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

INDIVIDUAL LIFE INSURANCE - SUPPLEMENTAL APPLICATION - CHILD RIDER MEDICAL DECLARATIONS

SECTION 1

Children's Term Rider _____ Units (1 Unit equals $1,000 Death Benefit – 25 Units maximum)

Please complete a separate form if you are applying for the Children's Term Rider on more than three (3) children.

CHILD #1		CHILD #2		CHILD #3	
Name: (First, Middle, Last)		*Name: (First, Middle, Last)*		*Name: (First, Middle, Last)*	
Gender	*Date of Birth*	*Gender*	*Date of Birth*	*Gender*	*Date of Birth*
Height	*Weight*	*Height*	*Weight*	*Height*	*Weight*
Social Security Number		*Social Security Number*		*Social Security Number*	
Place of Birth		*Place of Birth*		*Place of Birth*	
Relationship to Insured		*Relationship to Insured*		*Relationship to Insured*	

Please use the Continuation of Information form if additional space is needed for details listed below.

SECTION 2

Answer the following medical information for all children being applied for:

Has any child proposed for insurance 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.)	Child #1 Yes	Child #1 No	Child #2 Yes	Child #2 No	Child #3 Yes	Child #3 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 **cancer, tumor, cyst or nodule**……..	☐	☐	☐	☐	☐	☐
(k) 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.

	Question Number	Date of Diagnosis	Diagnosis, Medication or Treatment Prescribed	Medical Professional or Facility
Child #1				
Child #2				
Child #3				

SECTION 3

Answer the following medical information for all children being applied for:

Has any child proposed for insurance ever been diagnosed or treated by a member of the medical profession for: (Circle conditions to which "Yes" answer applies and give details below.)	Child #1 Yes No	Child #2 Yes No	Child #3 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……	☐ ☐	☐ ☐	☐ ☐
(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
Child #1				
Child #2				
Child #3				

SECTION 4

Answer the following information for all children age 15 through 18 being applied for:

Has any child age 15 through 18 proposed for insurance ever (Circle conditions to which "Yes" answer applies and give details below.)	Child #1 Yes No	Child #2 Yes No	Child #3 Yes 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
Child #1				
Child #2				
Child #3				

SECTION 5

Answer the following medical information for all children being applied for:

The following questions in Section 5 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 child proposed for insurance	Child #1 Yes No	Child #2 Yes No	Child #3 Yes 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 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 diagnostics test, 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	☐ ☐	☐ ☐	☐ ☐

Please provide details for any/all "Yes" responses.

	Question Number	Date of Diagnosis	Diagnosis, Medication or Treatment Prescribed	Medical Professional or Facility
Child #1				
Child #2				
Child #3				

SECTION 6

Name, Address and Phone Number of Personal Physician or Medical Facility that is consulted for routine health care or periodic check-ups.	
Child #1	Name:
	Address:
	Phone Number:
	Date and Reason of last consult:
Child #2	Name:
	Address:
	Phone Number:
	Date and Reason of last consult:
Child #3	Name:
	Address:
	Phone Number:
	Date and Reason of last consult:

Please use the Continuation of Information form if additional space is needed for details listed above.

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.

_____ _____ _____ _____

Signature of Parent or Guardian | Date | Signature of Witness | Date