

PROTECTIVE LIFE INSURANCE COMPANY

P.O. Box 830619
Birmingham, AL 35283-0619

INDIVIDUAL LIFE INSURANCE APPLICATION – RIDER WORKSHEET

Required if applying for additional benefits or riders.

☐ New Business ☐ In Force Protective Policy # : _____

Print Proposed/Primary Insured's Name _____

Proposed/Primary Insured's Social Security No. _____

**** If applying for Children's Term Rider, Income Provider Option, ExtendCare Rider or Chronic Illness Accelerated Death Benefit, please complete the rider specific supplemental application(s) per application instructions.***

ADDITIONAL BENEFITS

- ☐ Accidental Death Benefit Rider (Range \$10,000 - \$250,000) \$ _____
- ☐ * Children's Term Rider (1 Unit Equals \$1,000 Death Benefit – 25 Units Maximum) _____ Units
- ☐ * ExtendCare Rider or Chronic Illness Accelerated Death Benefit
- Maximum Monthly Benefit Amount \$ _____
- Elimination Period (Number of Days) _____
- ☐ Guaranteed Insurability Rider \$ _____
- ☐ * Income Provider Option
- ☐ Protected Insurability Rider \$ _____
- ☐ Waiver of Premium (Non-Universal Life Only)
- ☐ Waiver of Specified Premium Rider (Universal Life Only)
- Monthly Benefit Amount \$ _____
- ☐ Other _____

I have read or have had read to me the completed Supplemental Application before signing below. The above statements and answers are true and complete to the best of my knowledge and belief. I agree that such statements and answers shall be attached to and made part of the application and shall be considered the basis of any insurance issued.

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 in the third degree.

Signed at: (City and State) _____ Date _____

Owner Signature _____

Proposed/Primary Insured Signature _____

Witness to Owner Signature _____

Signature of Parent or Guardian _____

Agent Name Printed _____

Agent Signature _____

FL License ID Number: _____

PROTECTIVE LIFE INSURANCE COMPANY

P.O. Box 830619

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INDIVIDUAL LIFE INSURANCE - SUPPLEMENTAL APPLICATION - CHILD RIDER MEDICAL DECLARATIONS

SECTION 1

Children's Term Rider _____ Units (1 Unit equals \$1,000 Death Benefit – 25 Units maximum)

Please complete a separate form if you are applying for the Children's Term Rider on more than three (3) children.

CHILD #1		CHILD #2		CHILD #3	
Name: (First, Middle, Last)		Name: (First, Middle, Last)		Name: (First, Middle, Last)	
Gender	Date of Birth	Gender	Date of Birth	Gender	Date of Birth
Height	Weight	Height	Weight	Height	Weight
Social Security Number		Social Security Number		Social Security Number	
Place of Birth		Place of Birth		Place of Birth	
Relationship to Insured		Relationship to Insured		Relationship to Insured	

Please use the Continuation of Information form if additional space is needed for details listed below.

SECTION 2

Answer the following medical information for all children being applied for:

Has any child proposed for insurance ever been diagnosed, treated, tested positive for, or been given medical advice by a licensed member of the medical profession for a disease or disorder such as: (Circle conditions to which "Yes" answer applies and give details below.)	Child #1 Yes No	Child #2 Yes No	Child #3 Yes No
(a) Any disorder or disease of the brain or nervous system (such as paralysis, epilepsy, stroke, convulsions, chronic headache).....	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
(b) Any disorder or disease of the heart, blood vessels, or circulatory system (such as high blood pressure, heart attack, heart murmur, chest pain).....	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
(c) Any disorder or disease of the respiratory system (such as Asthma, bronchitis, emphysema, tuberculosis)....	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
(d) Any disorder or disease of the stomach, liver, intestines, rectum, pancreas, or abdominal organs.....	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
(e) Any disorder or disease of the genitourinary organs (such as kidneys, urinary tract, blood or sugar in the urine, chronic inflammation).....	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
(f) Any disorder or disease of the skeletal system (such as arthritis, osteoporosis, joints, bones, spine, muscles).....	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
(g) Any disorder or disease of the eyes, ears, nose or throat.....	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
(h) Any disorder or disease of the blood, skin, thyroid, lymph or other glands (such as anemia, diabetes).....	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
(i) Any psychiatric or mental health disorders or diseases (such as attempted suicide, Bipolar, Obsessive-compulsive).....	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
(j) Any cancer, tumor, cyst or nodule.....	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
(k) Any disorders or diseases of the immune system <i>except those related to the Human Immunodeficiency Virus (AIDS Virus)</i>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>

Please provide details for any/all "Yes" responses.

	Question Number	Date of Diagnosis	Diagnosis, Medication or Treatment Prescribed	Medical Professional or Facility
Child #1				
Child #2				
Child #3				

SECTION 3

Answer the following medical information for all children being applied for:

Has any child proposed for insurance ever been diagnosed or treated by a licensed member of the medical profession for specified symptoms such as: (Circle conditions to which "Yes" answer applies and give details below. Do not include details for HIV, ARC or AIDS, except for a positive test result for exposure to the HIV infection or a diagnosis for ARC or AIDS caused by the HIV infection.)	Child #1 Yes No	Child #2 Yes No	Child #3 Yes No
(a) Immune deficiency, anemia, recurrent fever, fatigue or unexplained weight loss, malaise, loss of appetite, diarrhea, fever of unknown origin, severe night sweats; unexplained or unusual infections or skin lesions; unexplained swelling of the lymph glands; Kaposi's Sarcoma or Pneumocystis Carinii Pneumonia.....	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
(b) Has any child proposed for insurance been tested positive for exposure to the HIV (Human Immunodeficiency Virus) infection or been diagnosed as having AIDS (Acquired Immune Deficiency Syndrome) or ARC (AIDS Related Complex) caused by the HIV infection or other sickness or condition derived from such infection?.....	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>

Please provide details for any/all "Yes" responses.

	Question Number	Date of Diagnosis	Diagnosis, Medication or Treatment Prescribed	Medical Professional or Facility
Child #1				
Child #2				
Child #3				

SECTION 4

Answer the following information for all children age 15 through 18 being applied for:

Has any child age 15 through 18 proposed for insurance ever (Circle conditions to which "Yes" answer applies and give details below.)	Child #1 Yes No	Child #2 Yes No	Child #3 Yes No
(a) Used narcotics, barbiturates, amphetamines, hallucinogens, marijuana, heroin, cocaine, or other habit forming drugs, except as prescribed by a licensed member of the medical profession.....	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
(b) Received medical treatment or counseling for, or been advised by a licensed member of the medical profession to discontinue, the use of alcohol or prescribed or non-prescribed drugs.....	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
(c) Been a member of any self-help group such as Alcoholics Anonymous or Narcotics Anonymous.....	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>

Please provide details for any/all "Yes" responses.

	Question Number	Date of Diagnosis	Diagnosis, Medication or Treatment Prescribed	Medical Professional or Facility
Child #1				
Child #2				
Child #3				

SECTION 5

Answer the following medical information for all children being applied for:

<i>The following questions in Section 5 do not include answers related to the Human Immunodeficiency Virus (AIDS virus) or for minor viruses, injuries, common colds that prevented normal activities for a period of less than five (5) days.</i>		Child #1		Child #2		Child #3	
Within the past five (5) years, has any child proposed for insurance		Yes	No	Yes	No	Yes	No
(a) Been treated, examined or advised by a licensed member of the medical profession for any condition other than stated above.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b) Been advised by a licensed member of the medical profession to get specified medical care which has not been completed, such as any hospitalization, surgery or diagnostic test.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(c) Been an inpatient or outpatient in a hospital, clinic, medical facility, or any similar entity.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(d) Had any diagnostic tests such as: an electrocardiogram (EKG), MRI, CT-Scan or X-ray.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(e) Been on, or advised to be on any prescribed, non-prescribed (over the counter) medication or prescribed diet by a licensed member of the medical profession.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(f) Been unable to work, attend school or perform normal activities of life age and gender or been confined at home.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please provide details for any/all "Yes" responses.

	Question Number	Date of Diagnosis	Diagnosis, Medication or Treatment Prescribed	Medical Professional or Facility
Child #1				
Child #2				
Child #3				

SECTION 6

Name, Address and Phone Number of Personal Physician or Medical Facility that is consulted for routine health care or periodic check-ups.

Child #1	Name:	
	Address:	
	Phone Number:	
	Date and Reason of last consult:	
Child #2	Name:	
	Address:	
	Phone Number:	
	Date and Reason of last consult:	
Child #3	Name:	
	Address:	
	Phone Number:	
	Date and Reason of last consult:	

Please use the Continuation of Information form if additional space is needed for details listed above.

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.

Signature of Parent or Guardian

Date

Signature of Witness

Date

Agent's Printed Name

Agent's Signature

Agent's FL License ID No.

PROTECTIVE LIFE INSURANCE COMPANY

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INDIVIDUAL LIFE INSURANCE – PART 1A SUPPLEMENTAL APPLICATION – MEDICAL DECLARATIONS

SECTION 1

Proposed Insured 1		
Name (First, Middle, Last)		
Height	Weight	<input type="checkbox"/> Gain Pounds in past year? <input type="checkbox"/> Loss
Reason for Weight Gain or Loss		
Currently pregnant <input type="checkbox"/> Yes <input type="checkbox"/> No		
If "Yes," anticipated delivery date		

Proposed Insured 2		
Name (First, Middle, Last)		
Height	Weight	<input type="checkbox"/> Gain Pounds in past year? <input type="checkbox"/> Loss
Reason for Weight Gain or Loss		
Currently pregnant <input type="checkbox"/> Yes <input type="checkbox"/> No		
If "Yes," anticipated delivery date		

Please use the Continuation of Information form if additional space is needed for details listed below.

SECTION 2

Has any person proposed for insurance ever been diagnosed, treated, tested positive for, or been given medical advice by a licensed member of the medical profession for a disease or disorder such as : (Circle conditions to which "Yes" answer applies and give details below)	Proposed Insured 1	Proposed Insured 2
	Yes No	Yes No
(a) Any disorder or disease of the brain or nervous system (such as paralysis, epilepsy, stroke, convulsions, chronic headache).....	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
(b) Any disorder or disease of the heart, blood vessels, or circulatory system (such as high blood pressure, heart attack, heart murmur, chest pain).....	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
(c) Any disorder or disease of the respiratory system (such as Asthma, bronchitis, emphysema, tuberculosis).....	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
(d) Any disorder or disease of the stomach, liver, intestines, rectum, pancreas, or abdominal organs	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
(e) Any disorder or disease of the genitourinary organs (such as kidneys, urinary tract, blood or sugar in the urine, chronic inflammation).....	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
(f) Any disorder or disease of the skeletal system (such as arthritis, osteoporosis, joints, bones, spine, muscles).....	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
(g) Any disorder or disease of eyes, ears, nose or throat	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
(h) Any disorder or disease of the blood, skin, thyroid, lymph or other glands (such as anemia, diabetes).....	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
(i) Any psychiatric or mental health disorders or diseases (such as attempted suicide, Bipolar, Obsessive-compulsive).....	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
(j) Any gynecological disorders or diseases (such as irregular Pap Smear, Toxic Shock Syndrome).....	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
(k) Any cancer, tumor, cyst or nodule	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
(l) Any sexually transmitted disorders or diseases.....	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
(m) Any disorders or diseases of the immune system <i>except those related to the Human Immunodeficiency Virus (AIDS Virus)</i>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Please provide details for any/all "Yes" responses.		
	Question Number	Date of Diagnosis
		Diagnosis, Medication or Treatment Prescribed
		Medical Professional or Facility
Proposed Insured 1		
Proposed Insured 2		

SECTION 3

Has any person proposed for insurance ever been diagnosed or treated by a licensed member of the medical profession for specified symptoms of: (Circle conditions to which "Yes" answer applies and give details below)				Proposed Insured 1 Yes No	Proposed Insured 2 Yes No
(a)	Immune deficiency, anemia, recurrent fever, fatigue or unexplained weight loss, malaise, loss of appetite, diarrhea, fever of unknown origin, severe night sweats; unexplained or unusual infections or skin lesions; unexplained swelling of the lymph glands; Kaposi's Sarcoma or Pneumocystis Carinii Pneumonia.....			<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
(b)	Have you been tested positive for exposure to the HIV (Human Immunodeficiency Virus) infection or been diagnosed as having AIDS (Acquired Immune Deficiency Syndrome) or ARC (AIDS-Related Complex) caused by the HIV infection or other sickness or condition derived from such infection?.....			<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Please provide details for any/all "Yes" responses.					
	Question Number	Date of Diagnosis	Diagnosis, Medication or Treatment Prescribed	Medical Professional or Facility	
Proposed Insured 1					
Proposed Insured 2					

SECTION 4

Has any person proposed for insurance ever (Circle conditions to which "Yes" answer applies and give details below)				Proposed Insured 1 Yes No	Proposed Insured 2 Yes No
(a)	Used narcotics, barbiturates, amphetamines, hallucinogens, marijuana, heroin, cocaine, or other habit forming drugs, except as prescribed by a licensed member of the medical profession.....			<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
(b)	Received medical treatment or counseling for, or been advised by a licensed member of the medical profession to discontinue, the use of alcohol or prescribed or non-prescribed drugs.....			<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
(c)	Been a member of any self-help group such as Alcoholics Anonymous or Narcotics Anonymous.....			<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Please provide details for any/all "Yes" responses.					
	Question Number	Date of Diagnosis	Diagnosis, Medication or Treatment Prescribed	Medical Professional or Facility	
Proposed Insured 1					
Proposed Insured 2					

SECTION 5

The following questions in Section 5 do not include answers related to the Human Immunodeficiency Virus (AIDS virus) or for minor viruses, injuries, common colds that prevented normal activities for a period of less than five (5) days.				Proposed Insured 1 Yes No	Proposed Insured 2 Yes No
Within the past five (5) years, has any person proposed for insurance (Circle items or conditions to which "Yes" answer applies and give details below)					
(a)	Been treated, examined or advised by a licensed member of the medical profession for any condition other than stated above.....			<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
(b)	Been advised by a licensed member of the medical profession to get specified medical care which has not been completed, such as any hospitalization, surgery or diagnostic test.....			<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
(c)	Been an inpatient or outpatient in a hospital, clinic, medical facility, or any similar entity.....			<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
(d)	Had any diagnostic tests such as: an electrocardiogram (EKG), MRI, CT-Scan or X-ray.....			<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
(e)	Been on, or advised to be on any prescribed, non-prescribed (over the counter) medication or prescribed diet.....			<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
(f)	Been unable to work, attend school or perform normal activities of life age and gender or been confined at home.....			<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
(g)	Has made a claim for or received benefits, compensation or pension for any injury, sickness or disability.....			<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Please provide details for any/all "Yes" responses.					
	Question Number	Date of Diagnosis	Diagnosis, Medication or Treatment Prescribed	Medical Professional or Facility	
Proposed Insured 1					
Proposed Insured 2					

SECTION 6

For the following Family Medical History question, please provide in section number 8 below for each parent or sibling: diagnosis, age of diagnosis, date last treated, age – if still alive and if not alive, age, date, and cause of death.					Proposed Insured 1 Yes No	Proposed Insured 2 Yes No
To the best of your knowledge, has any person proposed for insurance had a parent or sibling diagnosed or treated by a member of the medical profession for certain conditions, such as heart or vascular disease, cancer, diabetes, high blood pressure, kidney disease, attempted suicide or mental illness.....					<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
<i>Please provide details for any/all "Yes" responses.</i>						
	Family Member	Age of Diagnosis	Diagnosis	Date Last Treated	Age – if still alive and if not alive, age, date, and cause of death.	
Proposed Insured 1						
Proposed Insured 2						

SECTION 7

Name, Address and Phone Number of Personal Physician or Medical Facility that is consulted for routine health care or periodic check-ups.	
Proposed Insured 1	Name:
	Address:
	Phone Number:
	Date and Reason of last consult:
	Name:
	Address:
	Phone Number:
	Date and Reason of last consult:
Proposed Insured 2	Name:
	Address:
	Phone Number:
	Date and Reason of last consult:
	Name:
	Address:
	Phone Number:
	Date and Reason of last consult:

Please use the Continuation of Information form if additional space is needed for details listed above.

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.

Proposed Insured 1 (Sign Name in Full)	Date	Proposed Insured 2 (Sign Name in Full)	Date
Signature of Parent or Guardian	Date	Signature of Witness	Date
Agent's Printed Name	Agent's Signature	Date	
Agent's FL License ID No.			
PL-402-FL			

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INDIVIDUAL LIFE INSURANCE – CONTINUATION OF INFORMATION

Proposed Insured 1:

First Name

Middle Name

Last Name

Policy Number

Proposed Insured 2:

First Name

Middle Name

Last Name

Policy Number

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.

Proposed Insured 1 (Sign Name in Full)

Date

Proposed Insured 2 (Sign Name in Full)

Date

Signature of Parent or Guardian

Date

Signature of Witness

Date

Signature of Owner (Sign Name in Full)
(if other than Proposed Insured)

Date

Agent's Printed Name

Agent's Signature

Agent's FL License ID No

PROTECTIVE LIFE INSURANCE COMPANY

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SUPPLEMENT TO LIFE INSURANCE APPLICATION

APPLICATION SUPPLEMENT – PART I

The statements and answers to the questions listed below shall become a part of the attached application; shall be subject to the terms of the attached application; and shall become a part of any policy based on this application. In this form, family means the Owner or Insured's spouse and anyone who is related to the Owner or Insured or the Owner's or Insured's spouse by the following degree by blood, marriage, divorce, adoption or operation of law: parents, in-laws, grandparents, siblings, children, grandchildren, aunts, uncles, nephews and nieces.

Print Name of Proposed Insured(s): _____

For any policy to be issued as a result of this application:

- | | Yes | No |
|--|--------------------------|--------------------------|
| (1) Will anyone other than the Insured, his or her family, or employer/business partner pay any portion of the initial or future premiums or obtain any right, title or interest in this policy within 2 years of the effective date of coverage?
If Yes, complete the "Statement of Owner Intent" (Application Supplement – Part II) | <input type="checkbox"/> | <input type="checkbox"/> |
| (2) Will any portion of the initial or future premiums be borrowed, loaned or otherwise financed?
If Yes, complete the "Premium Financing Disclosure" (Disclosure and Acknowledgement) | <input type="checkbox"/> | <input type="checkbox"/> |
| (3) Will a trust, including family trust, own this policy?
If Yes, complete the "Trust Certification" (Application Supplement – Part III) | <input type="checkbox"/> | <input type="checkbox"/> |
| (4) Is the Proposed Insured age 65 or older AND total coverage applied for across all Protective companies \$1,000,000 or more?
If Yes, complete the "Statement of Owner Intent" (Application Supplement – Part II) | <input type="checkbox"/> | <input type="checkbox"/> |

SIGNATURES


I (We) have read or have had read to me (us) the completed Supplement before signing below. All statements and answers in the Supplement are correctly recorded and are full, complete and true. I (We) understand that the information being provided in this Supplement is being relied upon in considering the application for life insurance.

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.

Signed in _____, this _____ day of _____, _____.
(State) (Month) (Year)

Signature(s) of Proposed Insured(s): X _____ 

X _____ 

Signature(s) of Owner(s)/Trustee(s): X _____ 
(provide officer's title if policy is owned by a corporation) X _____ 

Signature of Witness: X _____ 

AGENT CERTIFICATION

By signing below, I hereby certify that to the best of my knowledge and belief, the information provided herein is complete, accurate, and correct and that the life insurance being applied for conforms to the Company's guidelines.

Signed at: _____ Date _____ Florida Agent License Number _____
(City and State)

X _____ 
Agent Signature Agent Name (Print)

PROTECTIVE LIFE INSURANCE COMPANY

P.O. Box 830619

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AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

This Authorization to Obtain and Disclose Information complies with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") as related to Life Insurance.

USE OF MEDICAL, NON-HEALTH AND NON-MEDICAL INFORMATION

I (we) authorize Protective Life Insurance Company (Protective Life) and its reinsurers to obtain, directly or through designated third parties, and to use any information about or relating to me (us) that may affect my (our) insurability. Protective Life and its reinsurers, Life Insurance Representative(s) or regional sales office representing me on my (our) application for insurance may:

- obtain and use health and medical information from all dates of service, medical records, prescription drugs, chart notes, electrocardiograms (EKG), and information about the diagnoses and/or treatments relating to Human Immunodeficiency Virus (HIV) infection or Acquired Immunodeficiency Syndrome (AIDS), sexually transmitted diseases, drug use, alcohol use, nicotine or tobacco use, physical and mental diseases and illnesses, and psychiatric disorders (excluding psychotherapy notes);
- obtain and use non-health and non-medical information, financial information, credit reports, consumer reports, driving record, criminal record, character, general reputation, personal characteristics or behavioral and lifestyle factors and information about avocations and aviation activity;
- use all of this information to evaluate an application for insurance, a claim for insurance benefits, or both;
- use any information relating to communicable diseases (e.g., hepatitis A, measles, influenza, tuberculosis) relating to me or to my spouse or life partner to evaluate an application for insurance on either me or my spouse or life partner.

RELEASE AND DISCLOSE INFORMATION FROM THIRD PARTIES

I (we) authorize the following persons and organizations to release and disclose the information described in the **USE OF MEDICAL, NON-HEALTH AND NON-MEDICAL INFORMATION** section to Protective Life, directly through the following designated third parties or its representative(s) acting on its behalf:

- my (our) doctor(s); medical practitioners; pharmacists and Pharmacy Benefit Managers;
- medical and related facilities, including hospitals, clinics, facilities run by the Veteran's Administration, Kaiser Permanente, The Cleveland Clinic Foundation including all satellite facilities and The Mayo Clinic;
- insurers; reinsurers;
- my (our) current and previous employers;
- MIB, LLC (**MIB**); and commercial consumer reporting agencies (**CRA**).

All of these persons and organizations other than **MIB** may release the information described above to a **CRA** acting for Protective Life. **MIB** may not release the information described in the **USE OF MEDICAL, NON-HEALTH AND NON-MEDICAL INFORMATION** section to a **CRA**.

TESTING OF BLOOD, ORAL FLUIDS AND URINE

I (we) authorize Protective Life to draw and test my (our) blood, and/or oral fluids, and urine as necessary to underwrite my (our) application for insurance. These tests may include:

- tests for cholesterol and related blood lipids, diabetes, liver or kidney disorders, immune disorders (**other than HIV/AIDS**).
- tests for the presence of drugs, nicotine, or their metabolites.

This authorization does not include genetic testing. Unless otherwise required by law or regulation, Protective Life may, but is not obligated to, release any of these test results directly to me or to my spouse or life partner.

RELEASE OF MEDICAL, NON-HEALTH, NON-MEDICAL AND TESTING INFORMATION

I (we) authorize Protective Life to release and disclose the information described in the **USE OF MEDICAL, NON-HEALTH AND NON-MEDICAL INFORMATION** section and the **TESTING OF BLOOD, ORAL FLUIDS AND URINE** section:

- to its affiliates, its reinsurers, persons or organization providing services relating to insurance underwriting for Protective Life, **MIB**, and as otherwise required by law. Such information as it relates to medical tests for HIV infection and AIDS will be released and disclosed as allowed per §627.429(4)(f) of the Florida Statutes. and as otherwise required by law.
- to release and disclose the information to other duly licensed life insurers if I (we) have applied or apply to the other insurers for insurance.
- to its reinsurers, to make a brief report of my personal health information to **MIB**.
- to the Life Insurance Representative(s) representing me to duly licensed specific life insurers for the purpose of applying for life insurance if my (our) application with Protective Life is declined or if Protective Life is unable to offer coverage at an acceptable rate.
- to the Life Insurance Representative(s) and its staff, affiliated companies and/or entities, insurance companies and their re-insurers representing me on my (our) application for life insurance.

GENERAL INFORMATION

- a. This authorization shall be valid for 24 months from the Date of Authorization shown below, or for the time limit, if any, permitted by applicable law in the state where the policy is delivered or issued for delivery.
- b. During the evaluation of my (our) insurance application, I (we) understand that I (we) have the right to revoke the authorizations in the previous sections (above) by writing to Protective Life at P.O. Box 830619 • Birmingham, Alabama 35283-0619. If this authorization is revoked, this would result in the file being closed and no coverage provided.
- c. I understand I do not have to sign this authorization in order to obtain **health care benefits (treatment, payment or enrollment)**.
- d. I (we) understand that any information about me (us) that is disclosed pursuant to this authorization may be subject to re-disclosure and no longer covered by certain federal rules governing privacy and confidentiality of health information. The information contained in these medical and financial records will be held in confidence and may be used only for the purpose of the procurement, or underwriting for the possible procurement or the evaluation of life, health, long term care, or other insurance products.
- e. I (we) understand that my (our) personal information, including my (our) protected health information disclosed under this authorization will be incorporated into and made a part of any life and/or disability insurance policy(ies) issued by the Company and that the policy(ies) will be delivered to the policy owner.
- f. *I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction. Any modifications to this authorization may preclude Protective Life's ability to process this application.*

AUTHORIZATIONS AND INVESTIGATIVE CONSUMER REPORT

- ☐ I (we) have been given a copy of this **Authorization to Obtain and Disclose Information** along with the **Description of Information Practices**.
- ☐ I (we) would like to be interviewed if an investigative consumer report will be made. (Please refer to the **Description of Information Practices** for additional information regarding the interview for an **Investigative Consumer Report**.)

THIS AUTHORIZATION MUST BE SIGNED WITHOUT MODIFICATION AND RETURNED WITH THE APPLICATION BEFORE PROCESSING.

SIGNATURES

Date of Authorization: X _____

List Health Care Providers

X _____
Proposed Insured 1 (Signature) Print Name of Proposed Insured 1 Birthdate Social Security Number

X _____
Proposed Insured 2 (Signature) Print Name of Proposed Insured 2 Birthdate Social Security Number

If Minor, Print Name X _____
Parent or Legal Guardian (Signature) Print Name of Parent or Legal Guardian

Agent's Printed Name X _____
Agent's Signature Agent's FL License I.D. Number

PROTECTIVE LIFE INSURANCE COMPANY

P.O. Box 830619

Birmingham, AL 35283-0619

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

This Authorization to Obtain and Disclose Information complies with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") as related to Life Insurance.

USE OF MEDICAL, NON-HEALTH AND NON-MEDICAL INFORMATION

I (we) authorize Protective Life Insurance Company (Protective Life) and its reinsurers to obtain, directly or through designated third parties, and to use any information about or relating to me (us) that may affect my (our) insurability. Protective Life and its reinsurers, Life Insurance Representative(s) or regional sales office representing me on my (our) application for insurance may:

- obtain and use health and medical information from all dates of service, medical records, prescription drugs, chart notes, electrocardiograms (EKG), and information about the diagnoses and/or treatments relating to Human Immunodeficiency Virus (HIV) infection or Acquired Immunodeficiency Syndrome (AIDS), sexually transmitted diseases, drug use, alcohol use, nicotine or tobacco use, physical and mental diseases and illnesses, and psychiatric disorders (excluding psychotherapy notes);
- obtain and use non-health and non-medical information, financial information, credit reports, consumer reports, driving record, criminal record, character, general reputation, personal characteristics or behavioral and lifestyle factors and information about avocations and aviation activity;
- use all of this information to evaluate an application for insurance, a claim for insurance benefits, or both;
- use any information relating to communicable diseases (e.g., hepatitis A, measles, influenza, tuberculosis) relating to me or to my spouse or life partner to evaluate an application for insurance on either me or my spouse or life partner.

RELEASE AND DISCLOSE INFORMATION FROM THIRD PARTIES

I (we) authorize the following persons and organizations to release and disclose the information described in the **USE OF MEDICAL, NON-HEALTH AND NON-MEDICAL INFORMATION** section to Protective Life, directly through the following designated third parties or its representative(s) acting on its behalf:

- my (our) doctor(s); medical practitioners; pharmacists and Pharmacy Benefit Managers;
- medical and related facilities, including hospitals, clinics, facilities run by the Veteran's Administration, Kaiser Permanente, The Cleveland Clinic Foundation including all satellite facilities and The Mayo Clinic;
- insurers; reinsurers;
- my (our) current and previous employers;
- MIB, LLC (**MIB**); and commercial consumer reporting agencies (**CRA**).

All of these persons and organizations other than **MIB** may release the information described above to a **CRA** acting for Protective Life. **MIB** may not release the information described in the **USE OF MEDICAL, NON-HEALTH AND NON-MEDICAL INFORMATION** section to a **CRA**.

TESTING OF BLOOD, ORAL FLUIDS AND URINE

I (we) authorize Protective Life to draw and test my (our) blood, and/or oral fluids, and urine as necessary to underwrite my (our) application for insurance. These tests may include:

- tests for cholesterol and related blood lipids, diabetes, liver or kidney disorders, immune disorders (**other than HIV/AIDS**).
- tests for the presence of drugs, nicotine, or their metabolites.

This authorization does not include genetic testing. Unless otherwise required by law or regulation, Protective Life may, but is not obligated to, release any of these test results directly to me or to my spouse or life partner.

RELEASE OF MEDICAL, NON-HEALTH, NON-MEDICAL AND TESTING INFORMATION

I (we) authorize Protective Life to release and disclose the information described in the **USE OF MEDICAL, NON-HEALTH AND NON-MEDICAL INFORMATION** section and the **TESTING OF BLOOD, ORAL FLUIDS AND URINE** section:

- to its affiliates, its reinsurers, persons or organization providing services relating to insurance underwriting for Protective Life, **MIB**, and as otherwise required by law. Such information as it relates to medical tests for HIV infection and AIDS will be released and disclosed as allowed per §627.429(4)(f) of the Florida Statutes. and as otherwise required by law.
- to release and disclose the information to other duly licensed life insurers if I (we) have applied or apply to the other insurers for insurance.
- to its reinsurers, to make a brief report of my personal health information to **MIB**.
- to the Life Insurance Representative(s) representing me to duly licensed specific life insurers for the purpose of applying for life insurance if my (our) application with Protective Life is declined or if Protective Life is unable to offer coverage at an acceptable rate.
- to the Life Insurance Representative(s) and its staff, affiliated companies and/or entities, insurance companies and their re-insurers representing me on my (our) application for life insurance.

GENERAL INFORMATION

- a. This authorization shall be valid for 24 months from the Date of Authorization shown below, or for the time limit, if any, permitted by applicable law in the state where the policy is delivered or issued for delivery.
- b. During the evaluation of my (our) insurance application, I (we) understand that I (we) have the right to revoke the authorizations in the previous sections (above) by writing to Protective Life at P.O. Box 830619 • Birmingham, Alabama 35283-0619. If this authorization is revoked, this would result in the file being closed and no coverage provided.
- c. I understand I do not have to sign this authorization in order to obtain **health care benefits (treatment, payment or enrollment)**.
- d. I (we) understand that any information about me (us) that is disclosed pursuant to this authorization may be subject to re-disclosure and no longer covered by certain federal rules governing privacy and confidentiality of health information. The information contained in these medical and financial records will be held in confidence and may be used only for the purpose of the procurement, or underwriting for the possible procurement or the evaluation of life, health, long term care, or other insurance products.
- e. I (we) understand that my (our) personal information, including my (our) protected health information disclosed under this authorization will be incorporated into and made a part of any life and/or disability insurance policy(ies) issued by the Company and that the policy(ies) will be delivered to the policy owner.
- f. *I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction. Any modifications to this authorization may preclude Protective Life's ability to process this application.*

AUTHORIZATIONS AND INVESTIGATIVE CONSUMER REPORT

- ☐ I (we) have been given a copy of this **Authorization to Obtain and Disclose Information** along with the **Description of Information Practices**.
- ☐ I (we) would like to be interviewed if an investigative consumer report will be made. (Please refer to the **Description of Information Practices** for additional information regarding the interview for an **Investigative Consumer Report**.)

THIS AUTHORIZATION MUST BE SIGNED WITHOUT MODIFICATION AND RETURNED WITH THE APPLICATION BEFORE PROCESSING.

SIGNATURES

Date of Authorization: X _____

List Health Care Providers

X _____
Proposed Insured 1 (Signature) Print Name of Proposed Insured 1 Birthdate Social Security Number

X _____
Proposed Insured 2 (Signature) Print Name of Proposed Insured 2 Birthdate Social Security Number

If Minor, Print Name X _____
Parent or Legal Guardian (Signature) Print Name of Parent or Legal Guardian

Agent's Printed Name X _____
Agent's Signature Agent's FL License I.D. Number

PROTECTIVE LIFE INSURANCE COMPANY

P.O. Box 830619

Birmingham, AL 35283-0619

DESCRIPTION OF INFORMATION PRACTICES

(Including MIB, LLC Notice and Fair Credit Reporting Act Notice)

DISCLOSURE OF INFORMATION

In considering your application for insurance, information from various sources must be considered. These include the results of your physical examination, if required, and any reports Protective Life may receive from doctors and hospitals who have attended you.

Information regarding your insurability will be treated as confidential. Protective Life, or its reinsurers, may, however, make a brief report of any personal health information thereon to the MIB, LLC ("MIB"), which operates an information exchange on behalf of insurance companies that are members of MIB Group, Inc. If you apply to another MIB member company for life or health insurance coverage or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 or go to its website at www.mib.com to request disclosure online. If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

Protective Life, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

INVESTIGATIVE CONSUMER REPORT

Furthermore, as part of our procedures for processing your insurance application, an investigative consumer report may be prepared by one or more of the commercial agencies offering this service whereby information is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted. This inquiry includes information as to your insurance risk score, character, general reputation, personal characteristics or behavioral and lifestyle factors, except as may be related directly or indirectly to your sexual orientation. You have the right to be personally interviewed if we order an investigative consumer report. You also have the right to receive a copy of the report by making a written request to Protective Life, within a reasonable period of time, to receive additional detailed information about the nature and scope of this investigation.

YOU CAN REVIEW AND CORRECT YOUR INFORMATION

As a general practice, we will not disclose personal or privileged information about you to anyone else without your consent, unless a legitimate business need exists or disclosure is required or permitted by law. You are entitled, upon request, to receive a more detailed statement of our information practices. You also have the right to access the personal information about you that we have in our records. You may see a copy of the information, or we will send it to you, whichever you prefer. You also have the right to request correction of personal information we may have about you which you think is wrong. To exercise these rights, please write to us at the address appearing at the end of this notice.

Ask our agent/producer for assistance or call or write us at Protective Life Insurance Company, Attention: New Business, P.O. Box 830619, Birmingham, Alabama 35283-0619. Telephone: 800-366-9378

THIS NOTICE MUST BE GIVEN TO THE PROPOSED INSURED

AGENT/PRODUCER COMPENSATION DISCLOSURE

Agents/Producers receive compensation from an insurer or third party, which may differ depending upon the product or insurer. Additional compensation may be received by the Agent/Producer based on other factors including premium volume placed with the company and loss or claim experience.

PROTECTIVE LIFE INSURANCE COMPANY

P.O. Box 830619

Birmingham, AL 35283-0619

BROKER / REPRESENTATIVE REPORT

<p>1. In what language were the questions on the application asked? *Please remember that Protective Life cannot accept or service any application from an applicant who does not speak English or Spanish. <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other* <i>*List Other Language:</i> _____</p>	Yes	No
<p>2. Is the Proposed Insured a relative or does the Proposed Insured have a business relationship with you? <i>If Yes, Details:</i> _____</p>	<input type="checkbox"/>	<input type="checkbox"/>
<p>3. (a) Will this policy replace or change existing policy(ies)? (b) If replacement of existing insurance is involved, have you complied with all relevant state requirements, including any Disclosure and Comparison Statements? <i>If No, Explain:</i> _____ Answer questions (c) and (d) <u>only</u> if this is a replacement: (c) Did you use any pre-printed company approved sales materials? <i>If Yes, List Name or Form Number:</i> _____ (d) Did you use any Company approved, electronically generated, individualized sales materials (such as illustrations or concept materials)? (If Yes, you must provide a copy of these materials with the application.)</p>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<p>4. Have you advised the proposed policyowner or do you know of any advice that has been given to the policyowner to transfer ownership of the policy to be issued, or its death benefits, to a life settlement company, investor, offshore trust, investment trust, or entity associated with stranger owned or investment owned life insurance (commonly called SOLI or IOLI) or are you otherwise aware that the policyowner may be contemplating such a transfer? <i>If Yes, please explain in Special Requests/Remarks below.</i></p>	<input type="checkbox"/>	<input type="checkbox"/>
<p>5. Has a mortality analysis or life expectancy analysis been performed on the Proposed Insured?</p>	<input type="checkbox"/>	<input type="checkbox"/>
<p>6. Has a medical examination been ordered? <i>If Yes, Name of Examiner:</i> _____ <i>Date of Exam:</i> _____</p>	<input type="checkbox"/>	<input type="checkbox"/>
<p>7. Is Premium Financing involved in this case? (If Yes, please submit a cover letter describing the parameters.)</p>	<input type="checkbox"/>	<input type="checkbox"/>
<p>I have verified the identity of the Owner by picture I.D. (Authorized Representative if Business or Trustee if Trust) <i>Identification Type:</i> _____ <i>Driver's License Number:</i> _____ Please include Driver's License Number if Owner is an individual and is other than the Proposed Insured. NOTE: Does not apply to direct marketing situations</p>	<input type="checkbox"/>	<input type="checkbox"/>

I certify that:

- both the Proposed Insured(s) and the Owner(s) read, speak and understand either the English or Spanish language; and
- each has explicitly told me that they understood each question and item contained in this application; and
- the answers given in this application are complete and true to the best of my knowledge and belief; and
- I know of nothing affecting the risk which is not set forth in my representative's report or this life insurance application; and
- I carefully explained each question before recording each answer and before the application was signed.

Signature of Broker/Representative	Date	PLICO Contract Number	Share %	Business Phone Number
Print Name of Above Signature	Email Address	Signed at (City and State)		
Signature of Additional Broker/Representative	Date	PLICO Contract Number	Share %	Business Phone Number
Print Name of Above Additional Signature	Email Address	Signed at (City and State)		
BGA/Broker Dealer Name	PLICO Contract Number			
New Business Key Contact	Email Address	Phone Number		
Broker/Representative Special Requests/Remarks:				