



Prudential

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**INDIVIDUAL LONG TERM CARE INSURANCE
POLICY CHANGE REQUEST
To THE PRUDENTIAL INSURANCE COMPANY OF AMERICA**

THE PRUDENTIAL INSURANCE COMPANY OF AMERICA
LONG TERM CARE CUSTOMER SERVICE CENTER
P. O. Box 8519 PHILADELPHIA, PA 19176
PHONE: 1-800-732-0416

IDENTIFICATION INFORMATION **POLICY NUMBER:**

PLEASE PRINT YOUR NAME AS IT APPEARS ON YOUR POLICY.

Mr. Ms. First Last

Mrs. Name: M. I.: Name:

Street Address: Apt.

(No P. O. Boxes Please): No.:

City: State: ZIP Code:

Social Security No.: Daytime Phone: Evening Phone:

Best Time To Call: AM PM

REQUESTED CHANGES **REQUESTED CHANGE EFFECTIVE DATE:** _____

FACILITY DAILY BENEFIT \$ INCREASE * DECREASE TO: _____

HOME CARE DAILY BENEFIT FACTOR 50% 75% 100% 150% INCREASE * DECREASE TO: _____

LIFETIME MAXIMUM 2 Year 4 Year 6 Year Unlimited

BASED ON A BENEFIT LIMIT OF: 3 Year 5 Year 10 Year INCREASE * DECREASE TO: _____

ELIMINATION PERIOD: 30 DAYS 90 DAYS 180 DAYS INCREASE

60 DAYS 120 DAYS 365 DAYS DECREASE * TO: _____

INFLATION RIDERS: GPO Compound – 2X Maximum

Simple Compound -- No Maximum Add * Delete

OPTIONAL BENEFIT RIDERS

HOME CARE PAYMENT OPTIONS:

MONTHLY BENEFIT RIDER Add* Delete

CASH BENEFIT RIDER Add* Delete

FLEXIBLE CASH BENEFIT RIDER Add* Delete

WAIVER OF PREMIUM OPTIONS:

JOINT WAIVER OF PREMIUMS RIDER Add* Delete

SURVIVOR WAIVER OF PREMIUMS RIDER Add* Delete

JOINT WAIVER OF PREMIUMS AND SURVIVOR WAIVER OF PREMIUMS RIDERS (BOTH) Add* Delete

RETURN OF PREMIUM UPON DEATH RIDER Add* Delete

NON-FORFEITURE BENEFIT RIDER Add* Delete

SHARED CARE RIDER Add* Delete **Shared Care Partner Name:** _____

PREMIUM PAYMENT MODE OPTIONS:

ANNUAL Add Delete

SEMI-ANNUAL Add Delete

QUARTERLY Add Delete

MONTHLY (EFT) Add Delete (Must Complete EFT Authorization Form)

LIMITED PAYMENT OPTIONS:

10 YEAR PAID UP Add* Delete (Limited to ages 40-75)

PAID UP AT AGE 65 Add* Delete (Must be 54 or under to issue)

PREMIUM REDUCTION AT AGE 65 Add* Delete (Must be 60 or under to issue)

NONE Add Delete

*The Requested Change requires underwriting approval of your insurability in addition to this Form if it has been more than 30 days from your Policy Effective Date. The addition of the following Riders will require surrender of your existing Policy: Shared Care Rider, Non-Forfeiture Benefit Rider or Return of Premium Upon Death Rider or the addition of the Joint Waiver of Premiums Benefit Rider after six months from original issue date.

Other Changes Requested (please specify):

INSURED'S AGREEMENTS

By my signature, I request that changes be made to my LTC3SM Insurance Policy as indicated in this Change Request Form and agree to the following:

1. I understand that any change requested is subject to current product availability.
2. I understand that reductions to my coverage will take effect as of the Requested Change Effective Date above.
3. I understand that changes to my Policy that increase coverage must be accepted by The Prudential Insurance Company of America (Prudential), and may be subject to underwriting approval. If underwriting approval is required, I have completed and attached the Long Term Care Insurance Application for the Requested Change(s).
4. If accepted by Prudential, the Requested Change(s) will take effect on the Effective Date assigned by Prudential.
5. I understand that premiums for a Requested Change that increases my coverage and which take effect more than 30 days after the original Policy Effective Date will be based on my age on the date I signed this Change Request Form and the Long Term Care Insurance Application (if required).
6. I understand that the Requested Change(s) will affect the amount of my premium payment and agree to make payment upon billing. If I use pre-authorized Electronic Funds Transfer (EFT) for premium payment, I understand that the premium amount deducted from my bank account will change and that the premium amount due as a result of this change will be deducted with the next EFT payment.
7. I understand that I will receive a revised Schedule of Policy Benefits (and if necessary, a revised Policy and Optional Riders) that reflects the terms of coverage under my Policy based on the Requested Change(s) accepted by Prudential.

Insured's Signature: X _____ Date: _____

HOME OFFICE USE ONLY: UNDERWRITING APPROVAL REQUIRED: NO YES:
by (initials): _____ REJECT ACCEPT: EFFECTIVE DATE _____

AGENT'S NAME: _____ AGENT'S LICENSE NUMBER: _____
ADDRESS: _____ AGENT'S PHONE NUMBER: _____