

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		Insured 2	
			Yes	No	Yes	No
1. Used tobacco or nicotine of any kind over the last 5 years? Type _____ Frequency _____ Date Last Used _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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? To Where _____ When _____ Why _____ For How Long _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	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
(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.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(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.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(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.)	<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

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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) Date
(if other than Proposed Insured)

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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 MUST BE SIGNED WITHOUT MODIFICATION AND RETURNED WITH THE APPLICATION BEFORE PROCESSING.

SIGNATURES

Date of Authorization: X _____

List Health Care Providers

X _____	_____	_____	_____
Proposed Insured 1 (Signature)	Print Name of Proposed Insured 1	Birthdate	Social Security Number

X _____	_____	_____	_____
Proposed Insured 2 (Signature)	Print Name of Proposed Insured 2	Birthdate	Social Security Number

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

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NOTICE AND CONSENT FOR HIV-RELATED TESTING

To evaluate your insurability, the Insurer named above, Protective Life Insurance Company, has requested that you provide a sample of your blood, oral fluid extracted from cheek and gum tissue, or urine, for testing and analysis to determine the presence of human immunodeficiency virus (HIV) antibodies. By signing and dating this form you agree that this test may be done and that underwriting decisions will be based on the test result. A series of three tests will be performed by a licensed laboratory through a medically accepted procedure.

Pre-Testing Considerations

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

Meaning of Positive Test Result

The test is not a test for AIDS. It is a test for antibodies to the HIV virus, the causative agents for AIDS, and shows whether you have been exposed to the virus. A positive test result does not mean that you have AIDS but that you are at significantly increased risk of developing problems with your immune system. The test for HIV antibodies is very sensitive. Errors are rare, but they do occur. Your private physician, a public health clinic, or an AIDS information organization in your city might provide you with further information on the medical implications of a positive test.

Positive HIV antibody test results will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged, or that other policy changes may be necessary.

Confidentiality of Test Results

All test results are required to be treated confidentially. They will be reported by the laboratory to the insurer. The test results may be disclosed as required by law or may be disclosed to employees of the insurer who have the responsibility to make underwriting decisions on behalf of the insurer or to outside legal counsel who needs such information to effectively represent the insurer in regard to your application. The test results may be disclosed to a reinsurer, if the reinsurer is involved in the underwriting process. A brief report of any personal health information and the test results may be released to an insurance medical information exchange under procedures that are designed to assure confidentiality, including the use of general codes that also cover results of tests for other diseases or conditions not related to AIDS, or for the preparation of statistical reports that do not disclose the identity of any particular person.

Notification of Test Result

If your test results are negative, no routine notification will be sent to you. If your test results are reported by the laboratory to the insurer as being positive, you will receive written notification of such results from a physician you have designated or, in the absence of such designation, from the Texas Department of Health. Because a trained person should deliver that information so that you can understand clearly what the test result means, please list your private physician so that the insurer can have him or her tell you the test result and explain its meaning.

Name of physician for reporting a possible positive test result: _____

Address: _____

In the event the test is positive and you are denied coverage because of that fact and you request the reason for the denial, the insurer may require you to name a physician at that time in order to receive the information.

If the test indicates a positive result, but you do not designate a private physician, the test results will be provided to you by a representative of the Texas Department of Health.

Consent

I have read and I understand this Notice and Consent for HIV-Related Testing. I voluntarily consent to the withdrawal of blood, oral fluid extracted from cheek and gum tissue, or urine from me, the testing of that sample, and the disclosure of the test results as described above. I have read the information on this form about what a test result means.

I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

Name of Proposed Insured

Signature of Proposed Insured or Parent/Guardian

Address

Date Signed

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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.