PROTECTIVE LIFE AND ANNUITY 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 or Income Provider Option 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

☐ Guaranteed Insurability Rider $______________

☐ Waiver of Premium Rider

☐ * Income Provider Option

☐ 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.

Signed at: (City and State) ______________________________________ Date ______________________

______________________________________ ______________________________________
Owner Signature Proposed/Primary Insured Signature

______________________________________ ______________________________________
Witness to Owner Signature Signature of Parent or Guardian

PROTECTIVE LIFE AND ANNUITY INSURANCE COMPANY

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

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

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 member of the medical profession for: (Circle conditions to which "Yes" answer applies and give details below.)	Child #1 Yes	Child #1 No	Child #2 Yes	Child #2 No	Child #3 Yes	Child #3 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……………	☐	☐	☐	☐	☐	☐
(b) Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS)…….………	☐	☐	☐	☐	☐	☐

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	Child #1 No	Child #2 Yes	Child #2 No	Child #3 Yes	Child #3 No
(a) Used narcotics, barbiturates, amphetamines, hallucinogens, marijuana, heroin, cocaine, or other habit forming drugs, except as prescribed by a physician……………	☐	☐	☐	☐	☐	☐
(b) Received medical treatment or counseling for, or been advised by a physician to discontinue, the use of alcohol or prescribed or non-prescribed drugs……………	☐	☐	☐	☐	☐	☐
(c) Been a member of any self-help group such as Alcoholics Anonymous or Narcotics Anonymous……….……	☐	☐	☐	☐	☐	☐

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:

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. Within the past five (5) years, has any child proposed for insurance	Child #1 Yes	Child #1 No	Child #2 Yes	Child #2 No	Child #3 Yes	Child #3 No
(a) Been treated, examined or advised by a member of the medical profession for any condition other than stated above…………………………	☐	☐	☐	☐	☐	☐
(b) Been advised by a member of the medical profession to get specified medical care which has not been completed, such as any hospitalization, surgery or diagnostic test…………………	☐	☐	☐	☐	☐	☐
(c) Been an inpatient or outpatient in a hospital, clinic, medical facility, or any similar entity…………………	☐	☐	☐	☐	☐	☐
(d) Had any diagnostics test, electrocardiogram (EKG), MRI, CT-Scan or X-ray…………………	☐	☐	☐	☐	☐	☐
(e) Been on, or advised to be on any prescribed, non-prescribed (over the counter) medication or prescribed diet	☐	☐	☐	☐	☐	☐
(f) Been unable to work, attend school or perform normal activities of life age and gender or been confined at home…………………………	☐	☐	☐	☐	☐	☐

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.

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 part of the application and shall be considered the basis of any insurance issued.

Signature of Parent or Guardian ______ Date ______ Signature of Witness ______ Date ______

Signature of Proposed Insured Age 14½ or Older ______ Date ______

PROTECTIVE LIFE AND ANNUITY INSURANCE COMPANY

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

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

SECTION 1

Proposed Insured 1		
Name (First, Middle, Last)		
Height	*Weight*	☐ *Gain* ☐ *Loss* *Pounds in past year?*
Reason for Weight Gain or Loss		
Currently pregnant ☐ *Yes* ☐ *No* *If "Yes," anticipated delivery date*		

Proposed Insured 2		
Name (First, Middle, Last)		
Height	*Weight*	☐ *Gain* ☐ *Loss* *Pounds in past year?*
Reason for Weight Gain or Loss		
Currently pregnant ☐ *Yes* ☐ *No* *If "Yes," anticipated delivery date*		

Please use and attach 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 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** Yes No	**Proposed Insured 2** Yes No
(a) Any disorder or disease of the **brain or nervous system** (such as paralysis, epilepsy, stroke, convulsions, chronic headache)……	☐ ☐	☐ ☐
(b) Any disorder or disease of the **heart, blood vessels, or circulatory system** (such as high blood pressure, heart attack, heart murmur, chest pain)……	☐ ☐	☐ ☐
(c) Any disorder or disease of the **respiratory system** (such as Asthma, bronchitis, emphysema, tuberculosis)………	☐ ☐	☐ ☐
(d) Any disorder or disease of the **stomach, liver, intestines, rectum, pancreas, or abdominal organs**……	☐ ☐	☐ ☐
(e) Any disorder or disease of the **genitourinary organs** (such as kidneys, urinary tract, blood or sugar in the urine, chronic inflammation)……	☐ ☐	☐ ☐
(f) Any disorder or disease of the **skeletal system** (such as arthritis, osteoporosis, joints, bones, spine, muscles)……	☐ ☐	☐ ☐
(g) Any disorder or disease of **eyes, ears, nose or throat** ……	☐ ☐	☐ ☐
(h) Any disorder or disease **(excluding HIV)** of the **blood, skin, thyroid, lymph or other glands** (such as anemia, diabetes)……	☐ ☐	☐ ☐
(i) Any **psychiatric or mental health** disorders or diseases (such as attempted suicide, Bipolar, Obsessive-compulsive)……	☐ ☐	☐ ☐
(j) Any **gynecological** disorders or diseases (such as irregular Pap Smear, Toxic Shock Syndrome)……	☐ ☐	☐ ☐
(k) Any **cancer, tumor, cyst or nodule**……	☐ ☐	☐ ☐
(l) Any **sexually transmitted** disorders or diseases **(exlcuding HIV)**……	☐ ☐	☐ ☐
(m) Any disorders or diseases of the **immune system** *except those related to the Human Immunodeficiency Virus (AIDS Virus)*……	☐ ☐	☐ ☐

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 member of the medical profession for specified symptoms such as: (**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………………………………….	☐ ☐	☐ ☐
(b) Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS)………..……………	☐ ☐	☐ ☐

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 physician………………………………………………………………………………	☐ ☐	☐ ☐
(b) Received medical treatment or counseling for, or been advised by a physician to discontinue, the use of alcohol or prescribed or non-prescribed drugs………………………………………………………………………………………	☐ ☐	☐ ☐
(c) Been a member of any self-help group such as Alcoholics Anonymous or Narcotics Anonymous……………………..	☐ ☐	☐ ☐

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. 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)	**Proposed Insured 1** Yes No	**Proposed Insured 2** Yes No
(a) Been treated, examined or advised by a member of the medical profession for any condition other than stated above………..	☐ ☐	☐ ☐
(b) Been advised by a member of the medical profession to get specified medical care which has not been completed, such as any hospitalization, surgery or diagnostic test………………………………………………………………………..	☐ ☐	☐ ☐
(c) Been an inpatient or outpatient in a hospital, clinic, medical facility, or any similar entity…………………………………	☐ ☐	☐ ☐
(d) Had any diagnostic tests such as: an electrocardiogram (EKG), MRI, CT-Scan or X-ray…………………………………	☐ ☐	☐ ☐
(e) Been on, or advised to be on any prescribed, non-prescribed (over the counter) medication or prescribed diet………	☐ ☐	☐ ☐
(f) Been unable to work, attend school or perform normal activities of life age and gender or been confined at home…..	☐ ☐	☐ ☐
(g) Has made a claim for or received benefits, compensation or pension for any injury, sickness, disability or impaired condition………	☐ ☐	☐ ☐

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
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………	☐ ☐	☐ ☐

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

	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 and attach the Continuation of Information form if additional space is needed for details listed above.

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.

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

PROTECTIVE LIFE AND ANNUITY INSURANCE COMPANY

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

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

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.

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

PROTECTIVE LIFE AND ANNUITY INSURANCE COMPANY

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

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.

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? If Yes, complete the "Statement of Owner Intent" (Application Supplement – Part II)	☐	☐
(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)	☐	☐
(3) Will a trust, including family trust, own this policy? If Yes, complete the "Trust Certification" (Application Supplement – Part III)	☐	☐
(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)	☐	☐

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 to the best of my (our) knowledge and belief. I (We) understand that the information being provided in this Supplement is being relied upon in considering the application for life insurance.

Signed in ______________________, this __________ day of ______________________, ______________.
(State) (Month) (Year)

SIGN HERE
______________________ ______________________
Signature of Proposed Insured 1 — Address, Date of Birth, Telephone Number, Social Security Number

SIGN HERE
______________________ ______________________
Signature of Proposed Insured 2 — Address, Date of Birth, Telephone Number, Social Security Number

SIGN HERE
______________________ ______________________
Signature of Owner/Trustee & Title if Corporation 1 — Address, Date of Birth, Telephone Number, Social Security Number

SIGN HERE
______________________ ______________________
Signature of Owner/Trustee & Title if Corporation 2 — Address, Date of Birth, Telephone Number, Social Security Number

SIGN HERE
____
Signature of Witness

PRODUCER 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: ______________________ ______________________
(City and State) Date

SIGN HERE
X ______________________ ______________________
Producer Signature — Producer Name (Print)

SUITABILITY AND BEST INTEREST QUESTIONNAIRE FOR LIFE INSURANCE

This form is an essential part of the application process. It helps your producer assess your insurance needs and financial objectives, and make recommendations appropriate to your situation. The questions to be completed will depend on the type of transaction. The form must be signed by each owner/applicant and the producer.

(FOR USE IN NEW YORK)

TYPE OF TRANSACTION:

☐ **New Business (purchase, exchange, or replacement of a life insurance policy)**

☐ **In Force (increase in death benefit, exercise of contractual right, or purchase of additional benefits, riders, or endorsements)**

Policy Number: ______________________________________

PURCHASE INFORMATION:

Premium Amount / Total Estimated Initial Purchase Price: $________________________

Plan Type: ☐ Qualified ☐ Non-Qualified

Face Amount: $________________________

Product Name: ____

Term Length: ________________________

Insured Name (if different than owner): ____

Payment Mode: ☐ Annual ☐ Quarterly ☐ Semi-Annual ☐ Monthly ☐ Single Payment

OWNERS/APPLICANTS: *(If the policy will be jointly owned, please provide information for both.)*

Owner/Applicant 1 – First Name ____________ **Last Name** ____________ **Soc. Sec. No. / Tax I.D. No.** ____________

Age ______ **Trust/Entity (if applicable)** ____________ **Trust Date** ____________

Owner/Applicant 2 – First Name ____________ **Last Name** ____________ **Soc. Sec. No. / Tax I.D. No.** ____________

Age ______ **Trust/Entity (if applicable)** ____________ **Trust Date** ____________

FINANCIAL PROFILE: *(If the policy will be jointly owned, the information may be combined for both.)*

1. **What is your gross annual household income?** $ ________________________
   a. What are your sources of income? *(select all that apply)*
      ☐ Wages/Salary ☐ Rental Income ☐ Investments
      ☐ Pension/Retirement Benefit ☐ SSI ☐ Other ______________________
   b. Describe your monthly income: ☐ it is stable -or- ☐ it fluctuates

2. **What are your annual household living expenses?** $ ________________________
   (Includes: housing, food, transportation, insurance, medical care, and property taxes.)

3. **What is the face amount that you have in force for existing life insurance policies?** $ ____________________

4. **Federal Income Tax Rate:** ☐ 0-10% ☐ 11-20% ☐ 21-30% ☐ 31-36% ☐ 37%+

5. **What is your liquid net worth?** $ ____________________
   (Liquid net worth is the amount that can be easily converted into cash without paying any kind of penalty or surrender charge.)

6. **Is your current income or liquid assets sufficient for living expenses, medical expenses, or any unexpected emergencies?** ☐ Yes ☐ No
   If No, please explain: ____________________

7. **Please provide the details of your household net worth.**

Total ASSETS $____________ *(Examples of Assets include: Primary Residence, Rental Properties, Checking Account, Savings Account, Money Market, Stocks, Bonds, Mutual Funds, CDs, Annuity Holdings, Life Insurance Cash Value, Retirement Plans/Pensions, Business Equity.)*	**Short-Term Total DEBTS** $____________ *(Short-Term Debt includes financial obligations that are expected to be paid off within a year. Examples of Short-Term Debt include: Bank Loans, Payday Loans, Consumer Loans, Online or Installment Loans, Lines of Credit, Credit Card Debt.)*
	Long-Term Total DEBTS $____________ *(Long-Term Debt includes non-current liabilities that are due after a year or more. Examples of Long-Term Debt include: Primary Mortgage/Rent Payments, Medical Bills, Auto/Vehicle Loans, Student Loans, Unpaid Taxes/Judgements.)*
	Short-Term + Long-Term = TOTAL DEBTS $____________

(Total Assets) $____________ — (Total Debts) $____________ = Household Net Worth $____________

8. **What percentage of your gross annual household income is used to pay installment debt?** ________%

9. **After the purchase of this life insurance policy, do you anticipate any material changes to the following?** ☐ Yes ☐ No
   (If Yes, please select the option(s) that will be affected and provide an explanation below.)
   ☐ Monthly Income ☐ Out-of-pocket Medical Expenses ☐ Living Expenses ☐ Liquid Assets
   If Yes, please explain: ____________________

10. **Do you have an emergency fund for unexpected expenses?** ☐ Yes ☐ No
    If No, please explain: ____________________

11. **Do you have a reverse mortgage?** ☐ Yes ☐ No

FINANCIAL OBJECTIVES AND EXPERIENCE:

12. **Intended use of Life Insurance Policy:** *(select all that apply)*
    ☐ Income Replacement/Family Protection ☐ Estate Planning/Wealth Transfers ☐ Gifting
    ☐ Cover Burial Expenses/Final Expenses ☐ Retirement Income/Protection ☐ Business Planning/Protection
    ☐ Non-Qualified Executive Benefit ☐ Build Up Cash Value/Accumulation ☐ Pay off Debts/Liabilities

13. **Which of the following financial products do you own and/or have previously owned and indicate number of years for each?** *(select all that apply)*
    ☐ Fixed Annuities _____ years ☐ Variable Annuities _____ years ☐ Life Insurance _____ years
    ☐ Bonds _____ years ☐ Stocks _____ years ☐ Other ____________ _____ years

14. **Source of funds for this life insurance purchase?** *(select all that apply)*
    (If life insurance policies are being replaced, the replacement questions on this questionnaire and the State required replacement forms will need to be completed.)
    ☐ Current Income ☐ Life Insurance ☐ IRA/Retirement Plan
    ☐ Cash/Savings/Checking ☐ Loan/Reverse Mortgage ☐ Stocks/Bonds/Mutual Funds
    ☐ CDs ☐ Other ____________________

15. **How long do you plan to keep this life insurance policy?** *(select one)*

☐ 1-10 years ☐ 11-20 years ☐ 21+ years ☐ Lifetime

16. **What is your risk tolerance for this life insurance policy?**

☐ Conservative ☐ Moderately Conservative ☐ Moderate ☐ Moderately Aggressive ☐ Aggressive

17. **Excluding the current transaction, have you replaced any other life insurance policies within the past 36 months?** ☐ Yes ☐ No

If Yes, please explain: ______________________________

18. **Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer or otherwise terminating existing life insurance policy(ies)?** ☐ Yes ☐ No

19. **Are you considering using funds from your existing life insurance policy(ies) to pay premiums due on the new life insurance policy?** ☐ Yes ☐ No

20. **If you answered "Yes" to either of questions 18 or 19, please list each existing life insurance policy you are contemplating replacing, and complete any State required replacement forms:**

	Policy 1	*Policy 2*	*Policy 3*
Company Name			
Policy Number			
Name of Insured			
Replace (R) or Change (C)			
Issue Date			
Annual Premium			
Face Amount			
Cash Value (if any)			

21. **The reason for replacing the existing life insurance policy(ies) is because:**

____

22. **Is there a surrender charge for liquidating the existing life insurance policy(ies)?** ☐ Yes ☐ No

If Yes, what is the Surrender Charge? $ ______________

23. **Please describe what benefit(s) the owner/applicant will achieve by replacing the existing life insurance policy(ies). If the owner/applicant is giving up certain riders or endorsements, please explain why the riders or endorsements are no longer needed.**

____

24. **Are you willing to accept non-guaranteed elements in the policy, including variability in premium, death benefit, or fees?** ☐ Yes ☐ No
(Non-guaranteed elements include, but are not limited to, expense and benefit charge rates, interest crediting rates, cost of insurance rates, index account parameter, etc.)

25. **Please include any other information provided by the owner/applicant that is relevant to the suitability of the transaction.**

____

26. **Did the owner/applicant refuse to provide any suitability information requested by the producer?** ☐ Yes ☐ No
If Yes, please provide an explanation in this section.

____

NOTE: Refusing to provide suitability information affects the producer's ability to determine if purchasing this life insurance policy is suitable and in the owner/applicant's best interest. If we are unable to determine suitability, the application will be rejected.

OWNER/APPLICANT'S STATEMENT:

I confirm that I provided the information above and that it is true and complete to the best of my knowledge. I discussed my current financial situation, anticipated financial needs, and risk tolerance with my producer. The producer discussed with me the advantages and disadvantages of this life insurance policy, potential consequences of the transaction, and how he or she is compensated for the sale and servicing of the life insurance policy. My producer provided me with a product summary, in the form of the product-specific Disclosure Statement and the Product Summary Disclosure, and explained to me the product features, including, if applicable, the interest crediting elements, the indexes upon which the interest calculation will be based, surrender charges, and other costs relating to the product. I understand the risks associated with this product include fluctuating interest rates and potentially lower returns. I understand and accept that the life insurance policy I am purchasing may include non-guaranteed elements such as changes in interest rates, availability of options, policy value, death benefits, fees, or additional premium limitations. I understand my refusal to provide certain information affects the ability of my producer to determine if purchasing this life insurance policy is suitable and in my best interest.

Please check the box next to *one* of the statements below. The application *will not be accepted* if this section is incomplete.

☐ I provided the necessary information requested by my producer to thoroughly assess my current financial situation and make a recommendation that I believe is suitable and in my best interest according to my financial goals and objectives.

☐ I have selected this product despite a contrary recommendation (or absence of a recommendation) from my producer.

Owner/Applicant 1: ______________________________ **Date:** ______________

Owner/Applicant 2: ______________________________ **Date:** ______________

PRODUCER'S STATEMENT:

I have made a reasonable effort to obtain the following information about the applicant(s): financial situation, net worth and liquidity, tax status, financial objectives, risk tolerance, time horizon, and financial goals and objectives. I have a reasonable basis to believe that the applicant(s) have the financial ability to meet the financial commitments under this life insurance policy. To the best of my knowledge and belief, the information provided by the applicant on this Suitability and Best Interest Questionnaire for Life Insurance is true, complete, and was obtained prior to the purchase of the life insurance policy. I considered only the interests of the applicant(s) when making the recommendation to purchase this life insurance policy, and the recommendation was not influenced by the amount of compensation or incentive that I or anyone affiliated with me would receive. I completed the product training and believe I am knowledgeable of the life insurance policy that I recommended to the applicant(s). I did not use the title or designation of "financial planner," "financial advisor," or any similar title without being appropriately licensed or certified to provide securities or other non-insurance financial services. I have discussed with the applicant how I am compensated, advantages and disadvantages of this product, potential consequences of the transaction, and I provided them with the basis of my recommendation. Sections a. and b. must be completed to confirm the advantages and disadvantages of this purchase.

a. **Advantages of purchasing the proposed life insurance policy:** ***(select all that apply)***
   ☐ Guarantees/Lapse Protection ☐ Temporary Death Benefit Protection ☐ Permanent Death Benefit Protection
   ☐ Supplemental Retirement Income Needs/Protection ☐ Long-Term Care Protection ☐ Business Needs/Planning
   ☐ Lower Premiums ☐ Increased Death Benefit Protection ☐ Guaranteed Level Premiums ☐ Reduced/Lower Fees
   ☐ Cash Value Growth ☐ Other, please explain: ______________________________

b. **Disadvantages of purchasing the proposed life insurance policy:** ***(select all that apply)***
   ☐ Surrender Period/Length ☐ Surrender Charges ☐ Reduction in Death Benefit ☐ Loss of Policy Features
   ☐ Higher Upfront Costs and Expenses/First Year Charges ☐ Chance for Less Gain than Current Product
   ☐ New Contestable Period ☐ Market Exposure ☐ Other, please explain: ______________________________

Please check the box next to *one* of the statements below. The application *will not be accepted* if this section is incomplete.

☐ Based on the information the applicant(s) provided and according to the applicant's financial goals and objectives, I believe the recommended life insurance policy contract is suitable and in the best interest of the applicant(s).

☐ The applicant(s) selected this product despite a contrary recommendation (or absence of a recommendation) from me.

Producer: ______________________________ **Date:** ______________

Protective Life and Annuity Insurance Company, Post Office Box 830619, Birmingham, AL 35283-0619
Toll Free: 800-366-9378; Fax: 205-268-5807

PROTECTIVE LIFE AND ANNUITY 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 and Annuity Insurance Company (Protective Life and Annuity) 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 Annuity and its reinsurers, Life Insurance Representative(s) or regional sales office representing me on my (our) application for insurance may:

a. obtain and use health and medical information from all dates of service, including but not limited to, 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, tobacco use, physical and mental diseases and illnesses, and psychiatric disorders (excluding psychotherapy notes);
b. obtain and use non-health and non-medical information, including but not limited to 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;
c. use all of this information to evaluate an application for insurance, a claim for insurance benefits, or both;
d. use any information relating to communicable diseases (e.g., hepatitis A, measles, influenza, tuberculosis) and other risk factors 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 and Annuity, directly through the following designated third parties or its representative(s) acting on its behalf:

a. my (our) doctor(s); medical practitioners; pharmacists and Pharmacy Benefit Managers;
b. 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;
c. insurers; reinsurers;
d. my (our) current and previous employers;
e. 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 and Annuity. **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 and Annuity 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, but are not limited to:

a. tests for cholesterol and related blood lipids, diabetes, liver or kidney disorders, immune disorders (other than HIV/AIDS).
b. 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 and Annuity 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 and Annuity 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:

a. to its affiliates, its reinsurers, persons or organization providing services relating to insurance underwriting for Protective Life and Annuity, **MIB** and as otherwise required by law.
b. 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.
c. to its reinsurers, to make a brief report of my personal health information to **MIB**.
d. 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 and Annuity is declined or if Protective Life and Annuity is unable to offer coverage at an acceptable rate.
e. 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.

SPECIAL REQUIREMENT FOR HIV/AIDS TESTING

If Protective Life and Annuity intends to test for the presence of antibodies to the Human Immunodeficiency Virus (HIV), which is the virus that has been associated with Acquired Immune Deficiency Syndrome (AIDS), Protective Life and Annuity may require a separate authorization. I (we) hereby authorize Protective Life and Annuity:

a. to obtain and use the results of any HIV tests that I (we) separately authorize.
b. (if permitted by law) to disclose the results of any tests to its reinsurers and **MIB**.

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, whichever period is shorter, or, in the event of a claim for benefits, for the duration of such claim.
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 and Annuity 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 and Annuity'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) authorize the preparation of an investigative consumer report and 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

________________________ X________________________ ________________________
If Minor, Print Name | Parent or Legal Guardian (Signature) | Print Name of Parent or Legal Guardian

PROTECTIVE LIFE AND ANNUITY 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 and Annuity Insurance Company (Protective Life and Annuity) 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 Annuity and its reinsurers, Life Insurance Representative(s) or regional sales office representing me on my (our) application for insurance may:

a. obtain and use health and medical information from all dates of service, including but not limited to, 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, tobacco use, physical and mental diseases and illnesses, and psychiatric disorders (excluding psychotherapy notes);
b. obtain and use non-health and non-medical information, including but not limited to 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;
c. use all of this information to evaluate an application for insurance, a claim for insurance benefits, or both;
d. use any information relating to communicable diseases (e.g., hepatitis A, measles, influenza, tuberculosis) and other risk factors 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 and Annuity, directly through the following designated third parties or its representative(s) acting on its behalf:

a. my (our) doctor(s); medical practitioners; pharmacists and Pharmacy Benefit Managers;
b. 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;
c. insurers; reinsurers;
d. my (our) current and previous employers;
e. 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 and Annuity. **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 and Annuity 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, but are not limited to:

a. tests for cholesterol and related blood lipids, diabetes, liver or kidney disorders, immune disorders (other than HIV/AIDS).
b. 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 and Annuity 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 and Annuity 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:

a. to its affiliates, its reinsurers, persons or organization providing services relating to insurance underwriting for Protective Life and Annuity, **MIB** and as otherwise required by law.
b. 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.
c. to its reinsurers, to make a brief report of my personal health information to **MIB**.
d. 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 and Annuity is declined or if Protective Life and Annuity is unable to offer coverage at an acceptable rate.
e. 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.

SPECIAL REQUIREMENT FOR HIV/AIDS TESTING

If Protective Life and Annuity intends to test for the presence of antibodies to the Human Immunodeficiency Virus (HIV), which is the virus that has been associated with Acquired Immune Deficiency Syndrome (AIDS), Protective Life and Annuity may require a separate authorization. I (we) hereby authorize Protective Life and Annuity:

a. to obtain and use the results of any HIV tests that I (we) separately authorize.
b. (if permitted by law) to disclose the results of any tests to its reinsurers and **MIB**.

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, whichever period is shorter, or, in the event of a claim for benefits, for the duration of such claim.
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 and Annuity 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 and Annuity'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) authorize the preparation of an investigative consumer report and 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

____________________	X____________________	____________________
If Minor, Print Name	Parent or Legal Guardian (Signature)	Print Name of Parent or Legal Guardian

PROTECTIVE LIFE AND ANNUITY 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 and Annuity may receive from doctors and hospitals who have attended you.

Information regarding your insurability will be treated as confidential. Protective Life and Annuity, 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 and Annuity, 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 and Annuity, 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 and Annuity 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

PROTECTIVE LIFE AND ANNUITY INSURANCE COMPANY

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

BROKER / REPRESENTATIVE REPORT

		Yes	No
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. ☐ English ☐ Spanish ☐ Other* **List Other Language* : ______		
2.	Is the Proposed Insured a relative or does the Proposed Insured have a business relationship with you? *If Yes, Details:* ______	☐	☐
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? *If No, Explain:* ______	☐	☐
	Answer questions (c) and (d) ***only*** if this is a replacement: (c) Did you use any pre-printed company approved sales materials? *If Yes, List Name or Form Number:* ______	☐	☐
	(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.)*	☐	☐
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? *If Yes, please explain in Special Requests/Remarks below.*	☐	☐
5.	Has a mortality analysis or life expectancy analysis been performed on the Proposed Insured?	☐	☐
6.	Has a medical examination been ordered? *If Yes, Name of Examiner:* ______ *Date of Exam:* ______	☐	☐
7.	Is Premium Financing involved in this case? (If Yes, please submit a cover letter describing the parameters.)	☐	☐
	I have verified the identity of the Owner by picture I.D. (*Authorized Representative if Business or Trustee if Trust)* *Identification Type:* ______ *Driver's License Number:* ______ 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	☐	☐

I certify that:

a) both the Proposed Insured(s) and the Owner(s) read, speak and understand either the English or Spanish language; and
b) each has explicitly told me that they understood each question and item contained in this application; and
c) the answers given in this application are complete and true to the best of my knowledge and belief; and
d) I know of nothing affecting the risk which is not set forth in my representative's report or this life insurance application; and
e) 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: