Protective

Protective Life Insurance Company
P.O. Box 830619
Birmingham, AL 35283-0619

SUPPLEMENTAL UNDERWRITING APPLICATION

PROPOSED INSURED:

First Name	M.I.	Last Name	Date of Birth:

Important! For ALL QUESTIONS ANSWERED YES, please provide details including: Name of physician, date diagnosed, medications, and current condition. If additional space is needed, please use the Continuation of Information form.

	Yes	No
1. **Has the Proposed Insured been diagnosed with or been treated within the past 10 years for:**		
a) Alzheimer's disease or dementia, memory loss, Mild Cognitive Impairment (MCI), or organic brain syndrome?	☐	☐
DETAILS: _____		
b) Systematic Lupus Erythematosis, Polymyositis, Dermatomyositis, Scleroderma, Progressive Systemic Sclerosis, CREST syndrome, mixed connective tissue disease, undifferentiated connective tissue disease, rheumatic or psoriatic arthritis, celiac disease, ulcerative colitis, Crohn's disease, Ankylosing spondylitis?	☐	☐
DETAILS: _____		
c) Seizures, fainting spells, Parkinson's disease, tremor, ALS (Lou Gehrig's Disease), Multiple Sclerosis, Aphasia, stroke, tumor or growth, transient ischemic attack (TIA), or Huntington's Disease?	☐	☐
DETAILS: _____		
d) Any history of fractures or falls?	☐	☐
DETAILS: _____		

2. **Has the Proposed Insured been:**		
a) Declined, refused, rated or turned down for life insurance, long-term care insurance, medical or disability insurance?	☐	☐
DETAILS: _____		
b) Required to have home care, nursing home care, or adult care for any reason within the past 12 months?	☐	☐
DETAILS: _____		
c) Advised to enter, planning to reside in, or currently residing in a nursing home, assisted care living facility, or other custodial facility, or attending adult day care?	☐	☐
DETAILS: _____		

3. **Does the Proposed Insured:** **Yes** **No**

a) Use one of the following medical devices: walker; wheelchair; hospital bed; quad cane; oxygen; stair lift; or dialysis? (If Yes, provide type of device and date usage began) ☐ ☐

DETAILS: _____

b) Participate in any type of exercise program? (If Yes, provide type and frequency) ☐ ☐

DETAILS: _____

c) Drive a motor vehicle? (If Yes, provide the number of miles driven in the past 12 months. If No, what date did you last drive and why did you stop driving?) ☐ ☐

DETAILS: _____

d) Manage finances, including paying bills, writing checks and balancing the check book? (If No, identify what activities require assistance, who provides it and why it is needed.) ☐ ☐

DETAILS: _____

e) Perform regular household tasks including cooking, cleaning, laundry, shopping, yard work? (If No, identify what activities require assistance, who provides it and why it is needed.) ☐ ☐

DETAILS: _____

f) Live alone? (If No, who do you live with?) ☐ ☐

DETAILS: _____

4. **Does ANYONE help the Proposed Insured** with getting around inside the home, getting into and out of bed or a chair, bathing, dressing, toileting or eating? (If Yes, identify the helper and give details of help required) ☐ ☐

DETAILS: _____

5. T**he Proposed Insured:**

a) Is the Proposed Insured's activity limited by shortness of breath, debility, gait/ambulation disturbance or pain? ☐ ☐

DETAILS: _____

b) How far can the Proposed Insured walk comfortably without the issue(s) in 5a causing him or her to stop?

DETAILS: _____

6. **Additional details or comments:**

The above statements and answers are true and complete to the best of my knowledge and belief.

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

Signed at (City/State): _____ **Date:** _____

Examiner as Witness: _____ **Proposed Insured:** _____