Prudential

APPLICATION FOR CONVERSION OF GROUP LIFE INSURANCE TO INDIVIDUAL LIFE INSURANCE

THE PRUDENTIAL INSURANCE COMPANY OF AMERICA

INSTRUCTIONS

1. Complete the application in its entirety, then sign and date it.
2. Mail pages 1-3 of the application with the premium to: **The Prudential Insurance Company of America**
   Prudential/Group Life Conversions
   P.O. Box 70180, Philadelphia, PA 19176

If you have any questions or would like more information:

- **WalMart** - call toll free 877-740-2116 between the hours of 7:00a.m. and 8:00p.m. Eastern time. Fax number 877-854-3645.
- **All Others** - call toll free 877-889-2070 between the hours of 8:00a.m. and 8:00p.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.

SPECIAL INSTRUCTIONS APPLICABLE ONLY TO SERVICEMEMBERS' AND VETERANS' GROUP LIFE INSURANCE CONVERSIONS

1. Insert in the space entitled "Employer/Association" the words "Servicemembers' (SGLI)/Veterans' (VGLI) Group Life Insurance", whichever is applicable.
2. Leave blank the spaces reserved for "Policy/Control Number". 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 on the copy of Notice of Conversion.

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 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 Contingent Beneficiary(ies) (Class 2) will receive any proceeds. 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.

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.

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NOTICE TO POLICYOWNER OF THE INDIVIDUAL LIFE POLICY

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

_____ _____

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 ____/____/____ Email Address _____

Daytime Contact Number (____) _____

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

Amount of Insurance Requested: $_____

NOT APPLICABLE TO WALMART: 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 in 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

TAX CERTIFICATION (PLEASE SEE IMPORTANT TAXPAYER 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 _____

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 _____

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

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

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: ____/____/_____