PROTECTIVE LIFE INSURANCE COMPANY
P.O. Box 830619
Birmingham, AL 35283-0619

POLICY CHANGE – WITH EVIDENCE

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 – Type of Change / Action Being Requested

1. FACE AMOUNT INCREASE – Plan selection may be limited by product face amount ranges and regulatory approval.

OPTION	BY AMOUNT	FOR TOTAL FACE AMOUNT OF	PREMIUM AMOUNT
☐ Increase Base Policy	$	$	$

2. ☐ MORTALITY CLASS IMPROVEMENT

3. ☐ RATE REDUCTION

SECTION III – 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 in the next 2 years? 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 IV – 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: (**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				

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	No	**Insured 2** 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……	☐	☐	☐	☐

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 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.

		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 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 Guardian
_____ 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 Company. Your policy is amended. This shall be an Endorsement to your policy and shall be proof of such change.

Date: _____ By Authorized Officer: _____

PROTECTIVE LIFE INSURANCE COMPANY

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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) *(if other than Proposed Insured)*	Date		

PROTECTIVE LIFE INSURANCE COMPANY
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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 <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
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NOTICE AND CONSENT FORM FOR AIDS VIRUS (HIV) ANTIBODY/ANTIGEN TESTING

To evaluate your eligibility for insurance coverage, it is requested that you consent to be tested to determine the presence of antibodies or antigens to the Human Immunodeficiency Virus (HIV). By signing and dating this form, you agree that these tests may be performed and that underwriting decisions (for example, the decision to accept or reject your application) will be based on the test results. You may have ten (10) days to decide whether you wish to sign this form. **You may refuse to be tested. However, such refusal may be used by the insurer as a reason to deny coverage.** Please see below for additional counseling information.

INFORMATION ON HIV

HIV, the virus that causes AIDS, is transmitted from one person to another through blood, semen, and vaginal fluids. The disease is spread primarily during anal, vaginal, or oral intercourse, the sharing of needles and syringes used for shooting drugs, or from a mother to her unborn child. HIV is not spread through casual contact, such as eating with or touching a person infected with the virus. There is no medical evidence that HIV is spread by kissing.

Persons most at risk of contracting HIV are men who have sex with other men; intravenous ("IV") drug users; prostitutes (male or female); persons who have had many sexual partners since 1977; persons who received transfusions of blood or blood products prior to March, 1985; the sexual partners of persons in any of these groups; and infants born to infected mothers.

PRE-TEST COUNSELING CONSIDERATIONS

Many public health organizations have recommended that before taking an HIV antibody/antigen test a person seek counseling to become fully informed about the implications of such tests. You may wish to consider obtaining such counseling at your own expense prior to being tested. **Free confidential counseling is available in most Arizona communities. If you need information about the availability of counseling in your area contact your county health department or:**

Phoenix metropolitan area: 253-2437
(Arizona AIDS Information Line)

Outside the Phoenix area: 1-800-334-1540
(Arizona Department of Health Services)

DISCLOSURE OF TEST RESULTS

All test results will be treated confidentially. The results of the tests will be reported to the insurer identified on this form. Results of the tests will not be otherwise disclosed without your written consent except as required or allowed by law. **Disclosure of HIV test results pertaining to your application for insurance is governed by A.R.S. § 20-448.01**

MEANING OF POSITIVE TEST RESULTS

The most commonly used test for HIV is designed to detect the presence of antibodies to the virus. Antibodies are made by the body's immune system to fight infection. While positive HIV antibody test results do not mean that you have AIDS, they do indicate that you have been infected with HIV, the virus that causes AIDS.

Positive HIV antibody/antigen test results will adversely affect your application for insurance. This means that your application will probably be declined.

CONSENT:

I have read and I understand this Notice and Consent Form. I voluntarily consent to testing and disclosure as described above. I understand that I have a right to request and receive a copy of this form. A photocopy of this form will be as valid as the original. I understand that the provisions of this consent form shall be effective for a period not to exceed 180 days from the date this form was signed by me or my legal representative. In addition, I authorize Protective Life Insurance Company to make a brief report of any personal health information to the MIB.

_____ _____

Signature of Proposed Insured or Parent/Guardian Date

OPTIONAL RELEASE OF INFORMATION TO PERSONAL PHYSICIAN

In addition to the release of information as described above, I hereby authorize the release of my HIV test results to my personal physician named below:

Physician's Name: _____

Address: _____

_____ _____

Signature of Proposed Insured or Parent/Guardian Date

THIS FORM IS VALID FOR 180 DAYS

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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.

PROTECTIVE LIFE INSURANCE COMPANY
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BROKER / REPRESENTATIVE REPORT

		Yes	No
1.	In what language were the questions on the application asked? *Please remember that Protective Life cannot accept or service any application from an applicant who does not speak English or Spanish. ☐ English ☐ Spanish ☐ Other* **List Other Language* : _____		
2.	Is the Proposed Insured a relative or does the Proposed Insured have a business relationship with you? *If Yes, Details:* _____	☐	☐
3.	(a) Will this policy replace or change existing policy(ies)?	☐	☐
	(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) *only* if this is a replacement:		
	(c) Did you use any pre-printed company approved sales materials? *If Yes, List Name or Form Number:* _____	☐	☐
	(d) Did you use any Company approved, electronically generated, individualized sales materials (such as illustrations or concept materials)? *(If Yes, you must provide a copy of these materials with the application.)*	☐	☐
4.	Have you advised the proposed policyowner or do you know of any advice that has been given to the policyowner to transfer ownership of the policy to be issued, or its death benefits, to a life settlement company, investor, offshore trust, investment trust, or entity associated with stranger owned or investment owned life insurance (commonly called SOLI or IOLI) or are you otherwise aware that the policyowner may be contemplating such a transfer? *If Yes, please explain in Special Requests/Remarks below.*	☐	☐
5.	Has a mortality analysis or life expectancy analysis been performed on the Proposed Insured?	☐	☐
6.	Has a medical examination been ordered? *If Yes, Name of Examiner:* _____ *Date of Exam:* _____	☐	☐
7.	Is Premium Financing involved in this case? (If Yes, please submit a cover letter describing the parameters.)	☐	☐
	I have verified the identity of the Owner by picture I.D. (*Authorized Representative if Business or Trustee if Trust)* *Identification Type:* _____ *Driver's License Number:* _____ Please include Driver's License Number if Owner is an individual and is other than the Proposed Insured. NOTE: Does not apply to direct marketing situations	☐	☐

I certify that:

a) both the Proposed Insured(s) and the Owner(s) read, speak and understand either the English or Spanish language; and
b) each has explicitly told me that they understood each question and item contained in this application; and
c) the answers given in this application are complete and true to the best of my knowledge and belief; and
d) I know of nothing affecting the risk which is not set forth in my representative's report or this life insurance application; and
e) I carefully explained each question before recording each answer and before the application was signed.

Signature of Broker/Representative	*Date*	*PLICO Contract Number*	*Share %*	*Business Phone Number*
Print Name of Above Signature	*Email Address*		*Signed at (City and State)*	
Signature of Additional Broker/Representative	*Date*	*PLICO Contract Number*	*Share %*	*Business Phone Number*
Print Name of Above Additional Signature	*Email Address*		*Signed at (City and State)*	
BGA/Broker Dealer Name	*PLICO Contract Number*			
New Business Key Contact	*Email Address*		*Phone Number*	

Broker/Representative Special Requests/Remarks: