Prudential

APPLICATION FOR CONVERSION OF GROUP LIFE INSURANCE

THE PRUDENTIAL INSURANCE COMPANY OF AMERICA

INSTRUCTIONS

1. Complete the application in its entirety, then sign and date it.
2. Refer to the "Conversion brochure" booklet on the Prudential website to calculate the 1st premium payment due.
3. Mail all 3 pages of the application with the premium to: **The Prudential Insurance Company of America**
   Prudential/Group
   P.O. Box 70180, Philadelphia, PA 19176

You may visit us on line at **www.prudential.com/giconversions** or call our toll-free number at 877-889-2070 between the hours of 8:00 a.m. and 8:00 p.m. Eastern time. Fax number 888-634-1118.

Insurance under the individual contract will become effective on the day after the last day of the conversion period provided by the group policy. If the effective date is after the 28th day of the month, the individual contract will be dated the 1st of the next month.

IMPORTANT INFORMATION ABOUT BENEFICIARY DESIGNATIONS

The beneficiary(ies) who will receive the proceeds for your converted group insurance must be designated in Section 1. You may name anyone or any entity as your beneficiary, and you may change your beneficiary at any time. The Primary Beneficiary(ies) (Class 1) will receive the proceeds payable at the Insured's death. If no Primary Beneficiary survives the Insured, the Contingent Beneficiary(ies) (Class 2) will receive any proceeds.

BENEFICIARY AND OWNERSHIP INSTRUCTIONS

1. BENEFICIARY DESIGNATION

- You may name more than one primary and more than one contingent beneficiaries. This form allows you to name up to three primary and three contingent beneficiaries.
- Please indicate the percentage share designated to each primary beneficiary. The total for all primary beneficiaries must equal 100%. If designating percentages for contingent beneficiaries, the percentage for all contingent beneficiaries must also equal 100%. If no percentages are specified, the proceeds will be split evenly among those named

Individual:

- Each name should be listed as first name, middle initial, last name ("Mary A. Doe" not "Mrs. M. Doe")
- Include the address and relationship for each individual listed.

Estate of the Insured:

- Select "Other" as the Beneficiary Description and write "Estate of the Insured" in the blank space provided.
- Indicate the percentage share designated to the estate.

Business (e.g., corporation, partnership) or other Organization:

- Select "Other" as the Beneficiary Description.
- Write the legal name of the business or organization in the space for the Beneficiary's First Name. If a business, indicate the structure, e.g., corporation, partnership, sole proprietorship, limited liability company.
- You must provide the address, city, and state of where the business or organization is located.

Trust under Trust Agreement:

- Select "Trust" as the Beneficiary Description.
- Complete Section 2, Trust Designation. The following information will need to be shown: the name of the trustee, name of the trust, date of the agreement, type of trust (revocable or irrevocable), and address.

2. TRUST DESIGNATION

- Complete this section if you have named a trust as a primary or contingent beneficiary.

3. OWNERSHIP

- If the owner is someone other than the primary proposed insured complete Section 3.

You may designate a third party (or "secondary addressee") to receive notice of past due premium payments or lapse/cancellation notice of the policy based on nonpayment of premium. If you wish to designate a third party, just provide written notification of the name and address of the designee at the time of this application, or at any time while the policy is in force.

Please note that payment is the sole responsibility of the policyowner. Naming a third party to receive notification does not create any financial obligation on the part of the third party to pay any current or past due policy premiums.

IMPORTANT TAXPAYER INFORMATION

The Company and its representatives and associates may not give tax or legal advice. We encourage you to consult your attorney or tax professional regarding tax questions or tax advice.

Taxpayer Identification Number. You must give us your Taxpayer Identification Number (TIN) in the Tax Certification section of this form. A TIN could be either a social security number or an Employer Identification Number. If the policyowner is an individual, the TIN is the Social Security number.

Backup Withholding. You must tell us if the Internal Revenue Service has notified you that you are subject to backup withholding because you didn't report all your taxable interest and dividends on your tax return. You are not subject to backup withholding if: (a) you did not receive such a notice from the IRS, or (b) if the IRS recently told you that your are no longer subject to a backup withholding order, or (c) you are exempt from such withholding. If you have been notified that you are subject to backup withholding, please check the appropriate box in the Tax Certification section on the reverse of this form.

Citizenship. You must state whether you are or are not a U.S. person (including resident alien) in the Tax Certification section on the reverse of this form. If you are not a U.S. person (including resident alien), you must provide the country of which you are a citizen and submit the applicable Form W-8(BEN, ECI, EXP, IMY). In most situations, the IRS Form W-8BEN will be the appropriate IRS Form W-8.

Penalties. You may be subject to IRS penalties, including fines and imprisonment, if you fail to provide your correct Taxpayer Identification Number, fail to report taxable interest or dividends on your tax return, or give false tax information.

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GROUP CONTRACTHOLDER INFORMATION

Employer/Association*_____ Policy/Control Number*_____

Employee's Name – First, Middle Initial, Last (Please print

Employee's Social Security Number

_____ _____

*If this is for servicemembers' and veterans' group life insurance conversions:

1. Insert the words "Servicemembers' (SGLI)/Veterans' (VGLI) Group Life Insurance", whichever is applicable for Employer/Association.
2. Attach the authorization letter or the copy of Notice of Conversion. Unless otherwise requested, insurance under the individual contract, if issued, will take effect on the date following the last day of life insurance protection under the group policy as shown in the copy of Notice of Conversion.

INSURED INFORMATION

Insured's Name – First, Middle Initial, Last (Please print)

Insured's Social Security Number

_____ _____

Address: Street _____

City _____ State _____ ZIP _____

Sex ☐ Male ☐ Female Date of Birth_____/____/_____

Type of policy applying for: ☐ **PGL** ☐ **Interim Term/PGL** (available only if mentioned in your conversion kit)

Amount of Insurance Requested: $ _____

If you were insured for accidental death benefits under the group plan, you may be eligible to add an accidental death benefit (ADB) rider to the conversion policy.* ADB pays an additional benefit if death is due to an accident as defined in the individual policy. The amount of ADB is equal to the amount of life insurance coverage you are converting. To be eligible, the amount of ADB must be at least $25,000 with the total amount of ADB (on the insured's life) not exceeding $500,000.

Are you requesting ADB? ☐ Yes ☐ No *Not available to residents of Florida or Massachusetts.

Select Premium Payment Option: ☐ Annually ☐ Semiannually ☐ Quarterly ☐ EFT/Monthly*

*Monthly is only via electronic funds transfer (EFT) from bank account.

Amount Paid (The full first premium must always be paid with application.) $

For Interim Term only (refer to Interim Term flyer for details):

Interim Term – Number of months requested Interim Term Premium submitted $ _____

Present Employer Name and Address _____

Can you get group life insurance with your present employer? ☐ Yes ☐ No

Are you now applying, or have you applied in the last 31 days, for any other Prudential insurance contract? ☐ Yes ☐ No

For Florida residents only: Name and address of secondary addressee for notification of a past due premium payment. Written notice of secondary addressee information may be provided to us now or at any time while the policy is in force.

Name _____

Address: Street _____

City _____ State _____ ZIP _____

TAX CERTIFICATION (PLEASE SEE IMPORTANT TAX PAYER INFORMATION ON THE INSTRUCTIONS PAGE)

To be completed by the policyowner. *(If joint policyowners, to be completed by policyowner who assumes tax reporting liability.)*

Policyowner's Name _____

Under penalties of perjury I (as policyowner) certify that I am a U.S. Person (including Resident Alien) and that my correct taxpayer identification number (TIN) is _____

(A TIN could be either a Social Security number or an Employer Identification Number. For individuals, a TIN is the Social Security number.)

I am not subject to backup withholding for the following reasons:

☐ (a) I have not been notified that I am subject to backup withholding as a result of a failure to report all interest or dividends, or

☐ (b) the IRS has notified me that I am no longer subject to backup withholding, or

☐ (c) I am exempt from backup withholding.

Complete the following if applicable:

☐ I have been notified by the IRS that I am subject to backup withholding due to the underreporting of interest or dividends.

☐ I am not a U.S. person (including Resident Alien), I am a citizen of _____
(*Attach the applicable IRS Form W-8BEN, ECI, EXP, IMY.)*

➔ *Signature of Policyowner* **X** _____ Date: _____/_____/_____

Name of company, if policyowner is a business or corporation _____

Title of signing officer, if policyowner is a business or corporation _____

1. BENEFICIARY DESIGNATION

PRIMARY BENEFICIARIES (CLASS 1)

Beneficiary Description (Check one): ☐ Individual ☐ Trust ☐ Other % Share _____
First Name _____ MI ___ Last Name _____ Relationship _____
Address: Street _____
City _____ State _____ ZIP _____

Beneficiary Description (Check one): ☐ Individual ☐ Trust ☐ Other % Share _____
First Name _____ MI ___ Last Name _____ Relationship _____
Address: Street _____
City _____ State _____ ZIP _____

Beneficiary Description (Check one): ☐ Individual ☐ Trust ☐ Other % Share _____
First Name _____ MI ___ Last Name _____ Relationship _____
Address: Street _____
City _____ State _____ ZIP _____

If a primary beneficiary predeceases the Insured, such beneficiary's share will be payable equally to any surviving primary beneficiary(ies). If no primary beneficiary survives the Insured, the proceeds will be payable to the contingent beneficiary(ies).

CONTINGENT BENEFICIARIES (CLASS 2)

Beneficiary Description (Check one): ☐ Individual ☐ Trust ☐ Other % Share _____
First Name _____ MI ___ Last Name _____ Relationship _____
Address: Street _____
City _____ State _____ ZIP _____

Beneficiary Description (Check one): ☐ Individual ☐ Trust ☐ Other % Share _____
First Name _____ MI ___ Last Name _____ Relationship _____
Address: Street _____
City _____ State _____ ZIP _____

Beneficiary Description (Check one): ☐ Individual ☐ Trust ☐ Other % Share _____
First Name _____ MI ___ Last Name _____ Relationship _____
Address: Street _____
City _____ State _____ ZIP _____

If a contingent beneficiary predeceases the Insured, such beneficiary's share will be payable equally to any surviving contingent beneficiary(ies). If no primary or contingent beneficiaries survives the Insured, the proceeds will be payable to the owner.

2. TRUST DESIGNATION – COMPLETE IF A TRUST HAS BEEN NAMED AS A BENEFICIARY

Name of Current Trustee(s) - First, Middle Initial, Last (Please print)

Name of Trust _____

Address: Street _____

City _____ State _____ ZIP _____

Trust Agreement ☐ Revocable ☐ Irrevocable Date of trust agreement _____/_____/_____

3. OWNERSHIP – COMPLETE IF THE OWNER IS SOMEONE OTHER THAN THE PRIMARY PROPOSED INSURED

First Name _____ MI____Last Name _____

Date of Birth ____/_____/_____ Relationship to the Insured _____ Social Security number _____

Address: Street _____

City _____ State _____ ZIP _____

FRAUD WARNING

For residents of all states and jurisdictions except Alabama, Alaska, Arizona, Arkansas, California, Colorado, Delaware, the District of Columbia, Florida, Idaho, Indiana, Kentucky, Louisiana, Maine, Maryland, Minnesota, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Puerto Rico, Rhode Island, Tennessee, Texas, Utah, Vermont, Virginia, Washington and West Virginia; WARNING: Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person, or knowing that he or she is facilitating commission of a fraud, submits incomplete, false, fraudulent, deceptive or misleading facts or information when filing an insurance application or a statement of claim for payment of a loss or benefit commits a fraudulent insurance act, is/may be guilty of a crime and may be prosecuted and punished under state law. Penalties may include fines, civil damages, and criminal penalties, including confinement in prison. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant or if the applicant conceals, for the purpose of misleading, information concerning any fact material thereto.

ALABAMA RESIDENTS – Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

ALASKA RESIDENTS – A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

ARIZONA RESIDENTS – For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

ARKANSAS, DISTRICT OF COLUMBIA, LOUISIANA, MASSACHUSETTS, RHODE ISLAND and WEST VIRGINIA RESIDENTS – Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

CALIFORNIA and TEXAS RESIDENTS – For your protection, California and Texas law requires the following to appear on this form. Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

COLORADO RESIDENTS – It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

DELAWARE RESIDENTS – Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

IDAHO RESIDENTS – Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement containing any false, incomplete, or misleading information is guilty of a felony.

INDIANA RESIDENTS – A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

KENTUCKY RESIDENTS – Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

MAINE, TENNESSEE, VIRGINIA, and WASHINGTON RESIDENTS – It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

FRAUD WARNING

MARYLAND RESIDENTS – Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

MINNESOTA RESIDENTS – A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NEW HAMPSHIRE RESIDENTS – Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638.20.

NEW JERSEY RESIDENTS – Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NEW MEXICO RESIDENTS – ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

NORTH CAROLINA RESIDENTS – Any person who, with the intent to injure, defraud, or deceive an insurer or insurance claimant, knowing that the statement contains false information concerning a fact or matter material to the claim may be guilty of a class H felony.

OHIO RESIDENTS – Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

OKLAHOMA RESIDENTS – WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete, or misleading information is guilty of a felony.

OREGON RESIDENTS – Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurance company, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

PENNSYLVANIA AND UTAH RESIDENTS – 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 material fact thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

PUERTO RICO RESIDENTS – Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances [be] present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

VERMONT RESIDENTS – Any person who knowingly presents a false or fraudulent claim for payment of a loss or knowingly makes a false statement in an application for insurance may be guilty of a criminal offense under state law.

FLORIDA RESIDENTS – Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

NEW YORK RESIDENTS – 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, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation. **This notice ONLY applies to accident and disability income coverage.**

SIGNATURES

I hereby request that Prudential convert my current group coverage into an individual policy. The terms of this conversion policy shall be in accordance with the conversion provision of the group insurance contract. I declare that, to the best of my knowledge and belief, the above statements are complete and true. By signing this form, I authorize the requests made on this form.

OWNERSHIP: The owner of the contract is the proposed insured, unless a different owner is named in the application.

Application Location (city and state where application is signed) **(CITY)** _____ **(STATE)** _____

➔ *Signature of Insured* **X** _____ Date ____/____/_____

➔ *Signature of existing certificateholder (if different from the employee)* **X** _____ Date ____/____/_____

➔ *Witness (Not beneficiary)* **X** _____ Date ____/____/_____