# 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)**

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

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

**2. EMPLOYMENT**

| *Insured 1 Employer's Name* | | *Occupation/Duties* |
|---|---|---|
| *Annual Income* | *Household Income* | *Net Worth* |
| *If unemployed, provide details:* | | |

| *Insured 2 Employer's Name* | | *Occupation/Duties* |
|---|---|---|
| *Annual Income* | *Household Income* | *Net Worth* |
| *If unemployed, provide details:* | | |

**3. OWNER (If other than Insured)**

| *Name* | | *Birthdate* |
|---|---|---|
| *Relationship to Insured* | *SSN/Tax ID* | *Phone Number* |
| *Address: (Street, City, State, Zip Code)* | | *Email Address* |

**SECTION II – Non-Medical History**

| HAS THE INSURED: *(Must be answered for all Insureds.)* | Insured 1 Yes | Insured 1 No | Insured 2 Yes | Insured 2 No |
|---|---|---|---|---|
| **1.** Used tobacco or nicotine of any kind over the last 5 years? | ☐ | ☐ | ☐ | ☐ |
| Type _____ Frequency _____ Date Last Used _____ | | | | |
| **2.** Consulted a physician or had treatment for the use or possession of: | | | | |
| A. Alcohol? | ☐ | ☐ | ☐ | ☐ |
| B. Narcotics, stimulants. sedatives, hallucinogenic drugs? | ☐ | ☐ | ☐ | ☐ |
| **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? | ☐ | ☐ | ☐ | ☐ |
| **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? | ☐ | ☐ | ☐ | ☐ |
| **5.** Flown as a pilot, student pilot or crew member, or intend to fly as such? If Yes, complete the Aviation Questionnaire. | ☐ | ☐ | ☐ | ☐ |
| **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? *If Yes, please list: branch of service, rank, duties, mobilization category and current duty station.* _____ _____ | ☐ | ☐ | ☐ | ☐ |
| **7.** Engaged in any of the following activities in the past 2 years? If Yes, complete the appropriate questionnaire. ☐ Racing ☐ Scuba Diving ☐ Hang Gliding ☐ Mountain Climbing ☐ Sky Diving ☐ Parachuting | ☐ | ☐ | ☐ | ☐ |
| **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.) _____ _____ | ☐ | ☐ | ☐ | ☐ |
| b) Have you traveled or resided outside of the United States in the past 2 years? (If Yes, provide details.) _____ | ☐ | ☐ | ☐ | ☐ |
| c) Intending to travel or reside outside the United States or Canada within the next 12 months? | ☐ | ☐ | ☐ | ☐ |
| 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** | | | ☐ Gain ☐ Loss | _____lbs | ☐ Yes ☐ No | |
| **Insured 2** | | | ☐ Gain ☐ Loss | _____lbs | ☐ Yes ☐ 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:<br>(**Circle** conditions to which **Yes** answer applies and give details below.) | **Insured 1** Yes | No | **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 the **eyes, ears, nose or throat**…….. | ☐ | ☐ | ☐ | ☐ |
| (h) Any disorder 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 **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**…… | ☐ | ☐ | ☐ | ☐ |
| (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 in questions (a) – (m) above.**

| | Question Number | Date of Diagnosis | Diagnosis, Medication or Treatment Prescribed | Medical Professional or Facility |
|---|---|---|---|---|
| **Insured 1** | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| **Insured 2** | | | | |
| | | | | |
| | | | | |
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**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 | Insured 1 No | Insured 2 Yes | Insured 2 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 |
|---|---|---|---|---|
| **Insured 1** | | | | |
| | | | | |
| **Insured 2** | | | | |
| | | | | |

**4.** Has any insured person ever:
(**Circle** conditions to which **Yes** answer applies and give details below.)

| | Insured 1 Yes | Insured 1 No | Insured 2 Yes | Insured 2 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 |
|---|---|---|---|---|
| **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.***
Within the past five (5) years, has any insured person:
(**Circle** items or conditions to which **Yes** answer applies and give details below.)

| | Insured 1 Yes | Insured 1 No | Insured 2 Yes | Insured 2 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 any specified medical care, hospitalization, surgery or diagnostic test, which has not been completed…… | ☐ | ☐ | ☐ | ☐ |
| (c) Been an inpatient or outpatient in a hospital, clinic, medical facility, or any similar entity…… | ☐ | ☐ | ☐ | ☐ |
| (d) Had any diagnostic tests: 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 |
|---|---|---|---|---|
| **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** Yes | **Insured 1** No | **Insured 2** Yes | **Insured 2** 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…… | ☐ | ☐ | ☐ | ☐ |

**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** | | | | | |
| | | | | | |
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**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 Yes | Insured 1 No | Insured 2 Yes | Insured 2 No |
|---|---|---|---|---|---|
| (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. | ☐ | ☐ | ☐ | ☐ |
| (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.) | ☐ | ☐ | ☐ | ☐ |
| (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.) | ☐ | ☐ | ☐ | ☐ |

**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 organization 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 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 is declined or if Protective Life 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 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 re-disclosure and no longer covered by certain federal rules governing privacy and confidentiality of health information. The information contained in these medical and financial records will be held in confidence and may be used only for the purpose of the procurement, or underwriting for the possible procurement or the evaluation of life, health, long term care, or other insurance products.
e. I (we) understand that my (our) personal information, including my (our) protected health information disclosed under this authorization will be incorporated into and made a part of any life and/or disability insurance policy(ies) issued by the Company and that the policy(ies) will be delivered to the policy owner.
f. *I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction. Any modifications to this authorization may preclude Protective Life's ability to process this application.*

## *AUTHORIZATIONS AND INVESTIGATIVE CONSUMER REPORT*

☐ I (we) have been given a copy of this **Authorization to Obtain and Disclose Information** along with the **Description of Information Practices**.

☐ I (we) would like to be interviewed if an investigative consumer report will be made. (Please refer to the **Description of Information Practices** for additional information regarding the interview for an **Investigative Consumer Report**.)

**THIS AUTHORIZATION <u>MUST</u> 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 INSURANCE COMPANY

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

## INFORMED CONSENT FORM FOR HIV TESTING

In order for us to evaluate your eligibility for insurance coverage, we request that you provide a blood or other bodily fluid sample for HIV testing and analysis. The test that will be performed will determine the presence of antibodies to the HIV virus. By signing and dating this form, you agree that the HIV antibody test may be performed on your blood or other bodily fluid sample and that underwriting decisions may be based on the test results. A positive test result will adversely affect your insurance application. It also may result in uninsurability for life, health, or disability insurance for which you may apply in the future.

**HUMAN IMMUNODEFICIENCY VIRUS (HIV)**

The HIV virus causes a life-threatening disorder of the immune system called Acquired Immune Deficiency Syndrome (AIDS). Antibodies to HIV are found in the blood and other bodily fluids of people who have been exposed to the virus. You do not have to have AIDS to have antibodies against HIV. The virus is spread by sexual contact with an infected person, by exposure to infected blood (as in needle sharing during intravenous drug use or, rarely, as a result of a blood transfusion), or from an infected mother to her new-born infant.

The HIV antibody test is actually a series of tests performed upon your blood or other bodily fluid sample by a medically accepted procedure which is extremely reliable. The testing will be performed by a licensed laboratory.

**PRE-TESTING CONSIDERATION:**

Many public health organizations have recommended that before taking an HIV virus antibody test a person seek counseling to become informed about the implications of such tests. You may wish to consider counseling, at your expense, prior to being tested.

**DISCLOSURE OF TEST RESULTS:**

All test results are confidential, except as provided by law. State law requires that the laboratory notify the Ohio Department of Health of positive test results.

The results of the test will be reported to the insurance company named on your application for insurance. The Insurer may not by law, release positive test results except as provided below:

- If your HIV antibody test result is normal (negative), you will not be notified. You will be notified of an abnormal (positive) test result if you indicate that you desire a positive result be made known to you. You may also identify another person to whom you want the positive results released.
- If you want a physician or other health care provider to be notified of an abnormal HIV antibody test result, you must indicate the name and address of that physician or provider.
- Abnormal test results may be disclosed to persons hired by the Insurer who participate in medical underwriting decisions of the Insurer. Abnormal test results may also be disclosed to affiliates of the Insurer who require the result for medical underwriting purposes.
- In addition, if your HIV antibody test is abnormal, a generic code signifying a nonspecific blood, oral fluid (saliva) or urine abnormality may be made known to the MIB, LLC (MIB). The MIB is an organization of life and health insurance companies which operates as an information exchange on behalf of its members. There will be no record with the MIB that you had a positive HIV antibody test; however, there will be a record at the MIB that you have some blood, oral fluid or urine abnormality. If you apply to another MIB member company for life or health insurance coverage, the MIB, upon request, will supply the information on you in its file to that member.

**TEST RESULTS:**

While a positive test result does not necessarily mean that you have AIDS, it does mean that you are at a greater risk of developing AIDS or AIDS-related conditions if you do not take appropriate medications. If you are infected with HIV, you are infectious to others. You should seek medical follow-up care with your personal health care provider.

HIV test results are highly reliable but not 100% accurate. If the test gives a positive result you should consider retesting in order to confirm the result. If the test gives a negative result, there is still a small possibility you may be infected with HIV. This is most likely to happen in recently infected persons. It takes at least 4 to 12 weeks for a positive test result to develop after a person is infected, and may take as long as 6 to 12 months.

**OTHER SOURCES OF INFORMATION:**
For more information about HIV or AIDS you may ask a doctor, a nurse, a counselor, or call the Ohio AIDS Hotline at 1-800-332-AIDS (2437). The hotline is a free call.

**CONSENT FOR HIV TESTING:**
I have read and I understand this HIV test informed consent form. I voluntarily consent to the withdrawal of blood or to the providing of another bodily fluid sample, the testing of my blood or other bodily fluid for HIV antibodies, and the disclosure of the test results a described above. I will be given a copy of this form. This consent is valid for ninety (90) days from the day of my signature below. The Insurer agrees to complete testing and provide the authorized notifications, as appropriate, within the 90 (ninety) day period. In addition, Protective Life Insurance Company or its reinsurers will make a brief report of any personal health information to the MIB.

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In the event of a positive test result:

☐ Send the result to me at:

Address: _____

☐ I authorize Protective Life Insurance Company to send the result to another person:

Name: _____

Address: _____

☐ I authorize Protective Life Insurance Company to send the result to the following physician or health care provider.

Physician's Name: _____

Address: _____

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**AUTHORIZATION:**

| | | |
|---|---|---|
| _____ | _____ | _____ |
| Name of Proposed Insured (Print) | Date | Signature of Proposed Insured |
| _____ | _____ | |
| Signature of Legal Guardian, if any | Date | |
| _____ | _____ | |
| Signature of Person Obtaining Consent | Date | |

# 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

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**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.