M. I. Last Name

Policy/Cert. Number (If Known)

First Name M. I. Last Name

Policy/Cert. Number (If Known)

Please indicate the bill date you prefer: 1st 8th 15th 22nd

BANKING INFORMATION:

Name of Financial Institution

Financial Institution 9-Digit Transit Routing Number Local Branch Telephone Number: -- Account Number Type of Account: Checking Savings

Name of Account Owner if Other Than Applicant/Insured Relationship to Applicant/Insured

EFT Payment Service Authorization:

I hereby request and authorize The Prudential Insurance Company of America (Prudential) to make electronic fund withdrawals or other forms of pre-authorized withdrawals from my account named above, up to the amount of \$_____, for payment of the premium under the policy(ies) or certificate(s) indicated above. My signature below is exactly as it appears in my financial institution's records for this account. I agree that monthly withdrawals shall be made approximately 3 to 5 days after the bill date indicated above. I understand that premium notices will not be mailed. I understand that if a withdrawal request is not honored by my financial institution, Prudential shall consider that my premium has not been paid. Any withdrawal returned due to insufficient funds may be redeposited for collection by Prudential, at its sole discretion.

If this authorization pertains to insurance (or an increase in insurance) for which an application is pending, this authorization shall take effect on the Effective Date of the insurance applied for. This authorization shall not be construed as: (a) an approval by Prudential of that application; or (b) a modification of any provisions of any existing coverage. Otherwise, this authorization shall take effect on the date signed.

Either I or Prudential may cancel this authorization at any time by giving 30 days written notice to the other party. Any notice hereunder will not be deemed effective until Prudential has had a reasonable time to act.

First Name of Account Owner	M.I.	Last Name		
Street Address (No P.O. Box Numbers Please)	Apt. No.	City	State	Zip Code
Signature of Account Owner X _____		Date _____		
(must be the same as that on file with the Financial Institution)				

PLEASE SIGN AND RETURN THIS COPY WITH YOUR APPLICATION

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ELECTRONIC FUNDS TRANSFER AUTHORIZATION

INSTRUCTIONS:

To enroll in Prudential's monthly electronic funds transfer (EFT) payment service, please provide us with the following information. **If you wish to use your checking account, enclose your blank, voided check for that account. If you wish to use your savings account, you must confirm that your financial institution permits electronic fund withdrawals from savings accounts, and obtain your financial institution's transit routing number.** Please note that we cannot obtain acceptable banking information from deposit slips. If you have any questions, please call our Long Term Care Customer Service Center, toll free, at 1-800-732-0416. Please print except where signatures are required. Use blue or black ink.

APPLICANT/INSURED INFORMATION: (COMPLETE INFORMATION FOR EACH APPLICANT FOR WHOM THIS EFT AUTHORIZATION WILL BE USED).

First Name M. I. Last Name

Policy/Cert. Number (If Known)

First Name M. I. Last Name

Policy/Cert. Number (If Known)

Please indicate the bill date you prefer: 1st 8th 15th 22nd

BANKING INFORMATION:

Name of Financial Institution

Financial Institution 9-Digit Transit Routing Number Local Branch Telephone Number: -- Account Number Type of Account: Checking Savings

Name of Account Owner if Other Than Applicant/Insured Relationship to Applicant/Insured

EFT Payment Service Authorization:

I hereby request and authorize The Prudential Insurance Company of America (Prudential) to make electronic fund withdrawals or other forms of pre-authorized withdrawals from my account named above, up to the amount of \$_____, for payment of the premium under the policy(ies) or certificate(s) indicated above. My signature below is exactly as it appears in my financial institution's records for this account. I agree that monthly withdrawals shall be made approximately 3 to 5 days after the bill date indicated above. I understand that premium notices will not be mailed. I understand that if a withdrawal request is not honored by my financial institution, Prudential shall consider that my premium has not been paid. Any withdrawal returned due to insufficient funds may be redeposited for collection by Prudential, at its sole discretion.

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First Name of Account Owner	M.I.	Last Name		
Street Address (No P.O. Box Numbers Please)	Apt. No.	City	State	Zip Code
Signature of Account Owner X _____		Date _____		
(must be the same as that on file with the Financial Institution)				

RETAIN THIS COPY FOR YOUR RECORDS

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