PROTECTIVE LIFE INSURANCE COMPANY
P.O. Box 830619
Birmingham, AL 35283-0619

INDIVIDUAL LIFE INSURANCE - APPLICATION FOR CONVERSION OR EXCHANGE

1. PROPOSED INSURED 1

Name: (First, Middle, Last)			
Gender	*Birthdate*	*Birth State*	*Marital Status*
Driver's License No. & State		*SSN / Tax ID*	
Home Phone	*Work Phone*		*Cell Phone*
Address (Street, City, State, Zip Code & Number of Years)			
Email Address			

2. PROPOSED INSURED 2 (Survivor Plans Only)

Name: (First, Middle, Last)			
Gender	*Birthdate*	*Birth State*	*Marital Status*
Driver's License No. & State		*SSN / Tax ID*	
Home Phone	*Work Phone*		*Cell Phone*
Address (Street, City, State, Zip Code & Number of Years)			
Email Address			

3. OWNER *(If other than Proposed Insured, must complete information below. If Trust, include Name and Date of Trust.)*

Name	*Date of Trust*	*Phone Number*	*SSN/Tax ID*
Address (Street, City, State, Zip Code)		*Email Address*	

BENEFICIARY DESIGNATIONS

1. PRIMARY BENEFICIARY(IES)

Name, Address, Phone Number	*SSN / Tax ID*	*Birthdate(s)*	*Relationship(s)*	*Percentage(s)*

2. CONTINGENT BENEFICIARY(IES)

Name, Address, Phone Number	*SSN / Tax ID*	*Birthdate(s)*	*Relationship(s)*	*Percentage(s)*

PLAN OF INSURANCE

Plan of Insurance: (Name of Product)	*Face Amount: (Proposed Insured 1)* $	*(Proposed Insured 2)* $

If Universal Life: ☐ *Level Face Amount* ☐ *Increasing Face Amount*	*Section 1035:* ☐ *Yes* ☐ *No*	*1035 Loan Transfer: (subject to product availability)* ☐ *Yes* ☐ *No*

Premium Payment:			☐ *Carry over from existing Bank Account*
☐ *Annual* $	☐ *Quarterly* $	☐ *Semi-Annual* $	☐ *Monthly (Pre-Authorized Withdrawal Only)* $
☐ *Cash with Application* $			☐ *Draft Initial Premium* $

POLICY CONVERSION

Existing Policy Number:	*Remove the Children's Term Rider:* ☐ Yes ☐ No (*if applicable and subject to policy contracted provisions*)
Are you converting the: ☐ *Base Plan* ☐ *Rider* *(subject to policy contracted provisions)*	*If this is a partial conversion, is the balance of the base plan being:* ☐ *Cancelled* ☐ *Kept $ _____* *(subject to product availability and face amount minimums)*

REPLACEMENT INFORMATION

Is the policy applied for to replace an existing insurance or annuity policy(ies) with this or any other company? ☐ Yes ☐ No

If Yes, list all life insurance in force on all persons proposed for insurance.

Name of Insured 1		*Company*	*Policy Number*
Replace or Change?	*Amount*	*Purpose: Business / Personal*	*Issue Date*
Name of Insured 2		*Company*	*Policy Number*
Replace or Change?	*Amount*	*Purpose: Business / Personal*	*Issue Date*

DECLARATIONS

A) No Agent can make, alter or discharge any contract, accept risks, or waive the Company's rights or requirements.
B) Acceptance of a policy by the Owner shall constitute ratification of any changes made by the Company under "Home Office Endorsements." In those states where it is required, changes as to plan, amount, age at issue, classification or benefits will be made only with the Owner's written consent.

Any person who knowingly with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties according to state law.

Remarks:

HOME OFFICE ENDORSEMENTS (NOT TO BE USED WHERE PROHIBITED BY STATUTE OR INSURANCE DEPARTMENT RULING.)

Signed at (City and State)	Date
Signature of Proposed Insured 1	Signature of Proposed Insured 2
Signature of Owner (if other than insured)	Signature of Witness
Agent's Name (Printed)	Agent's Signature
Agent's Contract Number	Agent's Email Address

PROTECTIVE LIFE INSURANCE COMPANY
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BIRMINGHAM, ALABAMA 35283-0619

SUMMARY DISCLOSURE STATEMENT for TERMINAL ILLNESS ACCELERATED DEATH BENEFIT

Protective Life Insurance Company:
"We, us, our".

Accelerated Death Benefit (the "Benefit"):
Subject to the terms of this Benefit, we will pay a portion of the death benefit upon receiving proof that the insured is terminally ill. An accelerated death benefit can only be paid one time. The Benefit is not intended as long-term care insurance.

Consequences of Receiving Accelerated Death Benefit:
The Benefit is intended to qualify for favorable tax treatment under Section 101g of the Internal Revenue Code. **The receipt of an accelerated death benefit may be considered a taxable event under the Internal Revenue Code. The receipt of an accelerated death benefit may also affect eligibility to receive, or continue to receive Medicaid benefits, or other state or federal government benefits and entitlements**. Before you elect to receive any accelerated benefits, you should consult with your tax advisor.

Amount You May Elect:
You may elect the amount of the accelerated death benefit to be paid. The limits are outlined in the Benefit but are generally limited to the lesser of 60% of the death benefit of the policy or $1,000,000. We will charge an administrative fee of not more than $300, deducted from any payment made. Upon request to accelerate the death benefit and upon payment of the Benefit, you and any irrevocable beneficiary will be provided a statement demonstrating the effect of the accelerated death benefit.

When Eligible for Payment of Benefit:
You are entitled to receive the accelerated death benefit when we have determined that the insured is terminally ill and has a life expectancy of 6 months or less.

Notice and Proof of Qualifying Event:
We will require proof that the insured is terminally ill. The diagnosis must be made by a physician as defined in the Benefit. Any diagnosis must be the result of clinical, radiological, histological, or laboratory evidence of the terminal illness. We may require a second medical opinion by a physician of our choice at our expense. If there is a conflict of opinion, a determination will be made by a third Physician who is acceptable by both us and the Insured.

Effect of an Accelerated Death Benefit:
When you elect to receive an accelerated death benefit, it will be treated as a lien against your policy. We will charge you interest on the accelerated death benefit paid to you. Interest on the lien is due on each Policy anniversary date. The Accelerated Death Benefit does not have an effect on the Premium and/or Cost of Insurance Charges of the base policy.

The maximum lien interest rate we may charge you is the greater of:

1. The policy loan interest rate stated in the Policy or 8% if a policy loan interest rate is not stated in the Policy; or

2. the current 90 day U.S. Treasury Bill rate in effect on the date that the accelerated death benefit is paid.

Interest accruing on the portion of the lien which is equal in amount to the Policy Value of the Policy, if applicable, on the Accelerated Death Benefit payment date shall be no more than the policy loan interest rate stated in the Policy.

The death benefit will be reduced by the amount of the lien. Your access to the cash surrender value of your policy, if any, will be limited to the excess of the cash surrender value over the lien.

Any irrevocable beneficiaries or assignees must send us a written consent to the accelerated death benefit payment. The written request must be in a form satisfactory to us.

Premiums: There are no premiums for this benefit, however, you will need to continue to pay any premium payments due under the Policy if the death benefit is accelerated.

Acknowledgement: I acknowledge that I have received and read the Summary and Disclosure Statement for Accelerated Death Benefit which was furnished to me prior to signing the application.

_____

Proposed Insured Signature

_____

Proposed Insured City State Date

_____

Owner Signature (If Owner is other than the Proposed Insured)

_____

Owner City State Date

_____

Joint Owner Signature (If applicable)

_____

Joint Owner City State Date

_____

Signature of Agent/Broker

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Acknowledgement: I acknowledge that I have received and read the Summary and Disclosure Statement for Accelerated Death Benefit which was furnished to me prior to signing the application.

_____

Proposed Insured Signature

_____

Proposed Insured City State Date

_____

Owner Signature (If Owner is other than the Proposed Insured)

_____

Owner City State Date

_____

Joint Owner Signature (If applicable)

_____

Joint Owner City State Date

_____

Signature of Agent/Broker

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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.

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 and is subject to the applicable Fraud Statement as provided in the Application for Life Insurance.

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

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

X _____ SIGN HERE

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

X _____ SIGN HERE

Signature of Witness: X _____ SIGN HERE

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

X _____ SIGN HERE _____
Producer Signature Producer Name (Print)

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LIFE INSURANCE ILLUSTRATION CERTIFICATION & ACKNOWLEDGEMENT

- **This certification must be submitted with the Application for Life Insurance if a signed illustration is not submitted for one of the reasons set forth below.**
- **This form must be signed on or before the application signed date in restricted states.**

1. PROPOSED INSURED *(please print)*

First, Middle, Last Name: _____

Social Security Number: _____ Date of Birth *(mm/dd/yyyy)*: _____

2. OWNER *(if other than Proposed Insured)*

First, Middle, Last Name: _____

3. AGENT/REPRESENTATIVE *(please print)*

First, Middle, Last Name: _____

Agent/Representative Number: _____ BGA Name *(if applicable)*: _____

4. ELECTRONIC ILLUSTRATION DATA – Complete this section if an electronic illustration is presented and no corresponding printed copy is provided.

Gender Class:_____ Initial Death Benefit: _____

Date of Birth *(mm/dd/yyyy)*: _____ Premium Amount Illustrated: _____

Underwriting Class: _____ Premium Mode: _____

Plan Type: _____ Number of Policy Years Illustrated: _____

Product Name: _____ Guaranteed Interest Rate: _____%

Policy Form Number: _____ Non-Guaranteed Illustrated Interest Rate: _____%

Rider(s): _____ Alternate Indexed Interest Rate: _____%
(for Indexed Products)

I, the Applicant, hereby acknowledge that *(check only one)*:

☐ No policy illustration was provided to me and I understand that a policy illustration conforming to the policy as issued will be provided no later than the time the policy is delivered.

☐ The policy applied for is different than the policy illustration shown to me, and I understand that a policy illustration conforming to the policy as issued will be provided no later than at the time the policy is delivered.

☐ I viewed a complete electronic illustration which was based on the personal and policy information shown on this form and I understand that a policy illustration conforming to the policy as issued will be provided no later than at the time the policy is delivered. No corresponding printed copy was provided.

Applicant Signature: X_____ Date: _____

I, the Agent/Representative, hereby certify that *(check only one)*:

☐ No illustration was used in the sale of the life insurance applied for.

☐ The life insurance applied for is other than as shown in the policy illustration.

☐ I displayed a complete electronic illustration to the proposed insured that was based on the personal and policy information shown on this form. I further certify that the policy illustration complies with applicable state requirements and that no corresponding printed copy was provided.

Agent/Representative Signature: X_____ Date: _____

A SIGNED COPY MUST BE PROVIDED TO THE APPLICANT AND TO THE COMPANY
See Page 2 for State Specific Disclosures

REQUIRED CALIFORNIA DISCLOSURE – For Universal Life Policies with No-Lapse Guarantees

This policy is guaranteed to stay in force for a specified number of years as long as you meet the requirements of the Policy, including the Minimum Monthly Premium provision found in the policy contract. This provision is also known as a no-lapse guarantee, and a general description of the provision is included in the Narrative Summary section of the Basic Illustration.

While this policy provides a no-lapse guarantee, it may provide nonforfeiture benefits, such as cash surrender values, which are less than those that would be provided if the guarantee were issued as a separate policy, such as a term policy. If a separate term policy has higher nonforfeiture benefits, the premiums for the separate policy might be higher than the premiums for the no-lapse guarantee provided in this policy. Therefore, when considering the purchase of this policy, you should compare the value of higher nonforfeiture benefits, such as cash surrender values, versus the premiums required to keep your insurance coverage in force.

REQUIRED SOUTH CAROLINA DISCLOSURE – For Universal Life Policies with No-Lapse Guarantees

If there is no policy debt or partial surrenders, this policy is guaranteed to stay in force during the no lapse period as long as you have paid the required minimum premiums. This guarantee could be provided by a separate policy (such as a term policy). However, the nonforfeiture benefits (such as cash surrender value) in this policy may be significantly less valuable than those provided by the separate policy. So, if you fail to pay a premium within a specified period of time from its due date or otherwise cause this policy to terminate early, the benefits paid to you upon termination could be much less than would customarily be paid if provided by the separate policy.

When thinking about purchasing this policy, you should consider the tradeoff you may be making between having significantly smaller nonforfeiture benefits (such as a cash surrender value) available to you upon surrender of the policy versus the reduction in premium, if any, you may receive for not having these benefits.