

PROTECTIVE LIFE INSURANCE COMPANY

P.O. Box 830619

Birmingham, AL 35283-0619

INDIVIDUAL LIFE INSURANCE APPLICATION FOR REINSTATEMENT

SECTION I – Policy and Insured Information

Policy Number:

1. INSURED(S)

<i>Insured 1 Name: (First, Middle, Last)</i>		<i>Gender</i>	<i>Birthdate</i>	<i>Birth State</i>
<i>Marital Status</i>	<i>Driver's License No. & State</i>		<i>Social Security No./Tax ID No.</i>	
<i>Home Phone Number</i>	<i>Work Phone Number</i>		<i>Cell Phone Number</i>	
<i>Address: (Street, City, State, Zip Code)</i>		<i>Years at Residence</i>	<i>Email Address</i>	

<i>Insured 2 Name: (First, Middle, Last)</i>		<i>Phone Number</i>
<i>Relationship to Insured</i>	<i>Social Security No./Tax ID No.</i>	<i>Email Address</i>
<i>Address: (Street, City, State, Zip Code)</i>		

2. EMPLOYMENT

<i>Insured 1 Employer's Name</i>		<i>Occupation/Duties</i>
<i>Annual Income</i>	<i>Household Income</i>	<i>Net Worth</i>
<i>If unemployed, provide details:</i>		

<i>Insured 2 Employer's Name</i>		<i>Occupation/Duties</i>
<i>Annual Income</i>	<i>Household Income</i>	<i>Net Worth</i>
<i>If unemployed, provide details:</i>		

3. OWNER (If other than Insured)

<i>Name</i>		<i>Birthdate</i>
<i>Relationship to Insured</i>	<i>SSN/Tax ID</i>	<i>Phone Number</i>
<i>Address: (Street, City, State, Zip Code)</i>		<i>Email Address</i>

SECTION II – Non-Medical History

HAS THE INSURED: (Must be answered for all Insureds.)			Insured 1		Insured 2				
			Yes	No	Yes	No			
1. Used tobacco or nicotine of any kind over the last 5 years?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
<table border="0" style="width:100%"> <tr> <td style="width:33%">Type _____</td> <td style="width:33%">Frequency _____</td> <td style="width:33%">Date Last Used _____</td> </tr> </table>			Type _____	Frequency _____	Date Last Used _____				
Type _____	Frequency _____	Date Last Used _____							
2. Consulted a physician or had treatment for the use or possession of:									
A. Alcohol?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
B. Narcotics, stimulants, sedatives, hallucinogenic drugs?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
3. In the past 5 years, been convicted of (i) two or more moving violations, (ii) driving under the influence of alcohol or other drugs, or (iii) had their driver's license suspended or revoked?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
4. Have any insureds ever been convicted of, or pled guilty or no contest to a felony, or do they have any such charge pending against them?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
5. Flown as a pilot, student pilot or crew member, or intend to fly as such? If Yes, complete the Aviation Questionnaire.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
6. Been a member of, or applied to be a member of, or received a notice of required service in, the armed forces, reserves or National Guard? <i>If Yes, please list: branch of service, rank, duties, mobilization category and current duty station.</i>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			

7. Engaged in any of the following activities in the past 2 years? If Yes, complete the appropriate questionnaire. <input type="checkbox"/> Racing <input type="checkbox"/> Scuba Diving <input type="checkbox"/> Hang Gliding <input type="checkbox"/> Mountain Climbing <input type="checkbox"/> Sky Diving <input type="checkbox"/> Parachuting			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
8. Is/Are the Insured(s):									
a) A citizen of any country other than the United States or Canada? (If Yes, provide country of citizenship, visa type and expiration date, and length of U.S. Residency.) _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
b) Have you traveled or resided outside of the United States in the past 2 years? (If Yes, provide details.) _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
c) Intending to travel or reside outside the United States or Canada within the next 12 months?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			

To Where When Why For How Long									
	Question #	Details to any Yes answers to non-medical history questions 1-8. (Must be answered if applicable.)							
Insured 1									
Insured 2									

SECTION III – Medical Declarations

1.		Height	Weight	Gain or Loss and number of pounds in past year	Currently pregnant?	If Pregnant, what is the anticipated delivery date?
	Insured 1			<input type="checkbox"/> Gain <input type="checkbox"/> Loss _____lbs	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Insured 2			<input type="checkbox"/> Gain <input type="checkbox"/> Loss _____lbs	<input type="checkbox"/> Yes <input type="checkbox"/> No	

2.	Has any insured person 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.)	Insured 1	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 the 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 in questions (a) – (m) above.

	Question Number	Date of Diagnosis	Diagnosis, Medication or Treatment Prescribed	Medical Professional or Facility
Insured 1				
Insured 2				

3.	Has any insured person 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.)				Insured 1 Yes No		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) Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS).....				<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				
Insured 1								
Insured 2								

4.	Has any insured person ever: (Circle conditions to which Yes answer applies and give details below.)				Insured 1 Yes No		Insured 2 Yes No	
	(a) Used narcotics, barbiturates, amphetamines, hallucinogens, marijuana, heroin, cocaine, or other habit forming drugs, except as prescribed by a physician.....				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	(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.....				<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				
Insured 1								
Insured 2								

5.	The following questions 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.				Insured 1 Yes No		Insured 2 Yes No	
	Within the past five (5) years, has any insured person: (Circle items or conditions to which Yes answer applies and give details below.)							
	(a) Been treated, examined or advised by a 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 member of the medical profession to get any specified medical care, hospitalization, surgery or diagnostic test, which has not been completed.....				<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: 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, disability or impaired condition.....				<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				
Insured 1								
Insured 2								

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

7.	For the following Family Medical History question, please provide details 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.				Insured 1		Insured 2	
					Yes	No	Yes	No
	Has any insured person 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"/>
Please provide details for any/all Yes responses.								
	Family Member	Age at Diagnosis	Diagnosis	Date Last Treated	Age – if still alive and if not alive, age, date, and cause of death.			
Insured 1								
Insured 2								

SECTION IV – Supplement to Life Insurance Application

The statements and answers to the questions listed below shall become a part of the application; shall be subject to the terms of the application; and shall become a part of any policy based on this application.

	Insured 1		Insured 2	
	Yes	No	Yes	No
<p>(1) For any policy to be issued as a result of this application, will any portion of the initial or future premiums be paid by anyone other than the Insured, his or her family, or employer? If Yes, complete the "Statement of Owner Intent" (Application Supplement – Part II) and the "Premium Financing Disclosure and Acknowledgement" form.</p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<p>(2) Will anyone other than persons with a familial or employment relationship with the Proposed Insured obtain any right, title or interest in any policy, or in any trust which is to own the policy, issued on the life of the Insured(s) as a result of this application? If Yes, complete the "Statement of Owner Intent" (Application Supplement – Part II) and the "Trust Certification" (Application Supplement – Part III.)</p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<p>(3) Is the issue age of any Insured 65 or older AND is the 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.)</p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SECTION V - Signatures

No insurance shall take effect unless: (1) the reinstatement is issued on this application and delivered to and accepted by the Owner; (2) the first premium for the reinstatement is paid in full while the insured is alive; and (3) there has been no change in health and insurability from that described in this application.

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

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.

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

Signature of Insured 1

Signature of Insured 2

Signature of Parent or Guardian

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

Signature of Witness

PROTECTIVE LIFE INSURANCE COMPANY

P.O. Box 830619

Birmingham, AL 35283-0619

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

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.

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

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:

- 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, drug use, alcohol use, nicotine or 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, 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. **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, but are not limited to:

- a. tests for cholesterol and related blood lipids, diabetes, liver or kidney disorders, immune disorders (other than HIV/AIDS, see **SPECIAL REQUIREMENT FOR HIV/AIDS TESTING** section).
- 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 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:

- a. to its affiliates, its reinsurers, persons or organizations providing services relating to insurance underwriting for Protective Life, **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 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.
- d. to the Life Insurance Representative(s) and its staff, affiliated companies and/or entities, insurance companies and their reinsurers representing me on my (our) application for life insurance.

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

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:

- a. to its reinsurers, to make a brief report of my personal health information to MIB.

SPECIAL REQUIREMENT FOR HIV/AIDS TESTING

If Protective Life 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 may require a separate authorization. I (we) hereby authorize Protective Life:

- 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 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 redisclosure 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**.)

SIGNATURES

Date of Authorization: _____

List Health Care Providers

Proposed Insured 1 (Signature) Print Name of Proposed Insured 1 Birthdate Social Security #

Proposed Insured 2 (Signature) Print Name of Proposed Insured 2 Birthdate Social Security #

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

PROTECTIVE LIFE INSURANCE COMPANY

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HUMAN IMMUNODEFICIENCY VIRUS (HIV) ANTIBODY TEST

IMPORTANT HEALTH INFORMATION BOOKLET with Consent Form

Q: What is an HIV Test?

A: Human Immunodeficiency Virus (HIV) is the virus that causes Acquired Immunodeficiency Syndrome (AIDS).

Laboratory tests tell whether you have been infected with HIV. A test is not considered positive unless a different, backup test is done and also reads positive. These tests are conducted on a single sample of your blood or on an oral sample from your mouth or on a urine sample. Test results may, on rare occasions, be inconclusive, and this possibility should be discussed with your health professional.

Q: Will the HIV test tell me if I have AIDS?

A: No. A positive test means you have become infected with the virus. While some people infected with the virus have gone on to develop AIDS, others have not yet developed AIDS. Healthy lifestyle and behavior changes, improved diet, and, most importantly, early medical treatment may help you delay, or avoid, the development of AIDS.

Q: How long after exposure does it take to tell if I am infected?

A: Most people will test positive within three months after exposure. The average time is less than one month. However, a few people have taken up to six months or even one year to test positive.

Q: How does a person become infected with HIV?

A: The virus is most commonly spread through sexual contact (vaginal, anal, or oral sex) and by sharing needles or works to shoot injectable drugs. An infected mother may infect her baby during pregnancy, at the time of birth, or while breast feeding. Very rarely, contact with blood through open cuts or wounds, or splashes to the eyes, may also spread the virus. **You cannot get infected with the virus by donating or giving blood, or through casual contact.**

Q: Do I have to have this test?

A: Generally, getting tested is your decision. In Michigan, testing is required if you are a potential organ, semen, tissue, or blood donor; a military recruit; an immigrant; or if you have been charged and bound over, or convicted of certain crimes in a court of law. In addition, some health care facilities may have an admission requirement that you consent to be tested if a health care worker is accidentally exposed to your blood during your stay in their facility.

An insurance company has the right to request that you take an HIV test if you apply for new health or life insurance. If you refuse or if you test positive, as with any other potentially serious health condition, you will probably be turned down for this new insurance.

Q: Who should consider having the HIV test?

A: The Michigan Department of Community Health recommends that HIV testing be considered by anyone who meets any of the following:

- People who have had a sexually transmitted disease (venereal disease).
- People who have shared needles or who have a history of drug abuse.
- Men who have had sex with other men.
- Men or women who have had unprotected sex with anyone whose HIV status is unknown. (Unprotected sex means there has been an exchange of semen or vaginal secretions between the partners.)
- People who have had more than one sex partner.
- People who have had sex with prostitutes (male or female).
- People who received blood products or blood transfusions between 1978 and 1985.
- People who exchange sex for drugs or money.
- People who are infected with tuberculosis.
- People who have had exposure to the blood of someone who may be infected.
- People who have had sex with any person from the above list, particularly with injecting drug users.
- Women who are pregnant or who are considering pregnancy.
- Women who are diagnosed with invasive cervical cancer.

Q: Where can I have the test done without my name being used?

A: All local health departments and other testing centers designated by the Michigan Department of Community Health will provide the option to you to be tested with your name (confidential testing) or without your name (anonymous testing). Any person giving you this test is required by law to keep your test results confidential, with a few exceptions specified by law. If you request testing without your name, these facilities have trained counselors who will counsel you on an anonymous basis.

If anonymous testing is done and you have a positive test, you need to know that health care and treatment are not provided on an anonymous basis.

Q: Who will know the results of my tests?

A: Any person giving you this test is required by law to keep your test results confidential. Even the courts must follow specific rules before they can require disclosure through a court order. A subpoena is not sufficient to require disclosure; you will be asked to sign a separate release form. If this information needs to be released beyond the requirements of the law, you will be asked to sign a separate release form.

In Michigan, positive test results are reportable to the state and local health departments. The health department will maintain your confidentiality and use this information to understand the extent of infection in Michigan's communities. This information may also be used by your health provider or local health department as needed to properly diagnose and care for you and protect your health, to assist you in notifying your sexual or needle sharing partners, and to prevent spread of the virus. The test results, if positive, will also be given to a potential spouse if you are planning to get married. If you are a health care worker, you should be aware of state guidelines regarding infected health care workers.

If you are tested in a physician's private practice office, or in the office of a physician affiliated with or under contract with a Health Maintenance Organization, you may request that your name, address, and phone number not be included in the HIV-positive report to your local health department. It is against the law in Michigan for local health departments to keep lists of names of infected people.

Michigan law now requires that, if you are infected, your physician or the local health officer must warn (notify) all of your known sexual or needle-sharing partners of the fact that they have been exposed. In doing this, they are required to keep your identity confidential.

Q: Are there any risks involved in having the test done?

A: There are three ways you can be tested for HIV. They are by drawing a sample of blood, taking an oral sample from your mouth, or testing your urine. There are virtually no medical risks in drawing a small sample of blood. Only sterile needles and syringes are used for this purpose. Once the needle or syringe is used, it is safely thrown away, or properly sterilized. If an oral sample from the mouth is used for the test, a specially-treated pad is placed between the lower cheek and gum and held for two minutes. This causes no risk or pain. The urine test requires only a urine sample.

Before you are tested, you should carefully think about to whom you would tell the results, and what emotional support systems are available to you. The Michigan Civil Rights Commission has ruled that AIDS, HIV infection, and the suspicion of AIDS or HIV infection are considered handicapping conditions. Therefore, people are not to be discriminated against, and have all the rights of a handicapped person as defined under the Michigan Persons with Disabilities Civil Rights Act, P.A. 220 of 1976 (formerly, Michigan Handicappers' Civil Rights Act). Federal laws make similar rulings through the federal Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990. The Americans with Disabilities Act of 1990 strictly forbids discrimination against persons with HIV or AIDS.

Q: What will happen to the consent form after I sign it?

A: If you decide to be tested, you will be asked to sign a consent form. If you test anonymously, you can sign using a number or a fake name. Procedures for filing the consent form will vary from facility to facility. Please ask your health professional if you would like to know what their confidentiality procedure is.

Q: Can I change my mind after I sign the consent form?

A: Yes, you can change your mind at any time before the laboratory performs the test. If you change your mind, you will have to provide a written request to the person or organization providing you with this information booklet.

Q: How will this test help me?

A: If you are tested, you most likely will be required to appear in person to get your test results. Whether your results are positive or negative, your overall health may be helped from discussions with your health professional.

If you test negative, the test indicates either that you are not infected, or possibly, that you were infected very recently (within the past 3-6 months). You can learn through counseling how to protect yourself from infection in the future. If you have recently practiced risky behavior, you may want to be retested.

If you test positive, the test indicates that you have been infected with HIV. You can still take action to benefit your health and **reduce the chance of infecting others**. This includes maintaining a good state of physical and mental health. By doing so, you may delay the development of AIDS. It is suggested that you:

- Seek medical treatment immediately. Many drugs are now available for treatment of persons infected with HIV even if symptoms are not present. Early treatment is usually beneficial to many people with HIV.
- Receive all recommended vaccines. Discuss with your physician which vaccines are recommended and which should be avoided.
- Maintain good nutrition, exercise and get adequate rest.
- Receive emotional support and work on managing stress.
- Eliminate recreational drugs, or at least reduce alcohol and smoking.
- Stop injecting drugs. If you continue to inject, stop sharing equipment, and use a new syringe and needle each time. At the very least, you should learn to clean your needles or works with full-strength bleach and water.
- Don't have vaginal, anal, oral or other sexual contact that exposes others to your semen, vaginal secretions or blood. Avoid exposing others and getting sexually-transmitted diseases (through abstinence or by always using latex or polyurethane condoms or barriers).

- Inform all known sexual or needle-sharing partners, including any new partners, about your infection.
- Do not donate blood or organs (change designation on driver's license).
- Seek counseling regarding becoming pregnant or fathering a child.
- If you are pregnant and planning to continue that pregnancy, discuss with your physician treatments that may protect your baby.

Q: Whom should I tell if I am HIV-positive?

A: If you test positive, you need to know that this infection is not passed to another person through casual contact. Michigan law requires that you must notify any new sexual partner prior to having sex with them. Past sexual and needle-sharing partners are to be notified so that they can also be counseled and offered testing. If requested, your local health department will provide you assistance in notifying partners.

Inform all health care providers, both medical and dental, who are providing you treatment, about your HIV infection. This will help them care for you.

The law prohibits health care providers from refusing to treat you based upon your HIV infection.

New guidelines indicate that HIV-infected pregnant women should undergo treatment for HIV disease. This treatment may reduce the risk of transmission to the newborn by 60-70%.

Finally, be careful about discussing your HIV status with others. Some people may not understand the nature of the infection or how it is actually spread. This may lead to misunderstanding and create problems for you with friends, co-workers, or others.

Q: What if I have more questions?

A: Please ask the health professional who gave you this booklet. Your health professional will have the answers to your questions or will get the answers for you.

You should feel free to call the statewide AIDS information hotline (1-800-872-AIDS; Spanish 1-800-862-SIDA; TDD 1-800-332-0849) or your local health department at any time, if you have questions or need help.

PROTECTIVE LIFE INSURANCE COMPANY

P.O. Box 830619

Birmingham, AL 35283-0619

CONSENT FORM FOR THE HUMAN IMMUNODEFICIENCY VIRUS (HIV) ANTIBODY TEST

I have been informed that my blood, an oral sample from my mouth, or my urine will be tested for antibodies to the Human Immunodeficiency Virus (HIV), the virus that causes AIDS.

I acknowledge that I have been given an explanation of the test, including its uses, benefits, limitations, and the meaning of test results.

I have been informed that the HIV test results are confidential and shall not be released without my written permission, except to _____, * and as permitted under state law.

I understand that I have the right to have this test done without the use of my name. If my private physician does not provide anonymous testing, I understand I may obtain anonymous testing at a Michigan Department of Community Health-approved HIV counseling and testing site.

I understand that I have the right to withdraw my consent for the test at any time before the test is complete.

I acknowledge that I have been given a copy of the booklet *Important Health Information*. I have been given the opportunity to ask questions concerning the test for HIV antibodies, and I acknowledge that my questions have been answered to my satisfaction.

I authorize Protective Life Insurance Company or its reinsurers to make a brief report of any personal health information to the MIB.

By my signature below, I consent to be tested for HIV.

Signature of Proposed Insured or Parent/Guardian

Date

Witness

Date

AT THIS TIME, I DO NOT WANT TO BE TESTED FOR THE HUMAN IMMUNODEFICIENCY VIRUS.

Signature of Proposed Insured or Parent/Guardian

Date

Witness

Date

*** Please write in the physician or health facility name who will receive the HIV test results.**

Name of Physician or Health Facility: _____

Address: _____

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PROTECTIVE LIFE INSURANCE COMPANY

P.O. Box 830619

Birmingham, AL 35283-0619

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Date

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Name of Physician or Health Facility: _____

Address: _____

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.