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

		POLICY C	HANGE	– WIT	H EVIDENCE			
CTION I – Policy and Insure	d Information		Policy	Numbe	r:			
INSURED(S)								
Insured 1 Name: (First, Mic	ddle, Last)					Gender	Birthdate	Birth State
Marital Status		Driver's Licens	se No. 8	State		Social Sec	urity No./Tax ID	No.
Home Phone Number		Work Phone N	lumber			Cell Phone	Number	
Address: (Street, City, State	te, Zip Code)			Years	at Residence	Email Addı	ress	
Insured 2 Name: (First, Mid	ddle, Last)					Phone Nui	mber	
Relationship to Insured		Social Security	y No./Ta	x ID N	0.	Email Addı	ress	
Address: (Street, City, State	te, Zip Code)							
EMPLOYMENT								
Insured 1 Employer's Nam	е				Occupation/Du	ıties		
Annual Income		Household Ind	come			Net Worth		
If unemployed, provide det	ails:							
Insured 2 Employer's Nam	е				Occupation/Du	ıties		
Annual Income		Household Inc	come			Net Worth		
If unemployed, provide det	tails:							
OWNER (If other than Ins	sured)							
Name						Birthdate		
Relationship to Insured		SSN/Tax ID				Phone Nui	mber	
Address: (Street, City, State	te, Zip Code)	1		Email Address				
CTION II – Type of Change	/ Action Being	Requested						
FACE AMOUNT INCREAS	SE – Plan selec	•			face amount rar			ıl. Um amount
☐ Increase Base Policy	\$		\$				\$	
☐ MORTALITY CLASS I	MPROVEMENT	ī	ı			L		

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3.

RATE REDUCTION

SECTION III – Non-Medical History

	HAS	THE INSURED:	(Must be ansi	vered for all Insureds.))				red 1 No	Insu Yes	red 2 No
1.	Used	tobacco or nico	tine of any kind	over the last 5 years?							
	Type			Frequency		Date Last Used	t				
2.	I	A. Alcohol?		nt for the use or posses tives, hallucinogenic dru							
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?						ence of				
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?						any such				
5.			ent pilot or crew Aviation Questio	member, or intend to fly nnaire.	y as such in the	next 2 years?					
6.	forces		ational Guard? I	member of, or received f Yes, please list: brancl				_	_	_	_
7.	□ Ra	•	a Diving 🗖 Ha	ties in the past 2 years?	•				_		_
				an the United States or and length of U.S. Reside							
	b)	Have you travel	ed or resided ou	tside of the United State	es in the past 2	years? (If Yes, provid	e details.)				
	c)	Intending to trav	el or reside out	side the United States or	r Canada within	the next 12 months?					
		To Where	When	Why		For How I	 _ong				
		Question #	Details to any	Yes answers to non-r	medical history	y questions 1-8. (M	ust be answe	red if a	applica	ble.)	
Insu	ired 1										
Inst	ıred 2										

SECTION IV – Medical Declarations

	Height	Weight	Gain or Loss and pounds in pa		Curre pregn	-		If Pregnant, what is anticipated delivery o			
Insured 1			□ Gain □ Loss	lbs	☐ Yes	□ No					
Insured 2			☐ Gain ☐ Loss	lbs	☐ Yes	□ No					
member of the condition of the convultation of	convulsions, chronic headache). Any disorder or disease of the heart, blood vessels, or circulatory system (such as high blood pressure, heart attack, heart murmur, chest pain). Any disorder or disease of the respiratory system (such as asthma, bronchitis, emphysema, tuberculosis). Any disorder or disease of the stomach, liver, intestines, rectum, pancreas, or abdominal organs. Any disorder or disease of the genitourinary organs (such as kidneys, urinary tract, blood or sugar in the urine, chronic inflammation). Any disorder or disease of the skeletal system (such as arthritis, osteoporosis, joints, bones, spine, muscles). Any disorder or disease of the eyes, ears, nose or throat. Any disorder or disease of the blood, skin, thyroid, lymph or other glands (such as anemia, diabetes). Any psychiatric or mental health disorders or diseases (such as attempted suicide, bipolar, obsessive-compulsive). Any gynecological disorders or diseases (such as irregular Pap Smear, Toxic Shock Syndrome). Any cancer, tumor, cyst or nodule. Any sexually transmitted disorders or diseases.								Insui Yes		
	Question Number	Date of Diagnosis	Diagnosis, Medication		Prescribed	l Me	dical Profe	essiona	l or Fac	ility	
Insured 1											
Insured 2											

3.	symptoms su (Circle condition	ch as: tions to which	Yes answer app	ed or treated by a member of the medical profession for s lies and give details below.)	•	Insu Yes		Insui Yes	
	diarrhe unexpl Pneum	a, fever of unk ained swelling onia	nown origin, sev of the lymph gla	fever, fatigue or unexplained weight loss, malaise, loss or rere night sweats, unexplained or unusual infections or sinds; Kaposi's Sarcoma or Pneumocystis Carinii S virus) or Acquired Immune Deficiency Syndrome (AIDS	kin lesions;				
Ì		,							
	Please provide details for any/all Yes responses. Question Date of Diagnosis Diagnosis, Medication or Treatment Prescribed Medical P							or Faci	lity
	Insured 1								
	Insured 2								
l.		red person eve		lies and give details below.)		Insu Yes	red 1 No	Insui Yes	
	(a) Used n forming	arcotics, barbi g drugs, excep	turates, ampheta t as prescribed b	amines, hallucinogens, marijuana, heroin, cocaine, or oth by a physicianeling for, or been advised by a physician to discontinue,					
	alcoho	or prescribed	or non-prescribe	ed drugs p such as Alcoholics Anonymous or Narcotics Anonymou					
Î			any/all Yes res			•			
		Question Number	Date of Diagnosis	Diagnosis, Medication or Treatment Prescribed	Medical	Profes	sional	or Faci	lity
	Insured 1								
ļ									
	Insured 2								
5. [virus) or for than five (5) Within the pa (Circle items	minor viruses days. st five (5) year or conditions t	s, injuries, comi s, has any insuro o which Yes ans	swer applies and give details below.)	od of less	Insu Yes	red 1 No	Insui Yes	
	stated	above	-	y a member of the medical profession for any condition o					
	 (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								
	diet				· 				
	(f) Been unable to work, attend school or perform normal activities of life age and gender or been confined at home								
ŀ									
\$	Please provi	Question Number	any/all Yes res Date of Diagnosis	Diagnosis, Medication or Treatment Prescribed	Medical	Profes	sional	or Faci	ility
	Insured 1								
ì	Insured 2								

	Name:					
	Address:					
	Phone Number:					
Insured 1	Date and Reason of	ast consult:				
insured i	Name:					
	Address:					
	Phone Number:					
	Date and Reason of	ast consult:				
	Name:					
	Address:					
	Phone Number:					
	Date and Reason of	ast consult:				
Insured 2	Name:					
	Address:					
	Phone Number:					
	Date and Reason of					
For the follo	owing Family Medical	History questio	n, please provide details below for each pard if still alive and if not alive, age, date, and cau	ent or sibling: use of death.	Insured 1 Yes No	
diagnosis, a Has a profes	owing Family Medical age of diagnosis, date la any insured person had assion for certain condition	History questionst treated, age a parent or siblons, such as he	 if still alive and if not alive, age, date, and cauling diagnosed or treated by a member of the meart or vascular disease, cancer, diabetes, high 	use of death. edical blood	Yes No	Yes No
diagnosis, a Has a profes press	owing Family Medical age of diagnosis, date la any insured person had assion for certain condition	History questio st treated, age a parent or sibl ons, such as he empted suicide	 if still alive and if not alive, age, date, and cauling diagnosed or treated by a member of the meart or vascular disease, cancer, diabetes, high or mental illness. 	use of death. edical blood		Yes No
diagnosis, a Has a profes press	owing Family Medical age of diagnosis, date la any insured person had assion for certain condition	History questio st treated, age a parent or sibl ons, such as he empted suicide	 if still alive and if not alive, age, date, and cauling diagnosed or treated by a member of the meart or vascular disease, cancer, diabetes, high or mental illness. 	use of death. edical blood	Yes No Graph Grap	Yes No
diagnosis, a Has a profes press	owing Family Medical age of diagnosis, date la any insured person had ssion for certain condition aure, kidney disease, att wide details for any/all	History questionst treated, age a parent or siblicons, such as he empted suicide Yes response Age at	- if still alive and if not alive, age, date, and cauting diagnosed or treated by a member of the meart or vascular disease, cancer, diabetes, higher mental illness	use of death. edical blood Date Last	Yes No Graph Grap	Yes No
diagnosis, a Has a profes press	owing Family Medical age of diagnosis, date la any insured person had ssion for certain condition aure, kidney disease, att wide details for any/all	History questionst treated, age a parent or siblicons, such as he empted suicide Yes response Age at	- if still alive and if not alive, age, date, and cauting diagnosed or treated by a member of the meart or vascular disease, cancer, diabetes, higher mental illness	use of death. edical blood Date Last	Yes No Graph Grap	Yes No
diagnosis, a Has a profes press	owing Family Medical age of diagnosis, date la any insured person had ssion for certain condition aure, kidney disease, att wide details for any/all	History questionst treated, age a parent or siblicons, such as he empted suicide Yes response Age at	- if still alive and if not alive, age, date, and cauting diagnosed or treated by a member of the meart or vascular disease, cancer, diabetes, higher mental illness	use of death. edical blood Date Last	Yes No Graph Grap	Yes No
diagnosis, a Has a profes press Please prov	owing Family Medical age of diagnosis, date la any insured person had ssion for certain condition aure, kidney disease, att wide details for any/all	History questionst treated, age a parent or siblicons, such as he empted suicide Yes response Age at	- if still alive and if not alive, age, date, and cauting diagnosed or treated by a member of the meart or vascular disease, cancer, diabetes, higher mental illness	use of death. edical blood Date Last	Yes No Graph Grap	Yes No
diagnosis, a Has a profes press Please prov	owing Family Medical age of diagnosis, date la any insured person had ssion for certain condition aure, kidney disease, att wide details for any/all	History questionst treated, age a parent or siblicons, such as he empted suicide Yes response Age at	- if still alive and if not alive, age, date, and cauting diagnosed or treated by a member of the meart or vascular disease, cancer, diabetes, higher mental illness	use of death. edical blood Date Last	Yes No Graph Grap	Yes No
diagnosis, a Has a profes press Please prov	owing Family Medical age of diagnosis, date la any insured person had ssion for certain condition aure, kidney disease, att wide details for any/all	History questionst treated, age a parent or siblicons, such as he empted suicide Yes response Age at	- if still alive and if not alive, age, date, and cauting diagnosed or treated by a member of the meart or vascular disease, cancer, diabetes, higher mental illness	use of death. edical blood Date Last	Yes No Graph Grap	Yes No
diagnosis, a Has a profes press Please prov	owing Family Medical age of diagnosis, date la any insured person had ssion for certain condition aure, kidney disease, att wide details for any/all	History questionst treated, age a parent or siblicons, such as he empted suicide Yes response Age at	- if still alive and if not alive, age, date, and cauting diagnosed or treated by a member of the meart or vascular disease, cancer, diabetes, higher mental illness	use of death. edical blood Date Last	Yes No Graph Grap	Yes No
diagnosis, a Has a profes press Please prov	owing Family Medical age of diagnosis, date la any insured person had ssion for certain condition aure, kidney disease, att wide details for any/all	History questionst treated, age a parent or siblicons, such as he empted suicide Yes response Age at	- if still alive and if not alive, age, date, and cauting diagnosed or treated by a member of the meart or vascular disease, cancer, diabetes, higher mental illness	use of death. edical blood Date Last	Yes No Graph Grap	Yes No
diagnosis, a Has a profes press Please prov	owing Family Medical age of diagnosis, date la any insured person had ssion for certain condition aure, kidney disease, att wide details for any/all	History questionst treated, age a parent or siblicons, such as he empted suicide Yes response Age at	- if still alive and if not alive, age, date, and cauting diagnosed or treated by a member of the meart or vascular disease, cancer, diabetes, higher mental illness	use of death. edical blood Date Last	Yes No Graph Grap	II alive and , age, date
diagnosis, a Has a profes press Please prov	owing Family Medical age of diagnosis, date la any insured person had ssion for certain condition aure, kidney disease, att wide details for any/all	History questionst treated, age a parent or siblicons, such as he empted suicide Yes response Age at	- if still alive and if not alive, age, date, and cauting diagnosed or treated by a member of the meart or vascular disease, cancer, diabetes, higher mental illness	use of death. edical blood Date Last	Yes No Graph Grap	Yes No

SECTION V – 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.

		Insu	red 1	Insu	red 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.				
(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.)	_	0	_	0
(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 VI - Signatures

No insurance shall take effect unless: (1) the change is issued on this application and delivered to and accepted by the Owner; (2) the first premium for the change 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 (city, state):	, this ₋	day of	(Month),	(Year).
Signature of Insured 1	_	Print Name of Insured 1		
Signature of Insured 2	_	Print Name of Insured 2		
Signature of Parent or Guardian		Print Name of Parent or Guardia	n	
Signature of Owner/Trustee (provide officer's title if policy is owned by a corporation)	_	Print Name of Owner/Trustee		
Signature of Witness	_	Print Name of Witness		
FOR HOME OFFICE USE ONLY				
Home Office Endorsements:				
Your application for Policy Change has been approved by the Corpolicy and shall be proof of such change.	mpan	y. Your policy is amended. T	his shall be an Endorseme	ent to your
Date: By Au	uthori	zed Officer:		

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	INDIVIDUAL LIFE	INSURANCE - CO	NTINUATION OF INFORMATION	
Proposed Insured 1:				
	First Name	Middle Name	LastName	Policy Number
Proposed Insured 2:	First Name	Middle Name	Last Name	Policy Number
	i iistivairie	IVIIIGAIC I VICITIC	LCSTIVELLIC	- Olicy Natribei
answers are true and	I complete to the best o	f my knowledge and I	I Application before signing below. The belief. I agree that such statements and	
the application and sl	hall be considered the b	asis of any insurance i	issued.	
Proposed Insured 1 (Si	gn 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 (Si (if other than Proposed		 Date	-	

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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).
- 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.

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NOTICE AND CONSENT FOR BLOOD, SALIVA AND/OR URINE TESTING WHICH MAY INCLUDE AIDS VIRUS (HIV) ANTIBODY/ANTIGEN TESTING

EXAMINER:	ADDRESS:	
To determine your insurability, the Insurer named above, Protective L blood, saliva and/or urine for testing and analysis. All tests will be pe		
Tests may be performed to determine the presence of antibodies or a AIDS virus. The HIV antibody test that we perform is actually a ser test directly identifies AIDS viral particles. These tests are extremely blood cholesterol and related lipids (fats) and screening for liver or kid	antigens to the Human ies of tests done by a reliable. Other tests v	Immunodeficiency Virus (HIV), also known as the medically accepted procedure. The HIV antiger which may be performed include determinations of
All test results will be treated confidentially. They will be reported by connection with insurance you have or have applied for with the I underwriting and claims review process. Your test results will not be will be reported to the local health department or the State Departm Bureau (MIB, LLC), the Insurer may report the results in a generic co test is normal, no report will be made about it to the MIB, LLC. Other The organizations described in this paragraph may maintain the test results or even that the tests have been done except as may be requ	nsurer, the Insurer man disclosed to your age the tent of Health and if the de which signifies only test results may be retresults in a file or dark.	ay disclose test results to others involved in the nt or broker. If the HIV test is positive, the results e Insurer is a member of the Medical Information on non-specific blood test abnormalities. If your HIV ported to the MIB, LLC in a more specific manner ta bank. There will be no other disclosure of test
If your HIV test results are normal, no routine notification will be sent designated physician will contact you. The Insurer may also conta opinion, are significant. The Insurer may ask you for the name of a may wish to discuss the results.	act you if there are ot	her abnormal test results which, in the Insurer's
Positive HIV antibody/antigen test results do not mean that you have or AIDS-Related conditions. Federal medical authorities have con considered infected with the AIDS virus and capable of infecting othe	cluded that persons v	
Positive HIV antibody or antigen test results or other significant abnormated that your application may be declined, that an increased premium materials.		
I have read and I understand this Notice and Consent For Blood, Testing. I voluntarily consent to the withdrawal of saliva, urine or of the disclosure of the test results as described above.		
In the event of a positive HIV test result, I authorize Protective Life I professional for post-test counseling and for Health Department repo		send the test results to the following health care
Physician:	_ Address:	
I understand that I have the right to request and receive a copy of this	authorization. A phot	cocopy of this form will be as valid as the original.
Proposed Insured (Print)		Date of Birth
Signature of Proposed Insured or Parent/Guardian	Date	State of Residence

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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.

PL-DIP 08/2022

P.O. Box 830619

Birmingham, AL 35283-0619

1.	In what language were the questions on the ap service any application from an applicant who a *List Other Language:	plication aske does not spea	k English or Spanish. 🗖 Engli			Yes	No	
2.	Is the Proposed Insured a relative or does the	Proposed Insu	ured have a business relationship v	vith you?				
	If Yes, Details:							
3.	(a) Will this policy replace or change existing							
(b) If replacement of existing insurance is involved, have you complied with all relevant state requirements, including any Disclosure and Comparison Statements?								
	If No, Explain: Answer questions (c) and (d) <u>only</u> if this is							
	(c) Did you use any pre-printed company app							
	If Yes, List Name or Form Number:							
	(d) Did you use any Company approved, elec			als (such as illus	strations or			
	concept materials)? (If Yes, you must pro	vide a copy o	f these materials with the application	on.)				
4.	Have you advised the proposed policyowner or							
	ownership of the policy to be issued, or its deal trust, or entity associated with stranger owned		. 3					
	you otherwise aware that the policyowner may		,	alled SOLI OF IC	or are			
	If Yes, please explain in Special Requests/Ren	narks below.						
5.	Has a mortality analysis or life expectancy ana	ysis been per	formed on the Proposed Insured?					
6.	Has a medical examination been ordered? If Yes, Name of Examiner:		Dato	of Exam:				
7.	Is Premium Financing involved in this case? (If	Yes, please s						
	I have verified the identity of the Owner by picti				ıst)			
	Identification Type:							
	Please include Driver's License Number if Own		dual and is other than the Propose	d Insured.				
Loc	NOTE: Does not apply to direct marketing situ	ations						
a)	rtify that: both the Proposed Insured(s) and the Owne	er(s) read sne	eak and understand either the Fr	nalish or Spani	ish language: and			
b)	each has explicitly told me that they unders							
c)	the answers given in this application are co							
d)	I know of nothing affecting the risk which is					nd		
e)	I carefully explained each question before r	ecording eac	m answer and before the applica	ition was signe	eu.			
Sig	nature of Broker/Representative	Date	PLICO Contract Number	Share %	Business Phone	Numbe	er	
Prii	nt Name of Above Signature	Email Add	ress	Signed at	(City and State)			
Sig	nature of Additional Broker/Representative	Date	PLICO Contract Number	Share %	Business Phone	Numbe	er	
Pri	nt Name of Above Additional Signature	Email Add	ress	Signed at	(City and State)			
	a name of ribove hadillohal Signature	a / idu		eignou at	(-ny and oldio)			
BG	A/Broker Dealer Name	PLICO Co	ntract Number					
Nei	N Business Key Contact	Email Add	ress	Phone Num	nber			
Bro	ker/Representative Special Requests/Remarks:							
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