The Prudential
Insurance
Company
of America

PRUDENTIAL LTC
evolution℠

INDIVIDUAL
APPLICATION
for Long-Term Care Insurance

NY

GRP 114112
GRP 114113
GRP 113394
GRP 113392
GRP 113124 4.1
GRP 113582
GRP 114688
GRP 98186
GRP 112991
GRP 114554
GRP 99214

Prudential

NOTE: You must also include:

New York

Shoppers Guide ORD99020

Medicare Shoppers Guide (over age 65) ORD99019

Prudential

THE PRUDENTIAL INSURANCE COMPANY OF AMERICA

LONG TERM CARE CUSTOMER SERVICE CENTER

PO BOX 8519
PHILADELPHIA PA 19176-8519
1.800.732.0416

LONG TERM CARE INSURANCE APPLICATION FOR

☐ **New Policy** ☐ **Reinstatement** (Indicate Current Policy Number if Coverage Change or Reinstatement request)

☐ **Coverage Change**

TO: THE PRUDENTIAL INSURANCE COMPANY OF AMERICA
Please print all information except where signatures are required. Use black ink. Read all questions carefully.

APPLICANT INFORMATION

☐ Mr. ☐ Ms. ☐ Mrs. ☐ ________________ Applicant's Social Security # ☐ Male ☐ Female

First Name M.I. Last Name
(As it should appear on your Policy)

Street Address (No PO Boxes) Apt. No.

City State Zip Code

Date of Birth Age Daytime Phone Evening Phone

IF THE MAILING ADDRESS IS OTHER THAN THE ADDRESS GIVEN ABOVE, PLEASE COMPLETE THE FOLLOWING:

Address Apt. No.

City State Zip Code

Best Time to Call ☐ AM ☐ PM Marital Status ☐ Yes, married ☐ No, not married

Is your Spouse/Domestic Partner applying for this insurance? ☐ Yes ☐ No

If No, does he/she currently have Prudential Long Term Care insurance? ☐ Yes ☐ No

If Yes, give Policy/Certificate Number

Spouse/Domestic Partner First Name M.I. Last Name

Spouse/Domestic Partner Social Security # ☐ Spouse ☐ Domestic Partner

PRUDENTIAL LTC evolution℠

INSURANCE HISTORY — Indicate yes or no

If coverage is being replaced, please submit a completed Replacement Notice.

1 Are you covered by Medicaid or Medi-Cal (not Medicare)? ☐ Yes ☐ No

2 Do you have other long term care or accident and sickness insurance in force (including policies, certificates, health care service contracts, or health maintenance organization contracts)? ☐ Yes ☐ No

3 Did you have other long term care insurance in force during **the last 12 months**? ☐ Yes ☐ No

4 Do you intend to replace any of your medical health insurance with this insurance? ☐ Yes ☐ No

IF YOU ANSWERED YES TO QUESTIONS 2, 3, OR 4 OF THIS SECTION, PLEASE PROVIDE THE FOLLOWING INFORMATION

☐ Group
☐ Individual
Type of Coverage
Policy #
Intend to replace? ☐ Yes ☐ No
Did insurance lapse? ☐ Yes ☐ No
If yes give date

☐ Group
☐ Individual
Type of Coverage
Policy #
Intend to replace? ☐ Yes ☐ No
Did insurance lapse? ☐ Yes ☐ No
If yes give date

Full name and address of insurance company

MEDICAL HISTORY – PART 1 INSURABILITY PROFILE — Indicate yes or no

1 Have you had, do you currently have, or have you ever been diagnosed as having any of the following medical conditions:

a Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig's Disease)? ☐ Yes ☐ No

b Alzheimer's Disease, Chronic Memory Loss, frequent or persistent forgetfulness, senility, dementia, or Organic Brain Syndrome? ☐ Yes ☐ No

c Chronic Obstructive Pulmonary Disease (COPD) or Emphysema **in combination with:** Current Smoking; Congestive Heart Failure (CHF); Asthma; or Chronic Bronchitis? ☐ Yes ☐ No

d Congestive Heart Failure **in combination with:** Current Smoking, Angina or Heart Surgery; Asthma or Chronic Bronchitis; Diabetes; or Tuberculosis? ☐ Yes ☐ No

e Congestive Heart Failure, diagnosed or symptomatic, within **the past 12 months**? ☐ Yes ☐ No

f Metastatic Cancer (Cancer that has spread from the original site or location)? ☐ Yes ☐ No

g Stroke or Cerebrovascular Accident (CVA)? ☐ Yes ☐ No

h Cystic Fibrosis? ☐ Yes ☐ No

i Liver Cirrhosis? ☐ Yes ☐ No

j Multiple Sclerosis (MS), Muscular Dystrophy, Parkinson's Disease, Huntington's Disease? ☐ Yes ☐ No

k Transient Ischemic Attack (TIA) within **the past 5 years;** multiple TIA's; or TIA in combination with Diabetes or any Heart Surgery? ☐ Yes ☐ No

l Within **the past 6 months**, have you had open heart surgery, spine surgery, back surgery? ☐ Yes ☐ No

2 Within **the past 48 months** have you had cancer of the: ☐ Yes ☐ No
☐ Bone ☐ Brain ☐ Esophagus ☐ Liver ☐ Lung ☐ Ovary ☐ Pancreas ☐ Stomach

3 Do you use a four pronged cane, kidney dialysis, motorized scooter, oxygen, respirator, walker, wheelchair? ☐ Yes ☐ No

4 Within **the past 12 months** have you: ☐ Yes ☐ No
☐ Used adult day care ☐ Needed home health care
☐ Been medically advised to enter or been confined to: ☐ A nursing home ☐ An assisted living facility ☐ Other long term care facility

5 Do you currently need assistance or supervision by another person in performing any of the following activities: ☐ Yes ☐ No
☐ Bathing ☐ Eating ☐ Toileting ☐ Dressing ☐ Bowel or Bladder Control ☐ Moving in and out of bed or chair
☐ Taking your medication

If you answered "Yes" to any question in this insurability profile, we recommend that you do not submit this Application.

MEDICAL HISTORY – PART 2 PERSONAL PROFILE

Please provide the requested information about yourself.

1a [ ] Height Ft./In. [ ] Weight Lbs.

1b Have you had any change in weight in the last 12 months?
☐ Gain ________ lbs. ☐ Loss ________ lbs. ☐ N/A

2a Are you retired? ☐ Yes ☐ No
2b If yes, what was your occupation? ________

3a Are you currently employed? ☐ Yes ☐ No
3b If yes, what occupation? ________
3c Is the work ☐ Full-time or ☐ Part-time? ☐ Inside the home or ☐ Outside the home?

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

____

____

5a Have you smoked or used tobacco products within the past three years? ☐ Yes ☐ No
5b Do you use more than 1 (one) pack of tobacco products per day? ☐ Yes ☐ No

6a Do you drive an automobile? ☐ Yes ☐ No
6b If yes, approximate number of miles driven each year? ________

7 With whom do you live? ☐ No one ☐ Spouse/Partner ☐ Other ________

8 Are you pregnant? ☐ Yes ☐ No

9a Are you living in a retirement community? ☐ Yes ☐ No
9b If yes, please list any services you currently receive (For example, housecleaning, laundry, meals, medications.) ________

____

____

10 Are you currently receiving any Disability benefits or have you during the past 1 year? ☐ 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

11 Have two or more years passed since you received any treatment or examination by **any** health care professional? ☐ Yes ☐ No

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

Name ________ Phone ___-___-____

Street Address ________ Apt. No. ________

City ________ State ____ Zip Code _____-____

Date last seen __/__/____

Reason(s) 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	☐	☐	Cardiovascular or circulatory disorder including congestive heart failure (CHF), peripheral vascular disease, heart attack, chest pain, angina, high blood pressure or irregular heart beat
b	☐	☐	Cancer or non-cancerous tumors
c	☐	☐	Hodgkin's Disease, Lymphoma, Leukemia, other blood disorder
d	☐	☐	Skin ulcers
e	☐	☐	Non-insulin dependent diabetes
f	☐	☐	Insulin dependent diabetes # of units per day________
g	☐	☐	Hepatitis
h	☐	☐	Asthma, chronic bronchitis, chronic obstructive pulmonary disease (COPD), emphysema, shortness of breath
i	☐	☐	Brain disorder, convulsions, epilepsy or seizures, dizziness or balance problems, fainting spells or black outs
j	☐	☐	Depression, anxiety, mental, emotional or nervous disorder, or confusion, or memory loss
k	☐	☐	Tremors
l	☐	☐	Visual disturbances
m	☐	☐	Amputation
n	☐	☐	Disabling back or spine injury
o	☐	☐	Fracture
p	☐	☐	Osteoarthritis
q	☐	☐	Osteoporosis
r	☐	☐	Myasthenia Gravis, Paralysis, weakness or numbness of the extremities
s	☐	☐	Replacement of the hip, knee or other joint
t	☐	☐	Rheumatoid arthritis, Lupus, Scleroderma or other connective tissue disease
u	☐	☐	Other conditions causing crippling or limited motion or requiring use of an adaptive device, chronic pain or fatigue, or Fibromyalgia
v	☐	☐	Renal insufficiency or Kidney disorder
w	☐	☐	Sarcoidosis

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: ☐ 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?
☐ received home health care? ☐ used adult day care? ☐ None

5 Within the **past five years**, have you been advised to limit, reduce, discontinue or seek counseling for the use of alcohol or drugs? ☐ Yes ☐ No

6 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 6.

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 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 primary care physician (PCP). If not treated by PCP, give name, address, and phone for other treating professional

____

____

MEDICAL HISTORY – PART 4 MEDICATIONS

1 Please provide the requested information. Within the past 12 months have you taken 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.

a Drug or Medication ______________________ Dosage __________ How long been taking? ______________________

Reason for taking ____

☐ Check here if prescribed by Primary Care Physician (PCP) only. If not prescribed by PCP, give name, address and phone number of treating professional:

____

____

b Drug or Medication ______________________ Dosage __________ How long been taking? ______________________

Reason for taking ____

☐ Check here if prescribed by Primary Care Physician (PCP) only. If not prescribed by PCP, give name, address and phone number of treating professional:

____

____

c Drug or Medication ______________________ Dosage __________ How long been taking? ______________________

Reason for taking ____

☐ Check here if prescribed by Primary Care Physician (PCP) only. If not prescribed by PCP, give name, address and phone number of treating professional:

____

____

d Drug or Medication ______________________ Dosage __________ How long been taking? ______________________

Reason for taking ____

☐ Check here if prescribed by Primary Care Physician (PCP) only. If not prescribed by PCP, give name, address and phone number of treating professional:

____

____

e Drug or Medication ______________________ Dosage __________ How long been taking? ______________________

Reason for taking ____

☐ Check here if prescribed by Primary Care Physician (PCP) only. If not prescribed by PCP, give name, address and phone number of treating professional:

____

____

f Drug or Medication ______________________ Dosage __________ How long been taking? ______________________

Reason for taking ____

☐ Check here if prescribed by Primary Care Physician (PCP) only. If not prescribed by PCP, give name, address and phone number of treating professional:

____

____

g Drug or Medication ______________________ Dosage __________ How long been taking? ______________________

Reason for taking ____

☐ Check here if prescribed by Primary Care Physician (PCP) only. If not prescribed by PCP, give name, address and phone number of treating professional:

____

____

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

ADDITIONAL MEDICAL INFORMATION PAGE

First Name M.I. Last Name

Applicant's Social Security #

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 M.I. Last Name

Street Address Apt. No.

City State Zip Code

☐ **Check here only if you do not wish to name a person for this purpose and sign below.**

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 of 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.**

X ____

Applicant Signature

Caution: Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, may commit a fraudulent insurance act, which is a crime that may subject such person to criminal and/or civil penalties. With respect to New York Residents, civil penalties not to exceed $5,000, plus the stated value of the claim for each violation, can apply.

APPLICANT AGREEMENTS

Caution: If your answers on this Application are incorrect or untrue, or fail to include all material medical information requested, Prudential may have the right to deny benefits or rescind your Policy. I understand and agree that:

1. To the best of my knowledge and belief, the answers on this Application are complete and true.
2. This Application will be part of the Policy for which I am applying to **The Prudential Insurance Company of America** (Prudential).
3. A Policy will **not** take effect unless: Prudential has approved this Application; the first full modal premium has been paid prior to the Effective Date; and only if the statements and answers given in applying for this Policy are without material change until the date this Application is approved.
4. If issued, my Long Term Care Insurance Policy will take effect on the Effective Date assigned by Prudential.
5. Prudential has the right to change premium rates in the future but only on a class basis.
6. I have received the Outline of Coverage and *A Shopper's Guide to Long Term Care Insurance* from the Agent.
7. If I am eligible for Medicare, I have received the *Guide to Health Insurance for People with Medicare* from the Agent.
8. I have read, or have had read to me, the completed Application, and where applicable, Potential Rate Increase Disclosure Form, and I understand that any false statement or misrepresentation in my Application may result in loss of coverage under the Policy.
9. **INFLATION:** I have reviewed the Outline of Coverage and the graphs that compare benefits and premiums of this Policy with and without inflation protection. Specifically, I have reviewed the 5% Automatic Compound Increase Option Rider.
   ☐ **Check this box if you REJECT the 5% Automatic Compound Increase Option Rider.**
10. **NON FORFEITURE:** I have reviewed the Outline of Coverage and the Nonforfeiture benefit described therein. Specifically, I have reviewed this optional benefit available to me.
   ☐ **Check this box if you REJECT the Shortened Benefit Period Rider Nonforfeiture Benefit.**
11. **Electronic Funds Transfer Authorization (EFT) if applicable:**

   Enclose a check for two month's premium.

   I authorize Prudential to make deductions from my bank account for payment of premiums. I understand that: 1) Prudential shall not incur any liability on a draft returned by the bank; 2) amounts not clearing after their initial deposit shall constitute non-payment of premium and coverage under the Policy shall lapse subject to its provisions; and 3) authorization shall remain in force until I revoke by signed writing to Prudential or Prudential revokes in accordance with Policy.

   BANK (Credit Union) NAME: ______________________________

   BANK ACCOUNT #: ______________________________

   BANK ROUTING #: ______________________________

   TYPE ACCOUNT: ☐ Checking ☐ Savings

   BILL DATE*: ☐ 1st ☐ 8th ☐ 15th ☐ 22nd *If no choice is indicated, bill date will default to the 1st of the month.

X ______________________________
Applicant Signature Date

X ______________________________
Witness (licensed and appointed agent)

____
Agent (print name) Agent's Contract Number

____
Signed at: City State

Prudential

THE PRUDENTIAL INSURANCE COMPANY OF AMERICA

LONG TERM CARE CUSTOMER SERVICE CENTER

PO BOX 8519
PHILADELPHIA PA 19176-8519
1.800.732.0416

Prudential LTC Evolution℠ PLAN DESIGN SELECTION — **A selection must be made for every option listed below.**

Lifetime Maximum (Choose one option only.)	☐ $200,000 ☐ $300,000 ☐ $400,000 ☐ $500,000 ☐ $600,000 ☐ $700,000 ☐ $800,000 ☐ $900,000 ☐ $1,000,000
Inflation Riders (Choose only one option where available.)	☐ Built-in Guaranteed Increase Feature (GIF). (No additional premium.) ☐ 3% Automatic Compound Inflation Rider ☐ 5% Automatic Compound Inflation Rider
Shared Care Options (Choose one option only.)	☐ None ☐ Shared Care Rider Shared Care Domestic Partner Name ________ (If elected, both partners must elect identical Plan Designs.)
Contingent Non-Forfeiture	☐ Yes ☐ None
Shortened Benefit Period Rider Nonforfeiture Benefit	☐ Yes ☐ No
Premium Payment Mode (Choose one option only.)	☐ Annual ☐ Semi-annual ☐ Quarterly ☐ Monthly EFT
Full Modal Premium	$ ____ . __
Cash Submitted with Application	$ ____ . __
Spouse/Domestic Partner Discount	☐ Yes ☐ No

Applicant's First Name ________ M.I. __ Applicant's Last Name ________

Applicant's Social Security # ___-__-____

Your signature on the Application signifies your consent with the benefit selections found on this form.

THIS PAGE IS INTENTIONALLY LEFT BLANK

THE PRUDENTIAL INSURANCE COMPANY OF AMERICA
LONG-TERM CARE CUSTOMER SERVICE CENTER
PO BOX 8519
PHILADELPHIA PA 19176-8519
1.800.732.0416

FEDERAL HIPAA NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

"We" refers to The Prudential Insurance Company of America in its capacity as a provider of Group and Individual Long Term Care insurance. "You" or "yours" refers to any individual covered by a Long Term Care insurance policy issued by The Prudential Insurance Company of America.

Federal law—means the Health Insurance Portability and Accountability Act and related privacy rules—requires The Prudential Insurance Company of America to keep your health information private. We are not allowed to use or disclose it unless we receive your permission or unless permitted by law. Federal law requires us to give you this Notice of our legal duties and privacy practices. This Notice is to inform you of uses and disclosures of your health information that we may make. It also informs you of your rights and our duties with regard to this health information.

We must follow the terms of this Notice. We do reserve the right to change the terms of this Notice and make the new Notice provisions apply to all the health information we keep. This includes health information we had prior to any change in this Notice. We must promptly change this Notice when there is a material change to our uses or disclosures, your rights, our duties and other related circumstances. We will mail you any such revised Notice, unless you have agreed to receive Notices electronically. To receive such Notices by E-mail, you should tell the contact listed at the end of this Notice.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Federal law permits us to use and disclose protected health information for purposes of treatment, payment and health care operations as those terms are defined under federal law. As an insurer, we do not provide treatment, but we may use and disclose protected health information for payment purposes, such as in connection with the payment of an insurance claim. We may also use and disclose protected health information for our health care operations such as when we decide to give you insurance or when we renew or replace your insurance. We will also comply with any state or federal law that is more restrictive as to our uses and disclosures of protected health information.

There are also times when federal law permits or requires us to use or disclose your information without your written permission.

Additionally, where appropriate, we may disclose protected health information to a group health plan or plan sponsor in accordance with federal law.

PERMITTED DISCLOSURES

We may not make all of the uses and disclosures listed here, but federal law permits use or disclosure of your information without your permission when:

- We disclose your information to you.
- To third party non-Prudential business associates that perform services for us or on our behalf, such as vendors.
- Where disclosure is required by law.
- To a public health authority authorized by law to collect or receive your information to prevent or control disease, injury or disability or when reviewing reports of child abuse or for the conduct of other authorized public health activities and responsibilities.
- To a governmental authority when we reasonably believe you may be a victim of abuse, neglect or domestic violence where the governmental authority is allowed by law to have such information.
- To a health oversight agency for such activities.
- For judicial and administrative proceedings.
- To a law enforcement official for a law enforcement purpose.
- To a medical examiner for the purpose of identifying a deceased person, determining the cause of death, or other duties authorized by law.
- To organ donor organizations in order to aid in such donations.
- For certain research purposes authorized by and subject to federal law.
- To avert a serious threat to health or safety.
- To government officials regarding military personnel and certain domestic and foreign government officials for certain functions authorized by federal law.
- To comply with workers' compensation and other similar programs.
- To make certain marketing communications and for certain fundraising purposes.

REQUIRED DISCLOSURES

We are required to disclose your information when required by the Secretary of the Department of Health and Human Services to make sure we comply with federal law.

We are also required, with certain exceptions, to provide you with access to inspect and obtain a copy of your information that we keep. See "Your Right To Inspect and Copy Protected Health Information" below.

NEED FOR AUTHORIZATION:

We will not make any uses or disclosures other than those mentioned above without your permission. You may withdraw such permission in writing. Your withdrawal will not be effective 1) if we took action relying on your permission before it was withdrawn, or 2) if we obtained your permission as a condition of issuing you insurance, and the law allows us to contest a claim under the policy or the policy itself. To withdraw your authorization, please write the contact listed at the end of this Notice. If you wish additional information, you should write to the contact listed at the end of this Notice.

INDIVIDUAL RIGHTS WITH RESPECT TO YOUR PROTECTED HEALTH INFORMATION

FEDERAL LAW PROVIDES YOU WITH THE RIGHT TO REQUEST RESTRICTIONS: You have the right to request that restrictions be placed on certain uses and disclosures of your information. We are not required to agree. If we do agree, we may not use or disclose any of your information except where you need emergency treatment. We may end an agreement to restrict as allowed by federal law. If you wish additional information, you should write to the contact listed at the end of this Notice.

FEDERAL LAW PROVIDES YOU WITH THE RIGHT TO ALTERNATIVE CONFIDENTIAL COMMUNICATION OF PROTECTED HEALTH INFORMATION: If you choose to have your information sent to you by a means of your choice or to an address of your choice, we will do so if the request is reasonable. You must clearly state that disclosure of all or any part of your information could endanger you if not sent per your choice. Any such request should be sent in writing to the contact listed at the end of this Notice. If you wish additional information, you should write to the contact listed at the end of this Notice.

FEDERAL LAW PROVIDES YOU WITH THE RIGHT TO INSPECT AND COPY PROTECTED HEALTH INFORMATION: You have the right to inspect and copy your information, except for any psychotherapy notes, certain information relating to civil, criminal, or administrative proceedings, and certain information prohibited by law from disclosure. We are allowed by law to deny access in some cases, and subject to certain procedures. Any request should be sent in writing to the contact listed at the end of this Notice. If you wish additional information, you should write to the contact listed at the end of this Notice.

FEDERAL LAW PROVIDES YOU WITH THE RIGHT TO AMEND PROTECTED HEALTH INFORMATION: You have the right to request that we amend your information kept in our records. We are allowed to deny your request if we did not create the information in the record. We will review your request and respond to you in writing. All requests should be in writing and sent to the contact listed at the end of this Notice. All requests should provide needed details, including your name, address, insurance policy number, and the reason you think your information needs to be changed. If you wish additional information, you should write to the contact listed at the end of this Notice.

FEDERAL LAW PROVIDES YOU WITH THE RIGHT TO AN ACCOUNTING: You have the right to receive an accounting from us of disclosures of your information made for up to the six (6) years prior to your request. This right does not apply to: disclosures made to carry out treatment, payment, or health care operations; disclosures made with your permission; disclosures made for police purposes; disclosures allowed by law; or disclosures made before April 14, 2003. Any request should be sent to the contact listed at the end of this Notice. If you wish additional information, you should write to the contact listed at the end of this Notice.

FEDERAL LAW PROVIDES YOU WITH THE RIGHT TO A PAPER COPY OF THIS NOTICE: You have the right, even if you have agreed to receive notice by E-mail, to get a paper copy of this Notice. All requests should be in writing and sent to the contact listed at the end of this Notice.

FEDERAL LAW PROVIDES YOU WITH THE RIGHT TO FILE A COMPLAINT: If you believe your privacy rights have been violated, you have the right to complain to us by writing to the contact listed at the end of this Notice or to the federal Secretary of the Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue, Washington, DC 20201. Federal law prohibits retaliation against you for filing such a complaint. The contact listed at the end of this Notice is also available to provide you information regarding questions you have or other information concerning this Notice.

WHEN YOU CONTACT US IN WRITING, YOU SHOULD INCLUDE YOUR NAME, ADDRESS, AND POLICY NUMBER

THE CONTACT TO WHOM YOU SHOULD ADDRESS YOUR COMPLAINT IS:

The Prudential Insurance Company of America
Privacy Contact
Long Term Care Customer Service Center
PO Box 8519
Philadelphia, PA 19101

Telephone Number: 800-732-0416

The effective date of this notice is March 1, 2005.

Prudential

THE PRUDENTIAL INSURANCE COMPANY OF AMERICA

LONG-TERM CARE CUSTOMER SERVICE CENTER

PO BOX 8519
PHILADELPHIA PA 19176-8519
1.800.732.0416

AUTHORIZATION FOR RELEASE OF HEALTH-RELATED INFORMATION — Attn: Underwriting

THIS AUTHORIZATION IS INTENDED TO COMPLY WITH THE HIPAA PRIVACY RULE

First Name | M.I. | Last Name

Name of Applicant (please print)

Date of Birth | Applicant's Social Security #

I authorize any health plan, doctor, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided 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 am applying for: underwrite or make rating determinations, evaluate and determine my eligibility for long term care insurance, 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, unless state law imposes a shorter time. A copy of this authorization is as valid as the original. I understand I have the right to withdraw this authorization in writing, at any time, by sending a written request 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 withdrawal 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.

X ______________________________________

Signature of Applicant or Personal Representative — Date

X ______________________________________

Description of Personal Representative's Authority or Relationship to Applicant

PLEASE SIGN AND RETURN THIS COPY WITH YOUR APPLICATION

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THE PRUDENTIAL INSURANCE COMPANY OF AMERICA
LONG-TERM CARE CUSTOMER SERVICE CENTER
PO BOX 8519
PHILADELPHIA PA 19176-8519
1.800.732.0416

AUTHORIZATION FOR RELEASE OF HEALTH-RELATED INFORMATION — Attn: Underwriting

THIS AUTHORIZATION IS INTENDED TO COMPLY WITH THE HIPAA PRIVACY RULE

First Name ____ M.I. ____ Last Name ____
Name of Applicant (please print)

Date of Birth ____ Applicant's Social Security # ____

I authorize any health plan, doctor, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided 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 am applying for: underwrite or make rating determinations, evaluate and determine my eligibility for long term care insurance, 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, unless state law imposes a shorter time. A copy of this authorization is as valid as the original. I understand I have the right to withdraw this authorization in writing, at any time, by sending a written request 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 withdrawal 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.

X ____
Signature of Applicant or Personal Representative Date

X ____
Description of Personal Representative's Authority or Relationship to Applicant

RETAIN THIS COPY FOR YOUR RECORDS

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THE PRUDENTIAL
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OF AMERICA

LONG TERM CARE
CUSTOMER
SERVICE CENTER

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PHILADELPHIA PA 19176-8519
1.800.732.0416

PRODUCER'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 First Name M.I. Applicant's Last 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? ☐ Yes ☐ No
If yes, please describe

4 Has the Applicant purchased any other health insurance policy from you during the past **5 years**? ☐ Yes ☐ No
If Yes, provide the information below:

COMPANY	POLICY NUMBER	CURRENT STATUS (IF TERMINATED, INDICATE YEAR)	
		☐ In force	☐ terminated:
		☐ In force	☐ terminated:
		☐ In force	☐ terminated:

5 Indicate Rating Class quoted for this Applicant: ☐ Preferred ☐ Standard I ☐ Standard II

6 I received the initial, modal premium, in full where permitted by law, with the Application and ☐ Yes ☐ No
provided to the Applicant as receipt of $ ___________________, a Premium Receipt.

7 Special requests, remarks and instructions: ___________________

BY MY SIGNATURE ON THIS FORM:

☐ I have reviewed the Applicant's current insurance coverage, financial needs, and resources and certify that this purchase is suitable for the Applicant.
☐ I understand that Medical Underwriting will determine the appropriate rate class.
☐ 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 comply with applicable Long Term Care insurance licensing requirements in the Applicant's state of residence as shown on the application.
☐ I certify that I have delivered the Outline of Coverage to the Applicant at the time of first solicitation.
☐ The applicant understands that I will be paid a commission from the sale of this policy, and may also receive performance based compensation.

X

Producer's Signature Date

Print Name Contract Number

State of Licensure License Number

Full Address Phone Number

PLEASE COMPLETE FOR SPLIT CASES ONLY

Additional Producer Information:

Name: ______________________________
Contract #: ______________________________
Percentage split: ______________________________
☐ Independent Producer and GA Name: ______________
☐ Agency Distribution

Name: ______________________________
Contract #: ______________________________
Percentage split: ______________________________
☐ Independent Producer and GA Name: ______________
☐ Agency Distribution

Name: ______________________________
Contract #: ______________________________
Percentage split: ______________________________
☐ Independent Producer and GA Name: ______________
☐ Agency Distribution

ADDITIONAL INFORMATION

THE PRUDENTIAL INSURANCE COMPANY OF AMERICA
LONG-TERM CARE CUSTOMER SERVICE CENTER
PO BOX 8519
PHILADELPHIA PA 19176-8519
1.800.732.0416

LONG-TERM CARE NOTICE

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 is being provided to inform you of certain information practices Prudential engages in, and your rights, with regard to your personal information. We would like you to know that:

- Personal information may be collected from persons other than yourself or other individuals, if applicable, proposed for coverage;
- This personal information as well as other personal or privileged information subsequently collected by us may in certain circumstances be disclosed to third parties without authorization;
- You have a right of access and correction with respect to personal information we collect about you; and
- Upon request from you, we will provide you with a more detailed notice of our information practices and your rights with respect to such information. Should you wish to receive this notice, please contact:

  The Prudential Insurance Company of America
  Long-Term Care Customer Service Center
  Attention: Privacy Contact
  P.O. Box 8519
  Philadelphia, PA 19101

Any information we obtain regarding a person's insurability will be treated as confidential. We may, however, make a brief report of it to the Medical Information Bureau (the Bureau), a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. When you apply for life, disability, or health insurance to any company, including Prudential, which is a member of the Bureau, or submit a claim for benefits to such a company, the Bureau will, on request, give the company the information in its files. In addition, upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If the information came from the Bureau and you question the accuracy of the information in the Bureau's files, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is: P.O. Box 105, Essex Station, Boston, MA 02112, (617) 426-3660.

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FOR NEW YORK RESIDENTS ONLY

Estimated Average New York State Nursing Home Rates[1]

These estimates are based on nursing home cost reports for the year 2007. It is important to note that these are average nursing home rates and nursing home rates can be significantly higher, depending on the type of facility you would prefer.

Region	Per day	Per year
Western Region — Buffalo (Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans, Wyoming)	$244 / day	$89,016 / year
Western Region — Rochester (Chemung, Livingston, Monroe, Ontario, Seneca, Schuyler, Steuben, Yates, Wayne)	$287 / day	$104,640 / year
Central Region (Broome, Cayuga, Chenango, Cortland, Herkimer, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence, Tioga, Tompkins)	$228 / day	$83,256 / year
Northeastern Region (Albany, Clinton, Columbia, Delaware, Essex, Franklin, Fulton, Greene, Hamilton, Montgomery, Otsego, Rensselaer, Saratoga, Schenectady, Schoharie, Warren, Washington)	$255 / day	$93,192 / year
Northern Metropolitan (Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster, Westchester)	$310 / day	$113,268 / year
New York City (Bronx, Kings, New York, Queens, Richmond)	$323 / day	$118,056 / year
Long Island (Nassau, Suffolk)	$357 / day	$130,224 / year

1 www.nyspltc.org/rates.htm

The long-term care insurance coverage is issued by The Prudential Insurance Company of America, a Prudential Financial company, 751 Broad Street, Newark, NJ 07102. The Booklet-Certificate contains all details, including any policy exclusions, limitations and restrictions, which may apply. Contract Series: 83500.

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THE PRUDENTIAL INSURANCE COMPANY OF AMERICA

LONG-TERM CARE CUSTOMER SERVICE CENTER

PO BOX 8519
PHILADELPHIA PA 19176-8519
1.800.732.0416

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 PRODUCER:

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 producers 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.

X ______________________________ Signature of Producer, Broker or Other Representative

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

______________________________ Name of Producer (please type or print)

______________________________ Date

____

____

______________________________ Address of Producer (please type or print)

PLEASE SIGN AND RETURN THIS COPY WITH YOUR APPLICATION

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THE PRUDENTIAL
INSURANCE COMPANY
OF AMERICA

LONG-TERM CARE
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______________________________ Applicant's Signature
The above "Notice to Applicant"
was delivered to me on:

______________________________ Name of Producer (please type or print)

______________________________ Date

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______________________________ Address of Producer (please type or print)

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THE PRUDENTIAL
INSURANCE COMPANY
OF AMERICA

LONG TERM CARE
CUSTOMER
SERVICE CENTER

PO BOX 8519
PHILADELPHIA PA 19176-8519
1.800.732.0416

AFFIDAVIT OF DOMESTIC PARTNERSHIP

Each of the undersigned attest that we satisfy the definition of Domestic Partnership as set forth below.

1. "Domestic Partnership" is defined as follows:

A Domestic Partnership consists of the subscriber and one other person of the same or opposite sex. Such persons must satisfy all of the following requirements:

a. They have a single dedicated relationship of at least 6 months duration and intend to remain in the relationship indefinitely;

b. They share the same permanent residence and have done so for at least 6 months;

c. They are not related by blood or a degree of closeness, which would prohibit marriage in the law of the state in which they reside;

d. Each is at least 18 years of age;

e. Each is mentally competent to consent to contract;

f. Neither is currently married to or legally separated from another person under either statutory or common law;

g. Neither has been registered as a member of another Domestic Partnership within the last six months.

h. They are financially interdependent and have furnished at least two of the following documents evidencing such financial interdependence:

  i) joint ownership of real property or a common leasehold interest in real property;

  ii) common ownership of an automobile;

  iii) joint bank account;

  iv) a will which designates the other as primary beneficiary;

  v) a beneficiary designation form for a retirement plan or life insurance policy signed and completed to the effect that one Domestic Partner is beneficiary of the other; or

  vi) if the Domestic Partners reside in a state which provides for registration of Domestic Partners, they have so registered and furnished evidence of such registration.

Date: ____________________ By: ____
Signature of Subscriber

____
Printed Name

Date: ____________________ By: ____
Signature of Domestic Partner of Subscriber

____
Printed Name

SUBSCRIBED AND SWORN TO ME

This__________day of __________________, 200___.

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THE PRUDENTIAL INSURANCE COMPANY OF AMERICA
LONG-TERM CARE CUSTOMER SERVICE CENTER
PO BOX 8519
PHILADELPHIA PA 19176-8519
1.800.732.0416

LONG-TERM CARE INSURANCE OUTLINE OF COVERAGE

POLICY NUMBER GRP 114201

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 8519, Philadelphia, PA 19176-8519.*

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.

TAX STATUS. The 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. It is also intended to qualify for purposes of the New York State Tax Law, Section 612(c)(31) and the City of New York Administrative Code Section 11-1712(c)(31).

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 **TERMS UNDER WHICH THE POLICY MAY BE RETURNED AND PREMIUM REFUNDED.**

30-Day Right to Review Policy: 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.

Pro-Rata Refund of Unearned Premium: Upon proper notification of your death or cancellation of this Policy, Prudential will refund on a pro-rata basis any part of the premium for you which applies to the period after death or cancellation.

4 **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.

5 **LONG-TERM CARE COVERAGE.** Policies of this category are designed to provide coverage for not less than 24 consecutive months for each covered person on an expense incurred, indemnity, prepaid or other basis and provides coverage of all levels of care in a nursing home and homecare benefits. This Policy provides coverage in the form of reimbursement benefits based on a specified percentage of the actual Eligible Charges incurred for covered long term care expenses up to the Policy Lifetime Maximum. Benefits are subject to Policy Exclusions, benefit limitations, the Calendar Day Elimination Period and coinsurance requirements. In some cases, if you choose the Starter benefit, benefits will be payable on an indemnity basis, subject to applicable terms and conditions of coverage.

6 **BENEFITS PROVIDED BY THIS POLICY.** After you have been certified as being Chronically Ill and have satisfied your Calendar Day Elimination Period, this Policy pays benefits for Eligible Charges incurred by you. Benefits paid for Eligible Charges count towards fulfillment of your Policy

80% of Eligible Charges will be reimbursed for the following care.

- Nursing Home Care
- Adult Foster Home Care
- Care in an Assisted Living Facility
- Care in a Residential Health Care Facility
- Care in an Adult Foster Home or Board and Care Facility
- Bed Reservation
- Hospice Care (not subject to Calendar Day Elimination Period)
- Respite Care
- Home Health Care
- Adult Day Care
- Homemaker Services
- Personal Care
- Alternate Plan of Care

100% of actual Eligible Charges will be reimbursed, up to the Home Support Services Policy Maximum of $10,000, for the following items. Benefits for Home Support Services are not subject to Calendar Day Elimination Period.

- Assistive Devices or Technology
- Caregiver Training
- Durable Medical Equipment
- Emergency Medical Response System
- Home Modifications
- Private Care Manager
- Transportation Services

A cash Starter Benefit is available during the Calendar Day Elimination Period. Consult the policy for details.

Calendar Day Elimination Period. The Calendar Day Elimination Period must be satisfied once during your lifetime before benefits are paid. Prudential will begin to count days to satisfy your Calendar Day Elimination Period with the date you are certified by a Licensed Health Care Practitioner as being Chronically Ill. Each day you are certified as a Chronically Ill Individual counts in satisfaction of this Calendar Day Elimination Period. Once a day of the Calendar Day Elimination Period is satisfied, it is satisfied for the life of your Policy.

Eligibility for Payment of Benefits. Before incurring Eligible Charges and submitting a claim, you must undergo an Assessment and be certified by a Licensed Health Care Practitioner as being Chronically Ill. A Chronically Ill individual 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 or elimination 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.

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 you have been certified as being Chronically Ill, Prudential will determine if you are eligible for benefits. If you are eligible, you will need a Plan of Care developed by a Licensed Health Care Practitioner. All benefits are paid pursuant to the Plan of Care.

Activities of Daily Living:

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.

Severe Cognitive Impairment: A loss or deterioration in intellectual capacity that is comparable to (and includes) Alzheimer's Disease and similar forms of irreversible dementia, and measured by clinical evidence and standardized tests that reliably measure impairment in the individual's short-term or long-term memory, orientation as to people, places, or time and deductive or abstract reasoning.

OPTIONAL RIDERS AVAILABLE TO YOU. If you choose an optional rider and pay the required premium, your Policy will change as indicated by the terms of the Rider.

LTC Insurance Rider – Shared Cared Rider: Prudential will allow your designated Shared Care Partner to access benefits available under your Policy once his or her Policy's Lifetime Maximum is exhausted. Additionally, if your Shared Care Partner dies, we will increase your Lifetime Maximum by the amount of the deceased Shared Care Partner's remaining Lifetime Maximum, if any.

However, in order to receive benefits the following conditions must be be met.

1) Your Shared Care Partner also has the Shared Care Rider in effect and you are the designated Shared Care Partner on his or her Policy.

2) You and your Shared Care Partner must have and maintain identical Policy Benefits, including Optional Benefit Riders.

3) You and your Shared Care Partner must have elected and maintain the same Premium Payment Option.

4) You keep this Rider in force.

7 **LIMITATIONS AND EXCLUSIONS.**

There is no pre-existing conditions limitation.

The Policy does not provide benefits for any of the following.

a) Illness, treatment or medical conditions arising out of
   i) War or an act of war, whether declared or undeclared, while you are insured; or
   ii) Your participation in a felony, riot or insurrection; or
   iii) Alcoholism and drug addiction.

b) Treatment provided in a government facility, unless payment of the charge is required by law or services provided by any law or governmental plan under which you are 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.

c) Charges for services or supplies in excess of those normally charged by the Provider in the absence of insurance.

d) Charges for care or treatment received outside the United States of America, its territories or possessions.

e) Charges for care or treatment rendered by a member of your Immediate Family, unless he or she is a Caregiver (other than an Independent Health Care Practitioner or Independent Caregiver), and he or she receives no compensation other than the normal compensation for employees in his or her job category.

f) Charges for any care received while in a hospital, except in a unit specifically designated and licensed as a Nursing Home or Hospice facility.

Benefits under your Policy are not payable for expenses for Qualified Long Term Care Services to the extent that such expenses are reimbursable under Medicare; or such expenses would be reimbursed under Medicare but for the application of a deductible or coinsurance amount.

Benefits under your Policy may be reduced if we also pay benefits for Qualified Long Term Care Services under any other Prudential Individual Long Term Care Insurance Policy.

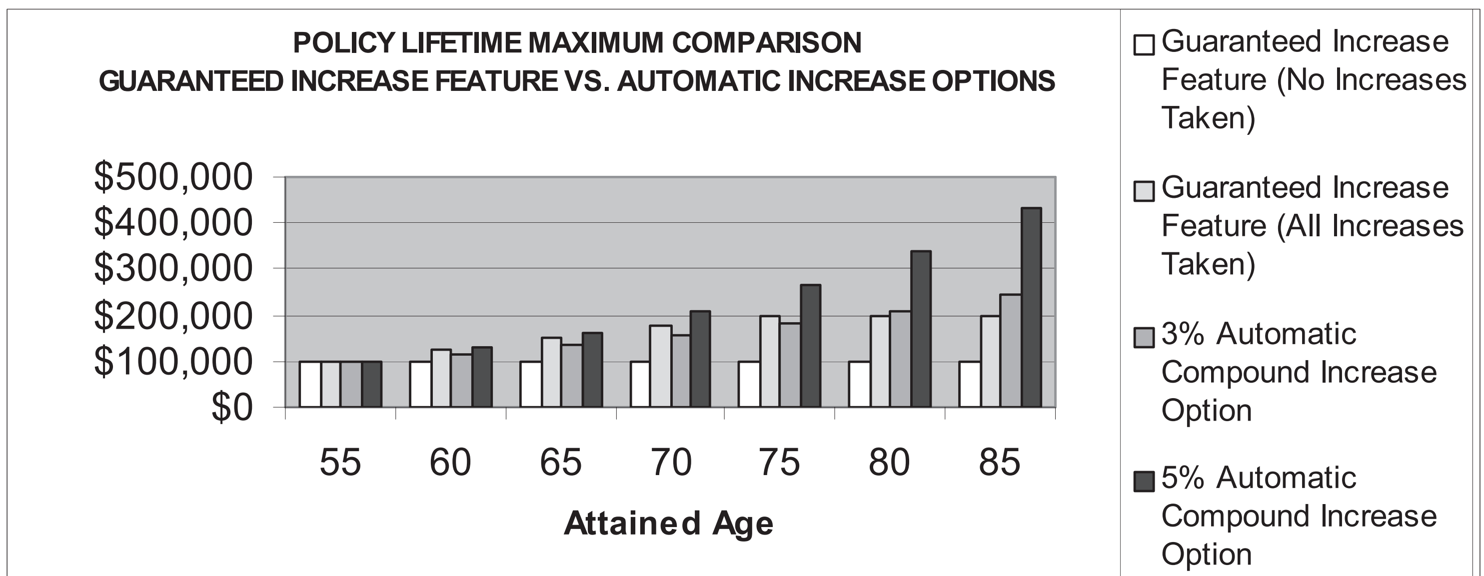
THIS POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LONG-TERM CARE NEEDS.

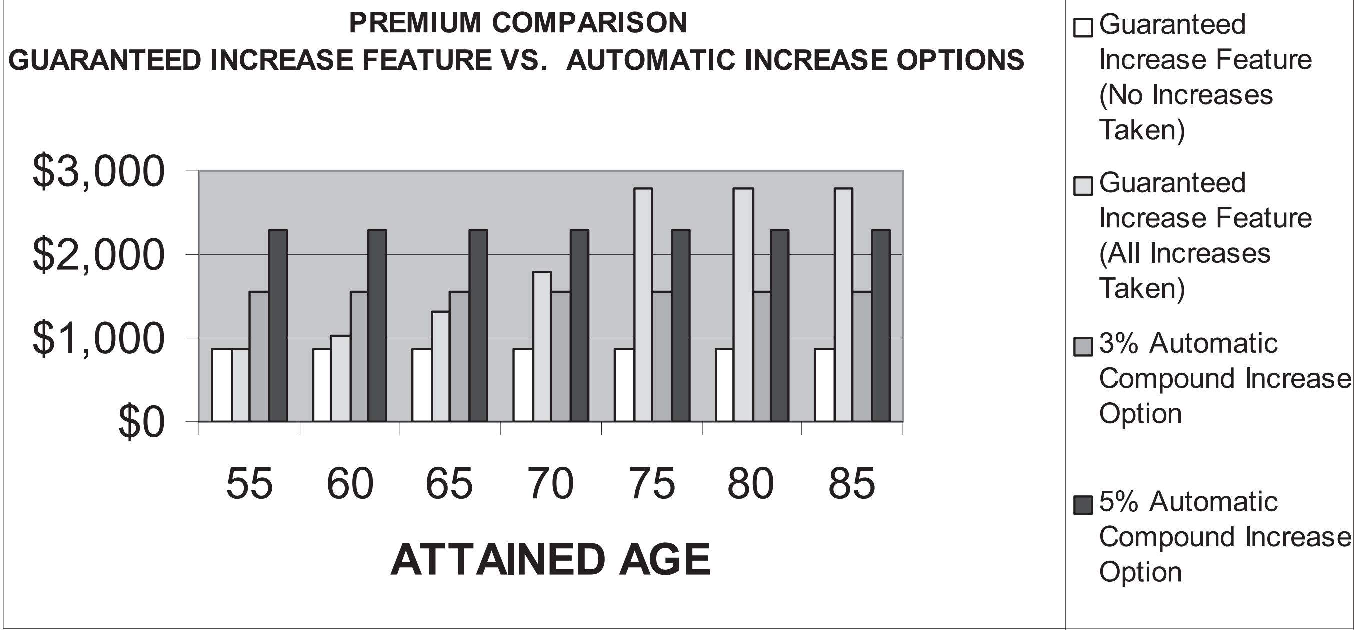
8 **RELATIONSHIP OF COST OF CARE AND BENEFITS.** Because the costs of long-term care services will likely increase over time, you should consider whether and how the benefits of this plan may be adjusted. Since there is no maximum daily benefit in your Policy, you will be reimbursed for either 80% or 100% of the actual Eligible Charges, depending on the service or care received. However, you will have a choice of three options to increase your Policy Lifetime Maximum. Your base policy contains a Guaranteed Increase Feature.

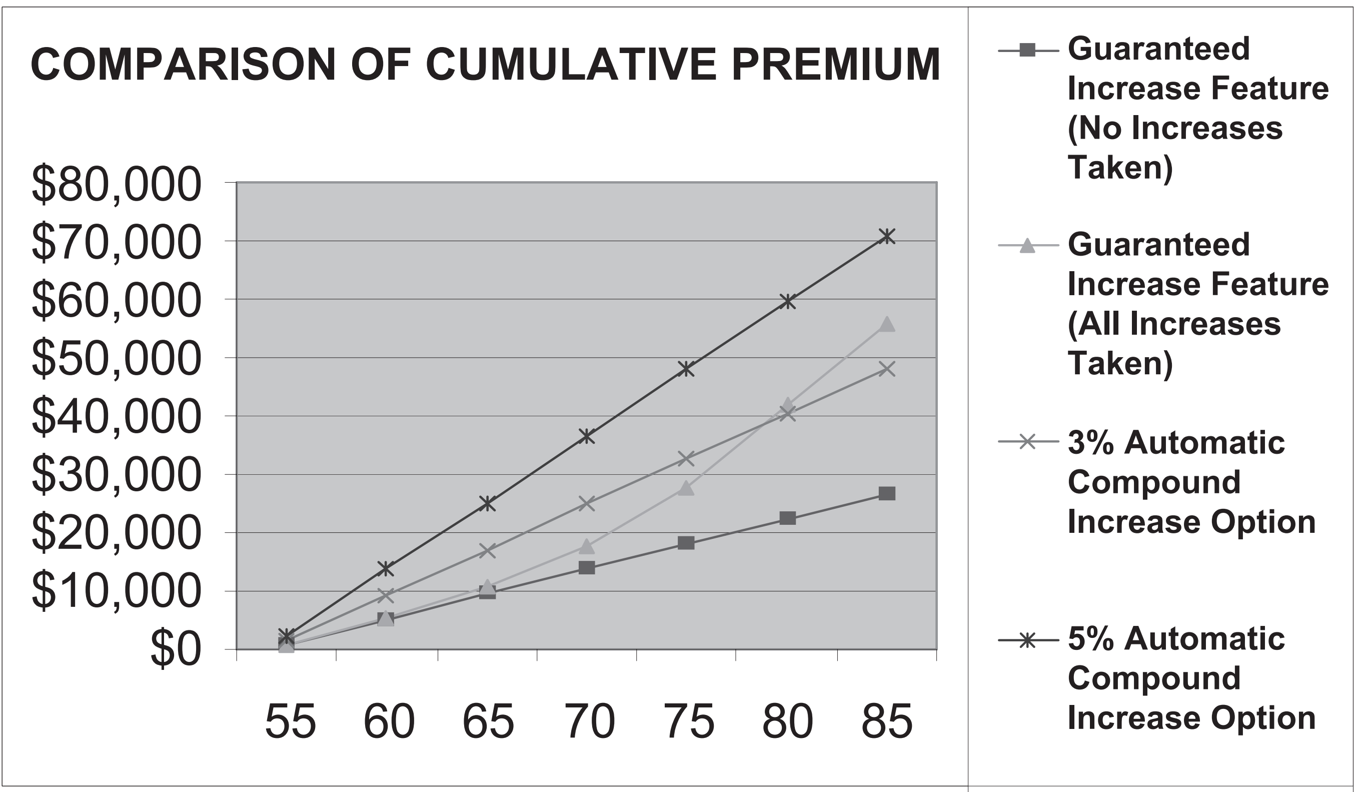
Guaranteed Increase Feature. Every five years on the Policy's Anniversary Date, Prudential will increase the Policy Lifetime Maximum with an associated increase in premium. With each benefit increase, your Policy Lifetime Maximum will be increased by 25% of the Policy Lifetime Maximum then in effect on that Policy Anniversary (not including any prior benefit increases applied under this Guaranteed Issue Feature, and excluding any amounts paid in claims). You will be notified of this benefit increase at least 60 days prior to the Policy Anniversary Date. You will not have to provide proof of good health to receive this benefit increase. The additional premium for the increase in coverage will be based on your attained age. All benefit increases will occur even if you are receiving benefits or have met the Benefit Eligibility Criteria at the time of the increase takes effect. No further benefit increases will be put into effect on or after the date of your 76th birthday.

For additional premium at the time you purchase coverage, you may elect one of two optional riders that will automatically increase your benefits annually without an annual increase in your premium. The 5% Automatic Compound Increase Rider increases your Policy Lifetime Maximum each year at an annual compounded rate of 5%. The 3% Automatic Compound Increase Rider increases your Policy Lifetime Maximum each year at an annual compounded rate of 3%.

The following is a hypothetical graphic comparison of the benefit and premium levels of a Policy that increases lifetime benefits over the period of coverage with a Policy that does not increase lifetime benefits. The graphic comparison shows benefit and premium levels over a thirty-year period. The example is based upon a $100,000 Policy Lifetime Maximum purchased by a 55 year old.







OPTIONAL INFLATION RIDERS. If you choose an Optional Inflation Rider and pay the required premium, your Policy will change as indicated by the terms of the Rider.

LTC Insurance Rider – 3% Automatic Compound Increase Benefit. A 3% increase to your benefit levels will occur each year that your Inflation Rider is in force. The increase will occur even if you are receiving benefits.

LTC Insurance Rider – 5% Automatic Compound Increase Benefit. A 5% increase to your benefit levels will occur each year that your Inflation Rider is in force. The increase will occur even if you are receiving benefits.

9 **TERMS UNDER WHICH THE POLICY MAY BE CONTINUED IN FORCE OR DISCONTNUED.**

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. The Policy contains a Waiver of Premium provision. After you meet the Benefit Eligibility Criteria and satisfy the required Calendar Day Elimination Period, the premiums for your Policy will be waived, subject to the terms and conditions of your Policy. These features are described in full detail in the Policy.

10 **TERMS UNDER WHICH THE COMPANY MAY CHANGE PREMIUMS.**

PRUDENTIAL MAY CHANGE THE PREMIUMS YOU PAY, BUT ONLY IF THE CHANGE APPLIES TO ALL INSUREDS WITHIN YOUR CLASS.

11 **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

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 **ADDITIONAL FEATURES.**

LTC Insurance Rider – Non-Forfeiture Benefits. If you choose the Optional Non-forfeiture Benefit Rider and pay the required premium, you will have certain rights in the event your Policy lapses. If your Policy lapses due to non-payment of premium, your coverage may be extended as a Non-Forfeiture Benefit. The Non-Forfeiture Benefit will NOT take effect if either of item 1) or item 2) occurs.
1) Your Policy ended before its third anniversary.
2) You have already received benefits that equal or exceed the total amount of premiums paid for your Policy.

Under the Non-Forfeiture Benefit Rider, benefits will be payable based on the Facility and Home Care Daily Benefits in effect on the date your coverage would otherwise have ended. However, a reduced Lifetime Maximum Benefit will apply. This means that your benefits will be paid for a shortened benefit period. The reduced Lifetime Maximum Benefit will be equal to the greater of items 1) or 2) stated below.

1) 3% of your initial Policy Lifetime Maximum as of your Original Effective Date, up to the Policy Lifetime Maximum in effect on the date your Policy would otherwise have ended.

2) The total amount of premiums paid for your Policy, and any optional Riders, less the sum of all benefits paid on your behalf, while your Policy is in effect.

The policy also contains a Contingent Non-forfeiture Provision. This provision is operative only if:
1) Your Policy does not include the Optional Non-forfeiture Benefit Rider; and
2) A substantial premium increase occurs that would cause your Policy to end.

If this occurs, you will have the choice of reduced benefit at the premium in effect prior to the increase, without undergoing medical underwriting, or a lesser Lifetime Maximum, with no further premium payment required.

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 79 are not eligible.

Protection Against Unintentional Lapse. You have the right to designate a person to receive notice that your Policy is about to lapse or terminate for nonpayment of premium. Unless you have chosen not to do so, your Application shows the name and address of the person you have designated to receive this notice. You may change this written designation at any time.

Reinstatement. If you fail to pay your premium and your Policy lapses for this reason, you may be eligible to reinstate your Policy. You may make a request for reinstatement within 90 days from the date the last notice of unpaid premium is given. If, due to your Chronic Illness or Disability, you fail to pay your premium and your Policy lapses for this reason, you may be eligible to reinstate your Policy. You or your representative may request reinstatement within five months of the date premiums were due.

14. 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 OR CERTIFICATE.

15. **SENIOR COUNSELING PROGRAMS.** Please refer to *A Shopper's Guide To Long Term Care Insurance* given to you by your Producer for the telephone number of the Senior Counseling Program in your state.

THE PRUDENTIAL
INSURANCE COMPANY
OF AMERICA

LONG TERM CARE
CUSTOMER
SERVICE CENTER

PO BOX 8519
PHILADELPHIA PA 19176-8519
1.800.732.0416

LIMITED LONG TERM CARE INSURANCE AGREEMENT

Thank you for choosing The Prudential Insurance Company of America (Prudential) for your insurance needs. In consideration of your pre-payment of the initial premium, with your Long Term Care Insurance Application (your Application), Prudential agrees to provide Limited Long Term Care Insurance (this Limited Insurance) to you, the Applicant, subject to all the following conditions and provisions. Your pre-payment does not apply to this Limited Insurance.

Health Certification: Your **pre-payment can only be accepted** and **this Limited Insurance can only take effect** if the following statement is true. Your Application does NOT include:

1 A "Yes" answer to any question in MEDICAL HISTORY - Part 1; or

2 A "Yes" answer to question 1 in MEDICAL HISTORY - Part 3.

3 Answers to ANY questions in MEDICAL HISTORY that indicate for *these listed conditions,*
- Brain disorder
- Fainting spells or black outs
- Convulsions
- Mental, emotional or nervous disorders
- Epilepsy or seizures
- Paralysis

that you have, during the past 5 years:
- received medical advice, examination or treatment from a health care professional;
- taken any medication;
- been medically diagnosed as having; or
- been confined to a hospital, nursing care facility, or other institution; or

4 Answers to ANY questions in MEDICAL HISTORY that indicate that, within the past 5 years, you have
- received home health care;
- used adult day care;
- been confined to a nursing home, assisted living facility, or long term care facility;
- been advised to have surgery that has not been performed.

Applicant: ____________________

Date of Application: ___ - ___ - _____

$ _____ . ___ has been received as pre-payment of the full, initial, modal premium required for ________________ months of insurance.
Your check 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. Do not pay cash. This agreement is valid only if:

1 **The check or other form of payment can be collected; and**

2 **Prudential receives your pre-payment and your Application on the same date.**

This Agreement is not available with an application for reinstatement or change to an existing policy.

Limited Long Term Care Insurance Agreement. Limited Insurance benefits will be payable based on the Daily Maximums shown in your Application. This Limited Insurance is subject to the same provisions, limitations, and exclusions of the Long Term Care Insurance Policy for which you applied, except that:

1 It is subject to a Maximum Benefit Limit of $10,000; and

2 It only covers eligible charges incurred while this Limited Insurance is in effect; and

3 It is not subject to the following provisions:
a Renewability;
b Benefit Waiting Period and Lifetime Maximum;
c Tax Status of Premiums and Benefits (that is, this Limited Insurance will not constitute qualified long term care insurance under IRC Section 7702B; therefore, benefits received under this Limited Insurance may not be excludable from income); and

PLEASE SIGN AND RETURN THIS COPY WITH YOUR APPLICATION

d any optional Benefit Riders; and

4 It will only be effective as stated in the Duration of this Limited Insurance provision herein.

The Outline of Coverage provides a brief description of the benefit provisions, limitations, and exclusions.

Duration of this Limited Insurance: This Limited Insurance takes effect on the date your Application and this Agreement are signed. This Limited Insurance ends when one of the following occurs:

1 The Effective Date of any policy issued as a result of your Application.

2 The date we notify you that Prudential has declined to issue you a policy. Notice can be given in person or by mail. Notice given by mail will be deemed received on the fifth day after the date mailed.

3 Ninety days have passed since the date this Agreement is signed.

4 Benefits paid under this Limited Insurance exhaust the Maximum Benefit Limit set forth in this Agreement.

If this Limited Insurance ends, and is not replaced by a policy, or you do not accept the policy that is issued, we will refund your premium pre-payment regardless of whether a claim has been submitted.

This Limited Long Term Care Insurance Agreement is effective only if your Application, to the best of your knowledge and belief, does not contain incorrect or untrue information or omit any material medical information requested.

This Limited Long Term Care Insurance Agreement is valid only if signed by the Applicant and our Licensed Agent on the date of your Application. No agent has the right to accept risks; to alter, amend, or waive any of Prudential's rights or requirements; or to change the terms of this Limited Long Term Care Insurance Agreement.

X____

Applicant Signature   Date (Must match date of Application)

X____

Agent Signature   Agent Contract Number - Printed Name of Agent

Prudential

THE PRUDENTIAL INSURANCE COMPANY OF AMERICA

LONG TERM CARE CUSTOMER SERVICE CENTER

PO BOX 8519
PHILADELPHIA PA 19176-8519
1.800.732.0416

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RETAIN THIS COPY FOR YOUR RECORDS

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X ____

Applicant Signature Date (Must match date of Application)

X ____

Agent Signature Agent Contract Number - Printed Name of Agent