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

The forms listed on page 1 are required on all cases submitted. **All forms must be dated on before the application signed date.**		
FORM NUMBER	**FORM NAME**	**INSTRUCTIONS**
PL-DIP-ME	Description of Information Practices	This notice MUST be given to the Proposed Insured on all cases submitted.
ICC21-400R	Individual Life Insurance Application	Protective Life can only accept or service an application from an applicant who speaks English or Spanish. Spanish speaking applicants must go through our TeleLife process. Complete each question in the Application for Insurance. If completing by hand, please use a pen with black ink. If applying for any riders see instructions for Rider Worksheet on Page 2.
ICC14-PL701	Supplement to Life Insurance Application (STOLI)	Must complete on all cases being submitted. Signatures and dating required.
PLX-HIPAA25	Authorization to Obtain and Disclose Information (HIPAA)	Must complete on all cases being submitted. Signatures and dating required.
PLX-408	Broker/Representative Report	The correct Broker/Representative PLICO Contract Number must be included in order to ensure commissions are paid correctly. Include Split Share Percentage.
ICC13-406A	Continuation of Information	Use this form if additional space is needed for information.
U-278-ME U-278-D.2(ME) U-AIDS	Notice and Consent Form for AIDS (HIV) Testing	Must complete on all cases being submitted. Leave a copy of this form with the applicant.
BG-ME	Life Insurance Buyer's Guide	Must leave this Buyer's Guide with the applicant.
PLX-588	Life Insurance Illustration Certification & Acknowledgement	Only required for illustrated UL products when an illustration is not obtained. Illustrations are required prior to issue.
ME-SA	Notification of Right to Name a Third Party Designee	Leave a copy of this form with the applicant.

NOT FOR USE WITH VARIABLE UNIVERSAL LIFE PRODUCTS

The forms listed on page 2 may be required if circumstances apply. Forms are available at www.protective.com

FORM NUMBER	FORM NAME	INSTRUCTIONS
ICC20-403R	Rider Worksheet	If applying for any additional benefits or riders, the Rider Worksheet must be completed. In addition, the following riders require these supplemental application forms, which can be found online at **www.protective.com**. Leave a copy of each form with the applicant. If applying for the Children's Term Rider, complete form number **ICC17-404R**. If applying for the Pre-determined Death Benefit Payout Endorsement (IPO), complete form number **ICC18-437R.** If applying for the ExtendCare Chronic Illness Accelerated Death Benefit Rider, the medical examiner will need to complete the Supplemental Underwriting Questionnaire **ICC13-P226**.
PL-104	Pre-Authorized Withdrawal Agreement	Use in cases where the applicant elects to have premium payments drafted from a bank account.
PL-CR	Conditional Receipt Agreement	If payment is submitted with the application, must complete and sign the Conditional Receipt Agreement. Leave a copy of this form with the applicant.
A-2043-N	Replacement Form	Must complete and sign regarding existing coverage. Leave a copy of this form with the Proposed Insured.
F-LAD-277	Assignment/Transfer of Ownership (Section 1035 Exchange)	Must complete on 1035 Exchange/Transfer cases. Leave a copy of this form with the owner. **Send the Original to the Home Office**.
ICC20-405R	Confidential Financial Statement	To be signed by the Proposed Insured if Face Amount is $5,000,001 or greater (for Proposed Insured(s) age 0-70) and $3,000,001 or greater (for Proposed Insured(s) age 71 and older) or at the discretion of underwriting.
ICC12-402	Part 1A Supplemental Application (Medical Declarations)	If the Proposed Insured is NOT being examined, this form must be completed.

MAILING INFORMATION

Email Address: NBApps@protective.com.
If emailing the application, you do not need to send the original application. However, we will need the original 1035 paperwork and assignment forms (if applicable).

Mailing Addresses:

HOME OFFICE – Regular Mail
Protective Life Insurance Company
ATTN: New Business
P.O. Box 830619
Birmingham, Alabama 35283-0619
Phone: (800) 366-9378
Fax: (205) 268-5807

HOME OFFICE – Overnight Mail
Protective Life Insurance Company
ATTN: New Business
2801 Highway 280 South
Birmingham, Alabama 35223
Phone: (800) 366-9378
Fax: (205) 268-5807

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

DESCRIPTION OF INFORMATION PRACTICES

(Including MIB, LLC Notice and Fair Credit Reporting Act Notice)

DISCLOSURE OF INFORMATION

In considering your application for insurance, information from various sources must be considered. These include the results of your physical examination, if required, and any reports Protective Life may receive from doctors and hospitals who have attended you.

Information regarding your insurability will be treated as confidential. Protective Life, or its reinsurers, may, however, make a brief report of any personal health information thereon to the MIB, LLC ("MIB"), which operates an information exchange on behalf of insurance companies that are members of MIB Group, Inc. If you apply to another MIB member company for life or health insurance coverage or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 or go to its website at **www.mib.com** to request disclosure online. If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

Protective Life, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at **www.mib.com**.

INVESTIGATIVE CONSUMER REPORT

Furthermore, as part of our procedures for processing your insurance application, an investigative consumer report may be prepared by one or more of the commercial agencies offering this service whereby information is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted. This inquiry includes information as to your insurance risk score, character, general reputation, personal characteristics or behavioral and lifestyle factors, except as may be related directly or indirectly to your sexual orientation. You have the right to be personally interviewed if we order an investigative consumer report. You also have the right to receive a copy of the report by making a written request to Protective Life, within a reasonable period of time, to receive additional detailed information about the nature and scope of this investigation.

YOU CAN REVIEW AND CORRECT YOUR INFORMATION

As a general practice, we will not disclose personal or privileged information about you to anyone else without your consent, unless a legitimate business need exists or disclosure is required or permitted by law. You are entitled, upon request, to receive a more detailed statement of our information practices. You also have the right to access the personal information about you that we have in our records. You may see a copy of the information, or we will send it to you, whichever you prefer. You also have the right to request correction of personal information we may have about you which you think is wrong. To exercise these rights, please write to us at the address appearing at the end of this notice.

Ask our agent/producer for assistance or call or write us at Protective Life Insurance Company, P.O. Box 830619, Birmingham, Alabama 35283-0619. Telephone: 800-366-9378.

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.

Proposed Insured 1 (print name):		Signature:
Date:	Date of Birth:	Social Security Number:
Proposed Insured 2 (print name):		Signature:
Date:	Date of Birth:	Social Security Number:

THIS NOTICE MUST BE GIVEN TO THE PROPOSED INSURED

THIS PAGE INTENTIONALLY LEFT BLANK.

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

DESCRIPTION OF INFORMATION PRACTICES

(Including MIB, LLC Notice and Fair Credit Reporting Act Notice)

DISCLOSURE OF INFORMATION

In considering your application for insurance, information from various sources must be considered. These include the results of your physical examination, if required, and any reports Protective Life may receive from doctors and hospitals who have attended you.

Information regarding your insurability will be treated as confidential. Protective Life, or its reinsurers, may, however, make a brief report of any personal health information thereon to the MIB, LLC ("MIB"), which operates an information exchange on behalf of insurance companies that are members of MIB Group, Inc. If you apply to another MIB member company for life or health insurance coverage or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 or go to its website at **www.mib.com** to request disclosure online. If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

Protective Life, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at **www.mib.com**.

INVESTIGATIVE CONSUMER REPORT

Furthermore, as part of our procedures for processing your insurance application, an investigative consumer report may be prepared by one or more of the commercial agencies offering this service whereby information is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted. This inquiry includes information as to your insurance risk score, character, general reputation, personal characteristics or behavioral and lifestyle factors, except as may be related directly or indirectly to your sexual orientation. You have the right to be personally interviewed if we order an investigative consumer report. You also have the right to receive a copy of the report by making a written request to Protective Life, within a reasonable period of time, to receive additional detailed information about the nature and scope of this investigation.

YOU CAN REVIEW AND CORRECT YOUR INFORMATION

As a general practice, we will not disclose personal or privileged information about you to anyone else without your consent, unless a legitimate business need exists or disclosure is required or permitted by law. You are entitled, upon request, to receive a more detailed statement of our information practices. You also have the right to access the personal information about you that we have in our records. You may see a copy of the information, or we will send it to you, whichever you prefer. You also have the right to request correction of personal information we may have about you which you think is wrong. To exercise these rights, please write to us at the address appearing at the end of this notice.

Ask our agent/producer for assistance or call or write us at Protective Life Insurance Company, P.O. Box 830619, Birmingham, Alabama 35283-0619. Telephone: 800-366-9378.

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.

Proposed Insured 1 (print name):		Signature:
Date:	Date of Birth:	Social Security Number:
Proposed Insured 2 (print name):		Signature:
Date:	Date of Birth:	Social Security Number:

THIS NOTICE MUST BE GIVEN TO THE PROPOSED INSURED

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PROTECTIVE LIFE INSURANCE COMPANY

P.O. BOX 830619 • BIRMINGHAM, ALABAMA 35283-0619

INDIVIDUAL LIFE INSURANCE APPLICATION

SECTION I: INSURED AND OWNER INFORMATION

1. PROPOSED INSURED

Name (First, Middle, Last) _____

Gender _____

Date of Birth _____

Birth State _____

Marital Status _____

Driver's License Number and State _____

Social Security Number _____

Home Phone _____

Work Phone _____

Cell Phone _____

Address 1 (Street or P.O. Box Number) _____

Address 2 (City, State, Zip Code) _____

Number of Years at Address _____

Email Address _____

2. SURVIVORSHIP PRODUCTS ONLY

(Provide Proposed Insured 2 Name and Date of Birth below. An additional application must be completed for the Proposed Insured 2.)

Proposed Insured 2 Name _____

Proposed Insured 2 Date of Birth _____

3. EMPLOYMENT INFORMATION

Employer's Name _____

Address 1 (Street or P.O. Box Number) _____

Address 2 (City, State, Zip Code) _____

Occupation _____

Number of Years with Employer _____

Annual Income _____

Spouse/Domestic Partner Annual Income _____

Net Worth _____

4. OWNER

(If other than Proposed Insured, must complete information below. If Trust, include Name and Date of Trust.)

Owner's Name or Name of Trust _____

Date of Trust (if applicable) _____

Birthdate _____ Phone Number _____

Relationship to Proposed Insured _____

Social Security Number/Taxpayer I.D. Number _____

Address 1 (Street or P.O. Box Number) _____

Address 2 (City, State, Zip Code) _____

Email Address _____

JOINT OWNER

(If applicable.)

Joint Owner's Name or Name of Trust _____

Date of Trust (if applicable) _____

Birthdate _____ Phone Number _____

Relationship to Proposed Insured _____

Social Security Number/Taxpayer I.D. Number _____

Address 1 (Street or P.O. Box Number) _____

Address 2 (City, State, Zip Code) _____

Email Address _____

5. SEND PREMIUM NOTICES TO
(If other than Owner.)

_____ _____ _____
Name Relationship to Proposed Insured Date of Birth

_____ _____
Address Social Security Number/Taxpayer I.D. Number

SECTION II: PLAN OF INSURANCE

1. _____
Plan of Insurance/Name of Product

2. _____
Face Amount

3. If Term or Alternative to Term (Indicate Years):
☐ 10 ☐ 15 ☐ 20 ☐ 25 ☐ 30 ☐ 35 ☐ 40

4. _____
Underwriting Class Quoted
(Protective will issue the best underwriting class.)

5. If Universal Life: ☐ Level Face Amount
☐ Increasing Face Amount

6. Death Benefit Compliance Test: ☐ CVAT ☐ GPT
(Subject to product availability.)

7. Section 1035: ☐ Yes ☐ No

8. 1035 Loan Transfer: ☐ Yes ☐ No

9. If any additional benefits, riders, or child coverage are requested, check here: ☐

(If checked, please complete the Rider Worksheet. If not checked, no additional benefits or riders are included in the policy.)

10. What is the source of Premium Payment?

☐ Current income or savings
☐ The Trust listed as the Owner
☐ A third-party source, such as Premium Financing
☐ Other: Please explain.

_____

11. Premium Payment:

☐ Annual $_____
☐ Quarterly $_____
☐ Semi-Annual $_____
☐ Monthly $_____
(Pre-Authorized Withdrawal Only)
☐ Cash with Application $_____

SECTION III: BENEFICIARY DESIGNATIONS

(If multiple beneficiaries are named, shares will be divided equally among the surviving beneficiaries, unless otherwise specified. The total percentage for each class of beneficiary must equal 100%.)

	Primary Beneficiary Name(s)	Address	Telephone	Date of Birth	Social Security No.	Relationship	Percentage
1.							

	Contingent Beneficiary Name(s)	Address	Telephone	Date of Birth	Social Security No.	Relationship	Percentage
2.							

SECTION IV: EXISTING COVERAGE/PENDING INSURANCE AND REPLACEMENT

(If you answer Yes to Questions 1-3 in this section, you will need to complete any state required replacement forms and comparison statements. All questions must be answered completely. If additional space is needed, use Section VII and follow the directions provided.)

1. Does the Proposed Insured have any existing life insurance policies or annuity contracts in force? ☐ Yes ☐ No

a)
_____ _____
Name of Insured Company

_____ _____
Policy Number Replace or Change

_____ _____ _____
Amount Purpose – Business or Personal Issue Date

b)
_____ _____
Name of Insured Company

_____ _____
Policy Number Replace or Change

_____ _____ _____
Amount Purpose – Business or Personal Issue Date

2. Is the policy applied for intended to be a replacement, modification, or discontinuation of any existing life insurance policies or annuity contracts? ☐ Yes ☐ No
(If you intend to replace existing coverage, complete any state required replacement forms and comparison statements.)
3. Is there any application now pending or being considered for other life or health insurance covering the Proposed Insured? (If Yes, provide details below.) ☐ Yes ☐ No

_____ _____ _____ _____
Company Name Amount of Coverage Total Amount to be Placed Purpose of Coverage

4. Has the Proposed Insured had a request for life or health insurance declined, postponed, rated, canceled, or restricted in any way? (If Yes, please explain.) ☐ Yes ☐ No
5. In the next 3 years, will the ownership of the policy or interest in any trust owning the policy be transferred? (If Yes, please explain.) ☐ Yes ☐ No
6. Is someone other than the Proposed Insured responsible for paying premiums? ☐ Yes ☐ No
(If Yes, please explain.)
7. Will anyone unrelated to the Proposed Insured receive any of the policy death benefit? ☐ Yes ☐ No
(If Yes, please explain.)
8. In the last two years has the Proposed Insured or Owner authorized a life expectancy analysis to be performed or has the Proposed Insured or Owner been asked to authorize a life expectancy analysis in the future? ☐ Yes ☐ No
9. Has the Proposed Insured discussed transfer 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 have you considered such a transfer? (If Yes, please explain.) ☐ Yes ☐ No

SECTION V: PURPOSE OF INSURANCE

(To be answered and completed by the Owner. If additional space is needed, use Section VII and follow the directions provided.)

1. What is the purpose of the insurance?
(Personal – Family Estate Protection, Asset Transfer or Business – Key Man, Buy-Sell, etc.)
(If Business insurance, complete Questions 2-6 below.)
☐ Personal
☐ Business – Key Person
☐ Business – Buy/Sell
☐ Business – Other
2. What percent of business does the Proposed Insured own or control? _____%
3. What is approximate net annual income of business? $_____
4. What is approximate market value of the business? $_____
5. What year was the business established? _____
6. Please complete the information below:

_____ _____ _____
Name/Business Partner Title % of Business Owned

_____ _____
Insurance Company Amount Now Carried or Applied For

SECTION VI: PERSONAL HISTORY

(If additional space is needed, use Section VII and follow the directions provided.)

1. Has the Proposed Insured used tobacco or nicotine of any kind over the last 5 years? ☐ Yes ☐ No

Type	Frequency	Date Last Used

2. Has the Proposed Insured consulted a physician or had treatment for the use or possession of:
(If Yes, complete the appropriate questionnaire for Alcohol and Drug Use.)
   A. Alcohol? ☐ Yes ☐ No
   B. Narcotics, stimulants, sedatives, hallucinogenic drugs? ☐ Yes ☐ No
3. In the past 5 years, has the Proposed Insured been convicted of (I) two or more moving violations, (II) driving under the influence of alcohol or other drugs, or (III) had driver's license suspended or revoked? ☐ Yes ☐ No
4. Has the Proposed Insured ever been convicted of, or pled guilty or no contest to a felony, or had any such charge pending against them? ☐ Yes ☐ No
5. Has the Proposed Insured flown as a pilot, student pilot or crew member, or intend to fly as such within the next 2 years? (If Yes, complete the Aviation Questionnaire.) ☐ Yes ☐ No
6. Has the Proposed Insured been a member of, or entered into a written agreement to become a member of, or received a notice of required service in the armed forces, reserve, or National Guard? (If Yes, provide details below. If on active duty, please complete the Military Questionnaire.) ☐ Yes ☐ No

Branch of Service	Rank	Duties	Mobilization Category	Current Duty Station

7. Has the Proposed Insured engaged in any of the following activities in the past 2 years? ☐ Yes ☐ No
(If Yes, complete the appropriate questionnaire.)
☐ Racing ☐ Scuba Diving ☐ Hang Gliding ☐ Mountain/Rock Climbing ☐ Sky Diving ☐ Parachuting
8. Is the Proposed Insured a U.S. citizen? ☐ Yes ☐ No
(If No, provide details below and complete the Foreign National Questionnaire.)

Country of Citizenship	Visa Type	Expiration Date	Length of U.S. Residency

9. Has the Proposed Insured traveled or resided outside of the United States in the past 2 years? ☐ Yes ☐ No
(If Yes, provide details below and complete the Foreign Travel and Residence Supplement.)

Travel Details

10. Does the Proposed Insured intend to travel or reside outside the United States or Canada within the next 12 months? (If Yes, provide details below and complete the Foreign Travel and Residence Supplement.) ☐ Yes ☐ No

To Where	Why

When	For How Long

11. Has the Proposed Insured filed for or declared bankruptcy in the past ten (10) years? ☐ Yes ☐ No
(If Yes, provide details below.)

Type of Bankruptcy (Chapter)	Date Filed	Date of Discharge or Reorganization	Status

SECTION VII: SPECIAL REMARKS AND DETAILS

(For each question that requires additional information, provide the section number, question number, date, details or reason. Where applicable, also include any attending physician, hospital, or medical facility name, address, and phone number.)

DECLARATIONS

I have read or have had read to me the completed application before signing below. I represent that all statements and answers made in all parts of this application are full, complete and true, to the best of my knowledge and belief. It is agreed that:

- All such statements and answers shall be the basis of any insurance issued, and my answers are material to the decision as to whether the risk is accepted by Protective Life.
- No representative or medical examiner can make, alter or discharge any contract, accept risks, or waive Protective Life's rights or requirements.
- Acceptance of a policy by the Owner shall constitute ratification of any changes made by the Company. In those states where it is required, changes as to plan, amount, age at issue, classification or benefits will be made only with the Owner's written consent.
- No insurance shall take effect unless: (I) a policy is delivered to the Owner, (II) the full first premium is paid while the Proposed Insured is alive, and (III) there has been no change in health and insurability from that described in this application. However, if the premium is paid as set forth in the attached Conditional Receipt Agreement or the Temporary Life Insurance Receipt (Collectively known as the "Receipt") and the Receipt is delivered to the Owner, the terms of the Receipt shall apply. No representative or medical examiner has any authority to waive or to alter these terms and conditions or to bind coverage under any other circumstances.
- I have reviewed the attached Receipt and understand and agree that it provides a limited amount of life insurance for a limited period of time, and that such coverage is subject to the terms and conditions set forth in the Receipt.
- The representative taking this application has made no statement or representation different from, contrary to or in addition to these Declarations and the terms and conditions of the attached Receipt.

IMPORTANT INFORMATION ABOUT IDENTIFICATION VERIFICATION

To help the government fight the funding or terrorism and money laundering activities, Federal Law requires all financial institutions to obtain, obtain, verify, and record information of its customers. We may ask for information or identifying documents that will allow us to verify the identity of our customers.

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Signed at: _____ _____ _____

City State Date

(X)_____ (X)_____

Signature of Proposed Insured Signature of Owner (if other than Proposed Insured)

(X)_____ (X)_____

Signature of Representative Signature of Joint Owner (if applicable)

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

SUPPLEMENT TO LIFE INSURANCE APPLICATION – APPLICATION SUPPLEMENT PART I

The statements and answers to the questions listed below shall become a part of the attached application; shall be subject to the terms of the attached application; and shall become a part of any policy based on this application.

Print Name of Proposed Insured(s):

For any policy to be issued as a result of this application:

(1) **Will anyone other than the Insured, his or her family, or employer/business partner pay any portion of the initial or future premiums or obtain any right, title or interest in this policy?** ☐ Yes ☐ No
If Yes, complete the "Statement of Owner Intent" (Application Supplement Part II)

(2) **Will any portion of the initial or future premiums be borrowed, loaned or otherwise financed?** ☐ Yes ☐ No
If Yes, complete the "Premium Financing Disclosure" (Disclosure and Acknowledgement)

(3) **Will a trust, including family trust, own this policy?** ☐ Yes ☐ No
If Yes, complete the "Trust Certification" (Application Supplement Part III)

(4) **Is the Proposed Insured age 65 or older AND total coverage applied for across all Protective companies $1,000,000 or more?** ☐ Yes ☐ No
If Yes, complete the "Statement of Owner Intent" (Application Supplement Part II)

SIGNATURES:

I (We) have read or have had read to me (us) the completed Supplement before signing below. All statements and answers in the Supplement are correctly recorded and are full, complete and true to the best of my (our) knowledge and belief. I (We) understand that the information being provided in this Supplement is being relied upon in considering the application for life insurance and is subject to the applicable Fraud Statement as provided in the Application for Life Insurance.

Signed in (City/State)_____ this ____ day of (Month) _____, (Year) _____.

Signature(s) of Owner(s)/Trustees(s): X_____
(provide officer's title if policy is owned by a corporation) X_____

Signature(s) of Proposed Insured(s): X_____

X_____

X_____

Signature of Witness: X_____

PRODUCER CERTIFICATION

By signing below, I hereby certify that to the best of my knowledge and belief, the information provided herein is complete, accurate, and correct and that the life insurance being applied for conforms to the Company's guidelines.

Producer Signature: X_____

Producer Name (Print): _____

Date: _____

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

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

This Authorization to Obtain and Disclose Information complies with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") as related to Life Insurance.

USE OF MEDICAL, NON-HEALTH AND NON-MEDICAL INFORMATION

I (we) authorize Protective Life Insurance Company (Protective Life) and its reinsurers to obtain, directly or through designated third parties, and to use any information about or relating to me (us) that may affect my (our) insurability. Protective Life and its reinsurers, Life Insurance Representative(s) or regional sales office representing me on my (our) application for insurance may:

a. obtain and use health and medical information from all dates of service, including but not limited to, medical records, prescription drugs, chart notes, electrocardiograms (EKG), and information about the diagnoses and/or treatments relating to Human Immunodeficiency Virus (HIV) infection or Acquired Immunodeficiency Syndrome (AIDS), sexually transmitted diseases, drug use, alcohol use, nicotine or tobacco use, physical and mental diseases and illnesses, and psychiatric disorders (excluding psychotherapy notes);
b. obtain and use non-health and non-medical information, including but not limited to financial information, credit reports, consumer reports, driving record, criminal record, character, general reputation, personal characteristics or behavioral and lifestyle factors and information about avocations and aviation activity;
c. use all of this information to evaluate an application for insurance, a claim for insurance benefits, or both;
d. use any information relating to communicable diseases (e.g., hepatitis A, measles, influenza, tuberculosis) and other risk factors relating to me or to my spouse or life partner to evaluate an application for insurance on either me or my spouse or life partner.

RELEASE AND DISCLOSE INFORMATION FROM THIRD PARTIES

I (we) authorize the following persons and organizations to release and disclose the information described in the ***USE OF MEDICAL, NON-HEALTH AND NON-MEDICAL INFORMATION*** section to Protective Life, directly through the following designated third parties or its representative(s) acting on its behalf:

a. my (our) doctor(s); medical practitioners; pharmacists and Pharmacy Benefit Managers;
b. medical and related facilities, including hospitals, clinics, facilities run by the Veteran's Administration, Kaiser Permanente, The Cleveland Clinic Foundation including all satellite facilities and The Mayo Clinic;
c. insurers; reinsurers;
d. my (our) current and previous employers;
e. MIB, LLC **(MIB)**; and commercial consumer reporting agencies **(CRA)**.

All of these persons and organizations other than **MIB** may release the information described above to a **CRA** acting for Protective Life. **MIB** may not release the information described in the ***USE OF MEDICAL, NON-HEALTH AND NON-MEDICAL INFORMATION*** section to a **CRA**.

TESTING OF BLOOD, ORAL FLUIDS AND URINE

I (we) authorize Protective Life to draw and test my (our) blood, and/or oral fluids, and urine as necessary to underwrite my (our) application for insurance. These tests may include, but are not limited to:

a. tests for cholesterol and related blood lipids, diabetes, liver or kidney disorders, immune disorders (other than HIV/AIDS, see ***SPECIAL REQUIREMENT FOR HIV/AIDS TESTING*** section).
b. tests for the presence of drugs, nicotine, or their metabolites.

This authorization does not include genetic testing. Unless otherwise required by law or regulation, Protective Life may, but is not obligated to, release any of these test results directly to me or to my spouse or life partner.

RELEASE OF MEDICAL, NON-HEALTH, NON-MEDICAL AND TESTING INFORMATION

I (we) authorize Protective Life to release and disclose the information described in the ***USE OF MEDICAL, NON-HEALTH AND NON-MEDICAL INFORMATION*** section and the ***TESTING OF BLOOD, ORAL FLUIDS AND URINE*** section:

a. to its affiliates, its reinsurers, persons or 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 INFORMATIION 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.*

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.**)

SIGNATURES

Date of Authorization: _____

_____

List Health Care Providers

_____

Proposed Insured 1 (Signature) Print Name of Proposed Insured 1 Birthdate Social Security #

_____

Proposed Insured 2 (Signature) Print Name of Proposed Insured 2 Birthdate Social Security #

_____

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

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

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 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 INFORMATIION 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.*

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.**)

SIGNATURES

Date of Authorization: _____

_____

List Health Care Providers

_____

Proposed Insured 1 (Signature) Print Name of Proposed Insured 1 Birthdate Social Security #

_____

Proposed Insured 2 (Signature) Print Name of Proposed Insured 2 Birthdate Social Security #

_____

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

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

Owner's Name: _____ **Policy Number:** _____

Insured's Name: _____

Please complete the applicable section(s) and return this form.



View the status of your pending cases online: **www.protective.com**

BROKER/REPRESENTATIVE REPORT

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:* _____ ☐ Yes ☐ No
3. a) Will this policy replace or change existing policies? ☐ Yes ☐ No

   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*:_____ ☐ Yes ☐ No

   ANSWER questions c) and d) *only* if this is a replacement:

   c) Did you use any pre-printed company approved sales materials? ☐ Yes ☐ No
   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.)* ☐ Yes ☐ No
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? ☐ Yes ☐ No
   *If Yes, please explain:*_____.
5. Has a mortality analysis or life expectancy analysis been performed on the Proposed Insured? ☐ Yes ☐ No
6. Has a medical examination been ordered? ☐ Yes ☐ No
   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.)* ☐ Yes ☐ No

I have verified the identity of the Owner by picture I.D. *(Authorized Representative if Business or Trustee if Trust)* ☐ Yes ☐ No

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.

SIGNATURES:

Signature of Broker/Representative: Date:

PLICO Contract Number: Share %: Business Phone:

Print Name of Above Signature: Email Address:

Signed at (City and State):

Signature of Additional Broker/Representative: Date:

PLICO Contract Number: Share %: Business Phone:

Print Name of Above 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:

PROTECTIVE LIFE INSURANCE COMPANY

P.O. Box 830619

Birmingham AL 35283-0619

INDIVIDUAL LIFE INSURANCE – CONTINUATION OF INFORMATION		
PROPOSED INSURED 1		
First Name:	Middle Name:	Last Name:
Policy Number:		
PROPOSED INSURED 2		
First Name:	Middle Name:	Last Name:
Policy Number:		

SIGNATURES

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:

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

HIV TEST - INFORMED CONSENT FORM

THIS FORM MUST BE READ ALOUD TO THE APPLICANT PRIOR TO IT BEING SIGNED.

BACKGROUND

Acquired Immunodeficiency Syndrome (AIDS) is a life-threatening disorder of the immune system. It is caused by a virus called HIV. The virus is spread by sexual contact with an infected person, by exposure to infected blood (as in needle sharing during intravenous drug use or, rarely, as a result of a blood transfusion), or from an infected mother to her newborn infant.

To evaluate your eligibility for insurance or insurance benefits, it is requested that you provide a sample of your body fluid or other specimen for testing and analysis. One of the tests is to determine the presence of antibodies to the HIV virus. This test is actually a series of tests performed upon your body fluid or other specimen sample by a medically accepted procedure which is extremely reliable. The testing will be performed by a licensed laboratory.

DISCLOSURE OF TEST RESULTS

All test results will be treated confidentially. The results of the test will be reported to the insurer named above. The results will also be reported to its affiliates, reinsurers, or contractors in connection with insurance you have or for which you have applied.

In addition, if your HIV antibody test is abnormal (positive), the insurer may request an additional sample as necessary. If the insurer is a member of the MIB, LLC (MIB) and you choose to decline that request, the insurer will report to MIB a generic code which specifies only that a test has been ordered and not received. If the final test result for HIV antibodies is other than normal, a generic code signifying a non-specific blood abnormality may be made known to the MIB as described in the notice given to you at the time of application. The MIB is a membership organization of life and health insurance companies which operates as an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage or make a claim for benefits to such a company, the MIB, upon request, will supply the information in its file to that member. The insurer will make a brief report of any personal health information to the MIB. The fact that the test has been done and the results of the test will not be otherwise disclosed except as may be required by law or as authorized by you.

TEST RESULTS

Positive Test Results. While positive test results do not necessarily mean that you have AIDS, they do mean that you are at serious risk of developing AIDS or AIDS-related conditions. You may be infected with HIV and infectious to others. You should seek medical follow-up with your personal health care provider. The insurer will contact you for the name of the health care provider to whom you may want your test results disclosed.

Test Accuracy. HIV test results are not 100% accurate. Possible errors include:

(a) False positives: The test gives a positive result, even though you are not infected. This happens only rarely and is more common in persons who have not engaged in high risk behaviors. Retesting should be done to help confirm the validity of a positive test.

(b) False negatives: The test gives a negative result, even though you are infected with HIV. This is most likely to happen in recently infected persons; it takes at least 4 to 12 weeks for a positive test result to develop after a person is infected, and may take as long as 6 to 12 months.

RISK FROM HAVING THE TESTS

A positive test result may cause you significant anxiety. It also will adversely affect your insurance application and may result in uninsurability for life, health, or disability insurance for which you may apply in the future.

YOU HAVE THE RIGHT TO ASK QUESTIONS AND OBTAIN FURTHER INFORMATION

If you have any questions relating to AIDS, the HIV test and the consequences of being tested or not being tested, you are entitled to answers to those questions by the person offering the test or other knowledgeable person before you agree to testing.

OTHER SOURCES OF INFORMATION

For more information about AIDS and the HIV test you may call the Maine Bureau of Health at (207) 287-3747. You may also call the Maine AIDS Hotline at 1-800-851-AIDS.

I have read and I understand this Notice of AIDS Virus (HIV) Antibody Testing and Consent for Testing. For my information, I have been given written material about AIDS. I voluntarily consent to the withdrawal of body fluid or other specimen from me by needle, the testing of my body fluid or other specimen for HIV antibodies, and the disclosure of the test results as described above.

Name of Proposed Insured (Please Print)	Date of Birth	State of Residence
Signature of Proposed Insured	Date	
Name of Person Obtaining Consent	Date	

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

HIV TEST - INFORMED CONSENT FORM

THIS FORM MUST BE READ ALOUD TO THE APPLICANT PRIOR TO IT BEING SIGNED.

BACKGROUND

Acquired Immunodeficiency Syndrome (AIDS) is a life-threatening disorder of the immune system. It is caused by a virus called HIV. The virus is spread by sexual contact with an infected person, by exposure to infected blood (as in needle sharing during intravenous drug use or, rarely, as a result of a blood transfusion), or from an infected mother to her newborn infant.

To evaluate your eligibility for insurance or insurance benefits, it is requested that you provide a sample of your body fluid or other specimen for testing and analysis. One of the tests is to determine the presence of antibodies to the HIV virus. This test is actually a series of tests performed upon your body fluid or other specimen sample by a medically accepted procedure which is extremely reliable. The testing will be performed by a licensed laboratory.

DISCLOSURE OF TEST RESULTS

All test results will be treated confidentially. The results of the test will be reported to the insurer named above. The results will also be reported to its affiliates, reinsurers, or contractors in connection with insurance you have or for which you have applied.

In addition, if your HIV antibody test is abnormal (positive), the insurer may request an additional sample as necessary. If the insurer is a member of the MIB, LLC (MIB) and you choose to decline that request, the insurer will report to MIB a generic code which specifies only that a test has been ordered and not received. If the final test result for HIV antibodies is other than normal, a generic code signifying a non-specific blood abnormality may be made known to the MIB as described in the notice given to you at the time of application. The MIB is a membership organization of life and health insurance companies which operates as an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage or make a claim for benefits to such a company, the MIB, upon request, will supply the information in its file to that member. The insurer will make a brief report of any personal health information to the MIB. The fact that the test has been done and the results of the test will not be otherwise disclosed except as may be required by law or as authorized by you.

TEST RESULTS

Positive Test Results. While positive test results do not necessarily mean that you have AIDS, they do mean that you are at serious risk of developing AIDS or AIDS-related conditions. You may be infected with HIV and infectious to others. You should seek medical follow-up with your personal health care provider. The insurer will contact you for the name of the health care provider to whom you may want your test results disclosed.

Test Accuracy. HIV test results are not 100% accurate. Possible errors include:

(a) False positives: The test gives a positive result, even though you are not infected. This happens only rarely and is more common in persons who have not engaged in high risk behaviors. Retesting should be done to help confirm the validity of a positive test.

(b) False negatives: The test gives a negative result, even though you are infected with HIV. This is most likely to happen in recently infected persons; it takes at least 4 to 12 weeks for a positive test result to develop after a person is infected, and may take as long as 6 to 12 months.

RISK FROM HAVING THE TESTS

A positive test result may cause you significant anxiety. It also will adversely affect your insurance application and may result in uninsurability for life, health, or disability insurance for which you may apply in the future.

YOU HAVE THE RIGHT TO ASK QUESTIONS AND OBTAIN FURTHER INFORMATION

If you have any questions relating to AIDS, the HIV test and the consequences of being tested or not being tested, you are entitled to answers to those questions by the person offering the test or other knowledgeable person before you agree to testing.

OTHER SOURCES OF INFORMATION

For more information about AIDS and the HIV test you may call the Maine Bureau of Health at (207) 287-3747. You may also call the Maine AIDS Hotline at 1-800-851-AIDS.

I have read and I understand this Notice of AIDS Virus (HIV) Antibody Testing and Consent for Testing. For my information, I have been given written material about AIDS. I voluntarily consent to the withdrawal of body fluid or other specimen from me by needle, the testing of my body fluid or other specimen for HIV antibodies, and the disclosure of the test results as described above.

Name of Proposed Insured (Please Print)	Date of Birth	State of Residence
Signature of Proposed Insured	Date	
Name of Person Obtaining Consent	Date	

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

ELECTION OF POST-TEST COUNSELING

Professional (or voluntary) Post-Test Counseling is available to all proposed insureds who have been requested to undergo blood tests for HIV antibodies. HIV has been identified as the causative agent of AIDS (Acquired Immunodeficiency Syndrome). Counseling shall be provided by a professional (or qualified voluntary) counselor selected by the proposed insured, whether or not Voluntary Post-test Counseling is available. Where both Voluntary and Professional Post-test Counseling are available, the proposed insured may elect to have either Voluntary or Professional Counseling. If such counseling is sought, Protective Life Insurance Company will pay the usual and customary charge for one (1) session of Professional or Voluntary Post-test Counseling received by the proposed insured.

☐ I wish to receive post-test counseling.

_____ _____ _____

Name of Proposed Insured (Print) Signature of Proposed Insured Date

RELEASE OF TEST RESULTS TO HEALTHCARE PROVIDER:

In the event of positive or indeterminate test results and in the event that the proposed insured has not designated a health care provider to receive test results, Protective Life Insurance Company shall provide written notification to the proposed insured that an abnormal test result has been obtained, recommend that a health care provider be authorized to receive test results, and recommend the proposed insured consult that provider.

_____

Healthcare Provider

_____

Address

_____

City, State, Zip Code

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

FROM AMERICAN RED CROSS PAMPHLET - HIV & AIDS: GET THE FACTS

HIV & AIDS

AIDS is on e of the leading causes of death for Americans between the ages of 25 and 44, according to the Centers for Disease Control and Prevention (CDC). Many of the people who are infected with HIV today did not believe they were at risk.

HIV is serious. HIV is deadly. HIV will be with us for a long time. You don't have to get HIV if you follow some simple rules of prevention. The following information about HIV infection and AIDS will help you and those you love learn to protect yourselves.

FACT: AIDS is caused by a virus called HIV.

HIV stands for human immunodeficiency virus. It is the virus that causes AIDS - acquired immunodeficiency syndrome. HIV is spread from one person to another through sex and blood-to-blood contact. When someone becomes infected with HIV, the virus attacks that person's immune system (the system that defends the body from illness). A person develops AIDS when his or her immune system becomes so damaged that it can no longer fight off diseases and infections. These diseases and infections can be fatal. Most people get infected with HIV by having unprotected sex or sharing needles with someone who already has the virus. HIV does not discriminate. Anyone can get HIV.

FACT: People infected with HIV may look and feel healthy for a long time.

It may take up to 10 years for people who are infected with HIV to develop AIDS. They may look and feel healthy for years after becoming infected. They may not know they are infected. Even if they don't look or feel sick, they can infect others.

FACT: When signs of illness do appear, they vary from person to person.

Some people get fevers or diarrhea. Most people get swollen glands that won't clear up. Many lose weight for no apparent reason. This is because the virus harms the body's defenses (immune system). When people develop AIDS, they may have illnesses that healthy people would usually resist. Only a blood test can tell if someone is infected with HIV. Only a doctor can diagnose AIDS.

FACT: You cannot "catch" HIV like you do a cold or flu.

Unlike many other viruses, HIV is not spread through the air or water. HIV is not spread through everyday casual contact.

You cannot get HIV from - handshakes, hugs, coughs or sneezes, sweat or tears, mosquitoes or other insects, pets, eating food prepared by someone else, being around an infected person. **Or from using** - swimming pools, toilet seats, phones or computers, straws, spoons, or cups, drinking fountains.

FACT: Most people with HIV or AIDS got the virus by having sex or sharing needles with someone who was already infected - even once may put you at risk.

These are the most common ways in which HIV is spread: Having vaginal, anal, or oral sex without a latex condom, with someone who has HIV. Sharing needles or syringes with someone who is infected with HIV. From an infected mother to her baby during pregnancy, childbirth, or, rarely, through breast feeding.

FACT: You can protect yourself from the virus.

The best way to prevent HIV infection are: Do not have sex. You can get infected from even one sexual experience. Avoid contact with another person's blood, semen, or vaginal fluid. Do not shoot drugs. Never share any kind of needle or syringe. Any object that breaks the skin should not be shared. Do not use drugs or alcohol. They can keep you from thinking clearly and cause you to make unwise decisions. **If you are sexually active** - have sex only with a partner who is not infected, who has sex only with you, and who does not shoot drugs or share needles and syringes. Keep in mind that it is difficult to know these things about another person. **Always use a latex condom** for any kind of sex because it's possible you wont' know if your partner is infected. **Make smart decisions.** Whether you have sex and whether you use condoms are decisions you can make over and over. You can choose not to have sex, even if you have had sex in the past. You can choose to use condoms even if you have not used condoms in the past. Use what you have learned to make decisions about sex that are good for you and for your partner. Get the **latest information** from the CDC.

FACT: Latex condom (rubbers) can help prevent HIV infection.
Latex condoms can help lower your risk of HIV infection during sex, as well as your risk of contracting other sexually transmitted diseases (STDs). Latex condoms act as an effective barrier to diseases. But condoms are not foolproof. They don't completely eliminate the risk of becoming infected because they can break, tear, or slip off. They must be put on before genital contact. And they must be used the right way - from start to finish - every time for vaginal, anal, and oral sex. **Find out how.**

Birth control pills and diaphragms will not protect you or your partner from HIV or other STDs.

FACT: It is impossible for a donor to get HIV from giving blood or plasma.
In the United States, every piece of equipment (needles, tubing, containers) used to draw blood is sterile and brand new. It is used only once, then destroyed. You cannot get HIV from giving blood.

FACT: The chances of getting HIV from a blood transfusion in the United States are now extremely low.
Early in the AIDS epidemic, some people became infected with HIV through infected blood in the nation's blood supply. Since then, the risk of getting an HIV-contaminated transfusion has dropped dramatically and is now estimated to be two in one million units of blood. The Red Cross and other blood banks use a combination of ways to protect the blood supply, including -

Screening of donors. Since 1983, those who want to give blood are not allowed to give blood if they indicate they are at risk of being infected with HIV.

Testing donated blood and plasma for signs of HIV since 1985, when tests became available. If a test shows the presence of HIV, that blood is destroyed. Over time, testing methods have greatly improved. However, testing cannot completely eliminate the risk of infected blood. If someone donates blood or plasma soon after becoming infected, current tests may not always be able to detect the presence of the virus.

FACT: There are blood tests for HIV.
If you think you may be infected with HIV, you may want to consider taking an antibody blood test and getting counseling both before and after being tested. These blood tests look for the presence of HIV antibodies in the blood as signs of the virus. The body almost always develops antibodies to fight off viruses that enter the blood stream.

The "window period" affects test results….. Current blood tests are over 99 percent accurate. However, there is usually a window period from a few weeks to a few months after a person becomes infected for enough antibodies to develop to be detected in a blood test. For this reason, if someone was infected recently, the test may not yet show that the person is infected. Contact your local public health department, AIDS service organization, Red Cross chapter, or doctor's office for more information about testing and HIV counseling.

FACT: So far, there is no vaccine for HIV or a cure for AIDS.
Some medicines that are now available help to treat the symptoms of AIDS patients and allow them to live more comfortably. None of these medicines can keep a person from becoming infected with HIV. None of the treatments can cure AIDS. But people can prevent HIV infection by learning the facts and acting on them. Find out more about **HIV/AIDS treatment.**

FACT: You can help fight the battle against HIV and AIDS by being a volunteer.
Volunteers are always needed. They can answer AIDS hotlines and help teach others about HIV and AIDS. They can help people living with AIDS by shopping for them or bringing meals to their homes. They can help raise funds to fight this epidemic. Call **your local Red Cross chapter** or AIDS service organization to learn how you can help.

To learn more facts about HIV and AIDS, order the American Red Cross HIV/AIDS Facts Book.

Further information about HIV/AIDS can be obtained from your Red Cross chapter, local or state health department, other community agencies, the National AIDS Network agency, or the National AIDS Hot Line. The Hot Line number is 1-800-342-AIDS.

PROTECTIVE LIFE INSURANCE COMPANY

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

LIFE INSURANCE BUYER'S GUIDE

This guide can show you how to save money when you shop for life insurance. It helps you to:

* Decide how much life insurance you should buy.
* Decide what kind of life insurance policy you need, and
* Compare the cost of similar life insurance policies.

This Information Guide was Prepared and Provided by the
Maine Bureau of Insurance

THIS GUIDE DOES NOT ENDORSE ANY COMPANY OR POLICY

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

December, 1999

BUYING LIFE INSURANCE

When you buy life insurance, you want a policy which fits your needs without costing too much.

First, decide how much you need - and for how long - and what you can afford to pay. Keep in mind the major reason you buy life insurance is to cover the financial effects of unexpected or untimely death. Life insurance can also be one of many ways you plan for the future.

Next, learn what kinds of policies will meet your needs and pick the one that best suits you.

Then, choose the combination of policy premium and benefits that emphasizes protection in case of early death, or benefits in case of long life, or a combination of both.

A good life insurance producer, consultant, or company will be able and willing to help you with each of these shopping steps.

If you are going to make a good choice when you buy life insurance, you need to understand which kinds are available. If one kind does not seem to fit your needs, ask about the other kinds which are described in this guide. If you feel that you need more information than is given here, you may want to check with a life insurance producer, consultant, or company or books on life insurance in your public library.

WHAT ABOUT THE POLICY YOU HAVE NOW

If you are thinking about dropping a life insurance policy, here are some things you should consider:

* If you decide to replace your policy, don't cancel your old policy until you have received the new one. You then have a minimum period to review your new policy and decide if it is what you wanted.

* It may be costly to replace a policy. Much of what you paid in the early years of the policy you have now, paid for the company's cost of selling and issuing the policy. You may pay this type of cost again if you buy a new policy.

* Ask your tax advisor if dropping your policy could affect your income taxes.

* If you are older or your health has changed, premiums for the new policy will often be higher. You will not be able to buy a new policy if you are not insurable.

* You may have valuable rights and benefits in the policy you now have that are not in the new one.

* If the policy you have now no longer meets your needs, you may not have to replace it. You might be able to change your policy or add to it to get the coverage or benefits you now want.

* At least in the beginning, a policy may pay no benefits for some causes of death covered in the policy you have now.

In all cases, if you are thinking of buying a new policy, check with the agent or company that issued you the one you have now. When you bought your old policy, you may have seen an illustration of the benefits of your policy. Before replacing your policy, ask your agent or company for an updated illustration. Check to see how the policy has performed and what you might expect in the future, based on the amounts the company is paying now.

HOW MUCH DO YOU NEED

Here are some questions to ask yourself:

* How much of the family income do I provide? If I were to die early, how would my survivors, especially my children, get by? Does anyone else depend on me financially, such as a parent, grandparent, brother or sister?

* Do I have children for whom I'd like to set aside money to finish their education in the event of my death?

* How will my family pay final expenses and repay debts after my death?

* Do I have family members or organizations to whom I would like to leave money?

* Will there be estate taxes to pay after my death?

* How will inflation affect future needs?

As you figure out what you have to meet these needs, count the life insurance you have now, including any group insurance where you work or veteran's insurance. Don't forget Social Security and pension plan survivor's benefits. Add other assets you have: savings, investments, real estate and personal property. Which assets would your family sell or cash in to pay expenses after your death?

CHOOSING THE RIGHT KIND

All life insurance policies agree to pay an amount of money if you die. But all policies are not the same. There are two basic kinds of life

1. Term Insurance
2. Cash Value Life Insurance

Term Insurance

Term Insurance is death protection for a "term" of one or more years. Death benefits will be paid only if you die within that term of years. Term insurance generally provides the largest immediate death protection for your premium dollar.

Some term insurance policies are "renewable" for one or more additional terms even if your health has changed. Each time you renew the policy for a new term premiums will be higher. You should check the premiums at older ages and the length of time the policy can be continued.

Some term insurance policies are also "convertible." This means that before the end of the conversion period, you may trade the term policy for a cash value policy even if you are not in good health. Premiums for the new policy will be higher than you have been paying for the term insurance.

Cash Value Life Insurance

Cash Value Life Insurance is a type of insurance where the premiums charged are higher at the beginning than they would be for the same amount of term insurance. The part of the premium that is not used for the cost of insurance is invested by the company and builds up a cash value that may be used in a variety of ways. You may borrow against a policy's cash value by taking a policy loan. If you don't pay back the loan and the interest on it, the amount you owe will be subtracted from the benefits when you die, or from the cash value if you stop paying premiums and take out the remaining cash value. You can also use your cash value to keep insurance protection for a limited time or to buy a reduced amount without having to pay more premiums. You also can use the cash value to increase your income in retirement or to help pay for needs such as a child's tuition without canceling the policy. However, to build up this cash value, you must pay higher premiums in the earlier years of the policy. Cash value life insurance may be one of several types: whole life, universal life and variable life are all types of cash value insurance.

Whole Life Insurance gives death protection for as long as you live. The most common type is called "straight life" or "ordinary life" insurance, for which you pay the same premiums for as long as you live. These premiums can be several times higher than you would pay initially for the same amount of term insurance. But they are smaller than the premiums you would eventually pay if you were to keep renewing a term insurance policy until your later years.

Some whole life policies let you pay premiums for a shorter period such as 20 years, or until age 65. Premiums for these policies are higher than for ordinary life insurance since the premium payments are squeezed into a shorter period.

Universal Life Insurance is a kind of flexible policy that lets you vary your premium payments. You can also adjust the face amount of your coverage. Increases may require proof that you qualify for the new death benefit. The premiums you pay (less expense charges) go into a policy account that earns interest. Charges are deducted from the account. If your yearly premium payment plus the interest your account earns is less than the charges, your account value will become lower. If it keep dropping, eventually your coverage will end. To prevent that, you may need to start making premium payments, or increase your premium payments, or lower your death benefits. Even if there is enough in your account to pay the premiums, continuing to pay premiums yourself means that you build up more cash value.

Variable Life Insurance is a kind of insurance where the death benefits and cash values depend on the investment performance of one or more separate accounts, which may be invested in mutual funds or other investments allowed under the policy. Be sure to get the prospectus from the company when buying this kind of policy and **STUDY IT CAREFULLY.** You will have higher death benefits and cash value if the underlying investments do well. Your benefits and cash value will be lower or may disappear if the investments you chose didn't do as well as you expected. You may pay an extra premium for a guaranteed death benefit.

FINDING A GOOD VALUE IN LIFE INSURANCE

After you have decided which kind of life insurance is best for you, compare similar policies from different companies to find which one is likely to give you the best value for your money. A simple comparison of the premiums is not enough. There are other things to consider. For example:

* Do premiums or benefits vary from year to year?
* How much do the benefits build up in the policy?
* What part of the premiums or benefits is not guaranteed?
* What is the effect of interest on money paid and received at different times on the policy?

Once you have decided which type of policy to buy, you should compare similar policies from several companies. Life insurance agents or companies should give you either a life insurance illustration, a cost comparison index, or both. Life insurance illustrations and cost comparison indexes are described below.

Remember that no one company offers the lowest cost at all ages for all kinds and amounts of insurance. You should also consider other factors:

* How quickly does the cash value grow? Some policies have low cash values in the early years that build quickly later on. Other policies have a more level cash value build-up. A year-by-year display of values and benefits can be very helpful. (The producer or company will give you a policy summary or an illustration that will show benefits and premiums for selected years.)
* Are there special policy features that particularly suit your needs?
* How are nonguaranteed values calculated? For example, interest rates are important in determining policy returns. In some companies increases reflect the average interest earnings on all of that company's policies regardless of when issued. In others, the return for policies issued in a recent year, or a group of years, reflects the interest earnings on that group of policies: in this case, amounts paid are likely to change more rapidly when interest rates change.

LIFE INSURANCE ILLUSTRATIONS

You may be thinking of buying a policy where cash values, death benefits, dividends or premiums may vary based on events or situations the company does not guarantee (such as interest rates). If so, you may get an illustration from the producer or company that helps explain how the policy works. The illustration will show how the benefits that are not guaranteed will change as interest rates and other factors change. The illustration will show you what the company guarantees. It will also show you what **could** happen in the future. Remember that nobody know what will happen in the future. You should be ready to adjust your financial plans if the cash value doesn't increase as quickly as shown in the illustration. You will be asked to sign a statement that says you understand that some of the numbers in the illustration are not guaranteed.

COST COMPARISON INDEXES

If you are provided cost comparison indexes, there will be two types:

Life Insurance Surrender Cost Index. This index is useful if you consider the level of the cash values to be of primary importance to you. It helps you compare costs if at some future point in time, such as 10 or 20 years, you were to surrender the policy and take its cash value.

Life Insurance Net Payment Cost Index. This index is useful if your main concern is the benefits that are to be paid at your death and if the level of cash values is of secondary importance to you. It helps you compare costs at some future point in time, such as 10 or 20 years, if you continue paying premiums on your policy and do not take its cash value.

How Do I Use Cost Indexes?

The most important thing to remember when using cost indexes is that a policy with a small index number is generally a better buy than a comparable policy with a larger index number. The following rules are also important:

* Cost comparisons should only be made between similar plans of life insurance. Similar plans are those which provide essentially the same basic benefits and require premium payments for approximately the same period of time. The closer policies are to being identical, the more reliable the cost comparison will be.

* Cost comparison indexes reflect only guaranteed benefits and premiums. If the policy has non-guaranteed elements such as dividends, the actual cost may turn out to be less than what the index reflects.

* Compare index numbers only for the kind of policy, for your age and for the amount you intend to buy. Since no one company offers the lowest cost for all amounts of insurance, it is important that you get the indexes for the actual policy, age and amount which you intend to buy. Just because one company's policy is a good buy for a particular age and amount, you should not assume that all of that company's policies are equally good buys.

* Small differences in index numbers could be offset by other policy features, or differences in the quality of service you may expect from the company or its agent. Therefore, when you find small differences in cost indexes, your choice should be based on something other than cost.

* In any event, you will need other information on which to base your purchase decision. Be sure you can afford the premiums, and that you understand its cash values, dividends and death benefits. You should also make a judgment on how well the life insurance company or agent will provide service in the future to you as a policyholder.

* These life insurance cost indexes apply to new policies and should not be used to determine whether you should drop a policy you have already owned for a while, in favor of a new one. If such a replacement is suggested, you should ask for information from the company which issued the old policy before you take action.

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

INDIVIDUAL LIFE INSURANCE APPLICATION – RIDER WORKSHEET

Required if applying for additional benefits or riders.

☐ New Business ☐ In Force Protective Policy # :_____

Print Proposed/Primary Insured's Name _____ Proposed/Primary Insured's Social Security No. _____

**** If applying for Children's Term Rider, Income Provider Option, ExtendCare Rider or Chronic Illness Accelerated Death Benefit, please complete the rider specific supplemental application(s) per application instructions.***

ADDITIONAL BENEFITS

☐ Accidental Death Benefit Rider *(Range $10,000 - $250,000)* $_____

☐ * Children's Term Rider *(1 Unit Equals $1,000 Death Benefit – 25 Units Maximum* _____ Units

☐ * ExtendCare Rider or Chronic Illness Accelerated Death Benefit

Maximum Monthly Benefit Amount $_____

Elimination Period *(Number of Days)* _____

☐ Conversion Choice Rider with ExtendCare *(ClassicChoice Term Only)*

☐ Guaranteed Insurability Rider $_____

☐ * Income Provider Option

☐ Protected Insurability Rider $_____

☐ Waiver of Premium *(Non-Universal Life Only)*

☐ Waiver of Specified Premium Rider *(Universal Life Only)*

Monthly Benefit Amount $_____

☐ Other _____

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 attached to and made part of the application and shall be considered the basis of any insurance issued.

Signed at: (City and State) _____ Date _____

_____ Owner Signature

_____ Proposed/Primary Insured Signature

_____ Witness to Owner Signature

_____ Signature of Parent or Guardian

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

PRE-AUTHORIZED WITHDRAWAL AGREEMENT

FOR DRAFTING OF PREMIUM PAYMENTS

The person paying the premium on the life insurance policy listed below must sign this agreement.

I request and authorize Protective Life Insurance Company to draw against the account listed below to pay premiums. I understand that no coverage exists until a policy is issued or I receive a Conditional Receipt/Temporary Life Insurance Receipt.

Policy Number: _____ Name of Insured: _____

Name of Bank: _____

Street Address or P.O. Box: _____

City: _____ State: _____ Zip Code: _____

Type of Account: ☐ Checking ☐ Savings

Routing Number: ____ ____ ____ ____ ____ ____ ____ ____ ____

Account Number: _____

Premium Frequency: ☐ *Monthly (*Only available by bank draft) ☐ Quarterly

☐ Semi-Annually ☐ Annually

☐ **Draft the initial premium** - I understand that authorizing the drafting of the initial premium and providing the account information does not provide any life insurance coverage on myself or any applicant listed on the application for life insurance unless I have signed, dated and met the terms and conditions of the Protective Life Conditional Receipt Agreement/Temporary Life Insurance Receipt.

If the Company receives a Conditional/Temporary Receipt with this form your premium will be drafted immediately and you will be provided with conditional coverage subject to limited terms and conditions.

Variable life insurance premiums will not be deducted unless a policy is issued.

I request future drafts be made on the _____ *(1st - 28th)* day of the month.

_____
Premium Payer - Depositor (Please Print)

_____ _____
Date Signature

PLEASE INCLUDE A VOIDED CHECK WITH APPLICATION. IF THIS IS TO DRAFT FROM A BROKERAGE ACCOUNT, A VOIDED CHECK IS NOT NECESSARY. DO NOT USE STAPLES.

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

CONDITIONAL RECEIPT AGREEMENT

PREMIUM RECEIPT

This Conditional Receipt Agreement ("Agreement") contains the entire terms regarding conditional coverage. The Agreement provides a limited amount of insurance, for a limited period of time, subject to the terms provided hereafter. No Agent of Protective Life Insurance Company ("Company") can alter or waive any of the provisions of this Agreement. Furthermore, in no event will there be conditional coverage unless the first full premium required by the Company has been paid at the time of application.

Premium Amount Received: $_____

Method of Payment: ☐ Check ☐ Pre-Authorized Withdrawal

☐ Other _____

The amount received is a conditional payment of the first premium for this insurance policy on the life of the following Proposed Insured(s) _____.

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO PROTECTIVE LIFE INSURANCE COMPANY.

DO NOT MAKE CHECKS PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK. CASH, MONEY ORDERS AND CASHIER'S CHECKS WILL NOT BE ACCEPTED.

TERMS AND CONDITIONS

Amount of Coverage

If a premium has been accepted by the Company for an application of insurance and any person proposed for insurance in such application dies while this Agreement is in effect, the Company will pay, subject to the conditions and limitations contained herein, to the beneficiary designated in such application, the lesser of:

(a) The amount of death benefit, if any, which would be payable under the policy covering the life or lives of the Proposed Insured(s) if issued as applied for under such application; or
(b) The greater of (i) $1,000,000 less the amount of death benefits due and payable by virtue of the Proposed Insured's death under any other policy, application, conditional receipt, or temporary life receipt with the Company, or (ii) $50,000.

Date of Conditional Coverage

Conditional coverage will begin when the application is completed, a premium has been accepted, this Agreement has been completed and signed, and all the terms and conditions stated herein have been satisfied.

Limitations

Premium shall not be collected and this Agreement will not be effective if:

(1) The Proposed Insured(s) is under 15 days of age or over age 80;
(2) The Proposed Insured(s), within the past 90 days, has been admitted to a hospital or other medical facility, been advised by a member of the medical profession to be admitted, or had surgery performed or recommended;
(3) Within the past two years, the Proposed Insured(s) has had treatment recommended by a member of the medical profession for heart trouble, stroke or cancer;
(4) The Proposed Insured(s) has been rated or declined for insurance within the past five years; or
(5) The Proposed Insured(s) intends to leave the United States within the next 60 days.

Termination and Refund of Premium

There shall be no insurance coverage under this Agreement and this Agreement shall be void if:

(1) Premium payment is by check, and it is not honored by the drawee bank upon presentation;
(2) Premium payment is by Pre-Authorized Withdrawal, and the deduction is not honored by the drawee bank;
(3) If the application to which this Agreement was attached is not approved as applied for by the Company within ninety days from the date of its receipt;
(4) There is a material misrepresentation in the answers to any questions or statements in the application; or
(5) If any Proposed Insured(s) dies by suicide, while sane or insane.

If any of the above-listed conditions do occur, the Company's liability under this Agreement is limited to a refund of the premium payment made.

Effective Date of Coverage

Insurance issued based on the application will take effect on the latest of:

(a) the date of the application;
(b) the date requested in the application; or
(c) the date of the last of any medical examinations or tests required under the rules and practices of the company.

Full life insurance coverage becomes effective when the policy is delivered and is governed by the policy contract. This Agreement will terminate when the policy contract is delivered.

Notice: **You should retain a copy of this Agreement. The Original will be retained by the Company.**

SIGNATURES:

I have read this agreement and declare that the answers are true to the best of my knowledge and belief. I understand and agree to the terms, conditions, and limitations of this Agreement.

_____ _____
Proposed Insured's Signature Date

_____ _____
Owner's Signature (if other than the Proposed Insured) Date

_____ _____
Joint Owner's Signature Date

_____ _____
Agent's Signature Date

PROTECTIVE LIFE INSURANCE COMPANY
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CONDITIONAL RECEIPT AGREEMENT

PREMIUM RECEIPT

This Conditional Receipt Agreement ("Agreement") contains the entire terms regarding conditional coverage. The Agreement provides a limited amount of insurance, for a limited period of time, subject to the terms provided hereafter. No Agent of Protective Life Insurance Company ("Company") can alter or waive any of the provisions of this Agreement. Furthermore, in no event will there be conditional coverage unless the first full premium required by the Company has been paid at the time of application.

Premium Amount Received: $_____

Method of Payment: ☐ Check ☐ Pre-Authorized Withdrawal

☐ Other _____

The amount received is a conditional payment of the first premium for this insurance policy on the life of the following Proposed Insured(s) _____.

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO PROTECTIVE LIFE INSURANCE COMPANY.

DO NOT MAKE CHECKS PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK. CASH, MONEY ORDERS AND CASHIER'S CHECKS WILL NOT BE ACCEPTED.

TERMS AND CONDITIONS

Amount of Coverage

If a premium has been accepted by the Company for an application of insurance and any person proposed for insurance in such application dies while this Agreement is in effect, the Company will pay, subject to the conditions and limitations contained herein, to the beneficiary designated in such application, the lesser of:

(a) The amount of death benefit, if any, which would be payable under the policy covering the life or lives of the Proposed Insured(s) if issued as applied for under such application; or
(b) The greater of (i) $1,000,000 less the amount of death benefits due and payable by virtue of the Proposed Insured's death under any other policy, application, conditional receipt, or temporary life receipt with the Company, or (ii) $50,000.

Date of Conditional Coverage

Conditional coverage will begin when the application is completed, a premium has been accepted, this Agreement has been completed and signed, and all the terms and conditions stated herein have been satisfied.

Limitations

Premium shall not be collected and this Agreement will not be effective if:

(1) The Proposed Insured(s) is under 15 days of age or over age 80;
(2) The Proposed Insured(s), within the past 90 days, has been admitted to a hospital or other medical facility, been advised by a member of the medical profession to be admitted, or had surgery performed or recommended;
(3) Within the past two years, the Proposed Insured(s) has had treatment recommended by a member of the medical profession for heart trouble, stroke or cancer;
(4) The Proposed Insured(s) has been rated or declined for insurance within the past five years; or
(5) The Proposed Insured(s) intends to leave the United States within the next 60 days.

Termination and Refund of Premium

There shall be no insurance coverage under this Agreement and this Agreement shall be void if:

(1) Premium payment is by check, and it is not honored by the drawee bank upon presentation;
(2) Premium payment is by Pre-Authorized Withdrawal, and the deduction is not honored by the drawee bank;
(3) If the application to which this Agreement was attached is not approved as applied for by the Company within ninety days from the date of its receipt;
(4) There is a material misrepresentation in the answers to any questions or statements in the application; or
(5) If any Proposed Insured(s) dies by suicide, while sane or insane.

If any of the above-listed conditions do occur, the Company's liability under this Agreement is limited to a refund of the premium payment made.

Effective Date of Coverage

Insurance issued based on the application will take effect on the latest of:

(a) the date of the application;
(b) the date requested in the application; or
(c) the date of the last of any medical examinations or tests required under the rules and practices of the company.

Full life insurance coverage becomes effective when the policy is delivered and is governed by the policy contract. This Agreement will terminate when the policy contract is delivered.

Notice: **You should retain a copy of this Agreement. The Original will be retained by the Company.**

SIGNATURES:

I have read this agreement and declare that the answers are true to the best of my knowledge and belief. I understand and agree to the terms, conditions, and limitations of this Agreement.

_____ _____
Proposed Insured's Signature Date

_____ _____
Owner's Signature (if other than the Proposed Insured) Date

_____ _____
Joint Owner's Signature Date

_____ _____
Agent's Signature Date

PROTECTIVE LIFE INSURANCE COMPANY

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

IMPORTANT NOTICE: REPLACEMENT OF LIFE INSURANCE OR ANNUITIES

This document must be signed by the applicant and the insurance producer/agent, if there is one, and a copy left with the applicant.

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new life insurance policy or annuity contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing life insurance policy or annuity contract, or an existing life insurance policy or annuity contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the life insurance policy values, including accumulated dividends, of an existing life insurance policy, to pay all or part of any premium or payment due on the new life insurance policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interests. You will pay acquisition costs and there may be surrender costs deducted from your life insurance policy or annuity contract. You may be able to make changes to your existing life insurance policy or annuity contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing life insurance policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements and ask that you answer the following questions and consider the questions on the back of this form.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing life insurance policy or annuity contract? ☐ Yes ☐ No

2. Are you considering using funds from your existing policies or annuity contracts to pay premiums due on the new life insurance policy or annuity contract? ☐ Yes ☐ No

If you answered "Yes" to either of the above questions, list each existing life insurance policy or annuity contract you are contemplating replacing (include the name of the insurer, the insured or annuitant, and the life insurance policy or annuity contract number if available) and whether each life insurance policy or annuity contract will be replaced or used as a source of financing:

	INSURER NAME	ANNUITY CONTRACT OR LIFE INSURANCE POLICY #	INSURED OR ANNUITANT	REPLACED (R) or FINANCING (F)
1.				
2.				
3.				
4.				
5.				
6.				

Make sure you know the facts. Contact your existing company or its insurance producer/agent for information about the old life insurance policy or annuity contract. If you request one, an in-force illustration, life insurance policy summary or available disclosure documents must be sent to you by the existing insurer. Ask for and keep all sales material used by the insurance producer/agent in the sales presentation. Be sure that you make an informed decision.

The existing life insurance policy or annuity contract is being replaced because _____.

I certify that the responses herein are, to the best of my knowledge, accurate:

Applicant/Proposed Insured's Signature	Printed Name	Date
Owner's Signature (if other than Applicant/Proposed Insured)	Printed Name	Date
Joint Owner's Signature	Printed Name	Date
Insurance Producer's/Agent Signature	Printed Name	Date

I do not want this notice read aloud to me _____ (Owner/Applicants must initial only if they do not want the notice read aloud.)

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing life insurance policy or annuity contract and the proposed life insurance policy or annuity contract. One way to do this is to ask the company or insurance producer/agent that sold you your existing life insurance policy or annuity contract to provide you with information concerning your existing life insurance policy or annuity contract. This may include an illustration of how your existing life insurance policy or annuity contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or annuity contracts. You should discuss the following with your agent to determine whether replacement or financing your purchase makes sense:

PREMIUMS:

Are they affordable?
Could they change?
You're older - are premiums higher for the proposed new life insurance policy?
How long will you have to pay premiums on the new life insurance policy? On the old life insurance policy?

POLICY VALUES:

New policies usually take longer to build cash values and to pay dividends.
Acquisition costs for the old life insurance policy may have been paid; you will incur costs for the new one.
What surrender charges do the policies have?
What expense and sales charges will you pay on the new life insurance policy?
Does the new life insurance policy provide more insurance coverage?

INSURABILITY:

If your health has changed since you bought your old life insurance policy, the new one could cost you more, or you could be turned down.
You may need a medical exam for a new life insurance policy.
(Claims on most new policies for up to the first two years can be denied based on inaccurate statements. Suicide limitations may begin anew on the coverage.)

IF YOU ARE KEEPING THE OLD LIFE INSURANCE POLICY AS WELL AS THE NEW LIFE INSURANCE POLICY:

How are premiums for both policies being paid?
How will the premiums on your existing life insurance policy be affected?
Will a loan be deducted from death benefits?
What values from the old life insurance policy are being used to pay premiums?

IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST SENSITIVE LIFE PRODUCT:

Will you pay surrender charges on your old annuity contract?
What are the interest rate guarantees for the new annuity contract?
Have you compared the annuity contract charges or other life insurance policy expenses?

OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:

What are the tax consequences of buying the new life insurance policy?
Is this a tax-free exchange? (See your tax advisor.)
Is there a benefit from favorable "grandfathered" treatment of the old life insurance policy under the Federal Internal Revenue Tax Code?
Will the existing insurer be willing to modify the old life insurance policy?
How does the quality and financial stability of the new company compare with your existing company?

PROTECTIVE LIFE INSURANCE COMPANY

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

IMPORTANT NOTICE: REPLACEMENT OF LIFE INSURANCE OR ANNUITIES

This document must be signed by the applicant and the insurance producer/agent, if there is one, and a copy left with the applicant.

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new life insurance policy or annuity contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing life insurance policy or annuity contract, or an existing life insurance policy or annuity contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the life insurance policy values, including accumulated dividends, of an existing life insurance policy, to pay all or part of any premium or payment due on the new life insurance policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interests. You will pay acquisition costs and there may be surrender costs deducted from your life insurance policy or annuity contract. You may be able to make changes to your existing life insurance policy or annuity contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing life insurance policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements and ask that you answer the following questions and consider the questions on the back of this form.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing life insurance policy or annuity contract? ☐ Yes ☐ No

2. Are you considering using funds from your existing policies or annuity contracts to pay premiums due on the new life insurance policy or annuity contract? ☐ Yes ☐ No

If you answered "Yes" to either of the above questions, list each existing life insurance policy or annuity contract you are contemplating replacing (include the name of the insurer, the insured or annuitant, and the life insurance policy or annuity contract number if available) and whether each life insurance policy or annuity contract will be replaced or used as a source of financing:

	INSURER NAME	ANNUITY CONTRACT OR LIFE INSURANCE POLICY #	INSURED OR ANNUITANT	REPLACED (R) or FINANCING (F)
1.				
2.				
3.				
4.				
5.				
6.				

Make sure you know the facts. Contact your existing company or its insurance producer/agent for information about the old life insurance policy or annuity contract. If you request one, an in-force illustration, life insurance policy summary or available disclosure documents must be sent to you by the existing insurer. Ask for and keep all sales material used by the insurance producer/agent in the sales presentation. Be sure that you make an informed decision.

The existing life insurance policy or annuity contract is being replaced because _____.

I certify that the responses herein are, to the best of my knowledge, accurate:

Applicant/Proposed Insured's Signature	Printed Name	Date
Owner's Signature (if other than Applicant/Proposed Insured)	Printed Name	Date
Joint Owner's Signature	Printed Name	Date
Insurance Producer's/Agent Signature	Printed Name	Date

I do not want this notice read aloud to me _____ (Owner/Applicants must initial only if they do not want the notice read aloud.)

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing life insurance policy or annuity contract and the proposed life insurance policy or annuity contract. One way to do this is to ask the company or insurance producer/agent that sold you your existing life insurance policy or annuity contract to provide you with information concerning your existing life insurance policy or annuity contract. This may include an illustration of how your existing life insurance policy or annuity contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or annuity contracts. You should discuss the following with your agent to determine whether replacement or financing your purchase makes sense:

PREMIUMS:

Are they affordable?
Could they change?
You're older - are premiums higher for the proposed new life insurance policy?
How long will you have to pay premiums on the new life insurance policy? On the old life insurance policy?

POLICY VALUES:

New policies usually take longer to build cash values and to pay dividends.
Acquisition costs for the old life insurance policy may have been paid; you will incur costs for the new one.
What surrender charges do the policies have?
What expense and sales charges will you pay on the new life insurance policy?
Does the new life insurance policy provide more insurance coverage?

INSURABILITY:

If your health has changed since you bought your old life insurance policy, the new one could cost you more, or you could be turned down.
You may need a medical exam for a new life insurance policy.
(Claims on most new policies for up to the first two years can be denied based on inaccurate statements. Suicide limitations may begin anew on the coverage.)

IF YOU ARE KEEPING THE OLD LIFE INSURANCE POLICY AS WELL AS THE NEW LIFE INSURANCE POLICY:

How are premiums for both policies being paid?
How will the premiums on your existing life insurance policy be affected?
Will a loan be deducted from death benefits?
What values from the old life insurance policy are being used to pay premiums?

IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST SENSITIVE LIFE PRODUCT:

Will you pay surrender charges on your old annuity contract?
What are the interest rate guarantees for the new annuity contract?
Have you compared the annuity contract charges or other life insurance policy expenses?

OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:

What are the tax consequences of buying the new life insurance policy?
Is this a tax-free exchange? (See your tax advisor.)
Is there a benefit from favorable "grandfathered" treatment of the old life insurance policy under the Federal Internal Revenue Tax Code?
Will the existing insurer be willing to modify the old life insurance policy?
How does the quality and financial stability of the new company compare with your existing company?

PROTECTIVE LIFE INSURANCE COMPANY

P.O. Box 830619

Birmingham, AL 35283-0619

ASSIGNMENT/TRANSFER OF OWNERSHIP SECTION 1035 EXCHANGE

Insured(s): _____

Owner(s)/Joint Owner(s): ***(REQUIRED)*** _____

Insurer/Existing Insurance Company Name: _____

(Please include Street Address, City, State, and Zip Code) : _____

Policy Number(s):_____

Estimated Cash Surrender Value: $_____ Phone Number(s): _____

For value received, I hereby assign and transfer to Protective Life Insurance Company (Protective Life) all right, title, and interest to the above listed policy(ies) in an exchange intended to qualify under Section 1035 of the Internal Revenue Code. However, this assignment and all other terms and agreements set forth below are conditioned upon Protective Life's underwriting and approving a new life insurance policy on the life of the Insured(s) named above. This conditional assignment will not become effective unless and until Protective Life approves a new life insurance policy.

I understand that if Protective Life approves a new life insurance policy on the life of the Insured(s) named above, then Protective Life will surrender the assigned policy(ies) and it/they will no longer be in force or effect as of the date of surrender. I further understand that, if Protective Life approves the new life insurance policy, Protective Life will collect whatever cash surrender values are available from the existing insurance company on the assigned policy(ies) and apply such amount received as premium on the new life insurance policy. I understand that the cash surrender value of the policy on the actual date of surrender is likely to be different from the cash surrender value of the policy today. This is especially true if the policy to be surrendered is a variable policy, since the cash surrender value of a variable policy fluctuates with the market. I agree that Protective Life assumes no responsibility if the full scheduled cash surrender values of the assigned policy(ies) are not received.

I certify that the above listed policy(ies) is/are currently in force and not subject to any prior assignments, any legal or equitable claims, or liens. I further certify that there is no proceeding in bankruptcy pending against me.

I hereby designate Protective Life as beneficiary of the above listed policy(ies) to the extent of the cash surrender value thereof at the date of death of the Insured(s) named above. All other beneficiary designations under the above listed policy(ies) will remain in effect. **I FURTHER UNDERSTAND THAT THE POLICY(IES) TO BE ISSUED BY PROTECTIVE LIFE WILL HAVE THE SAME DESIGNATED INSURED(S) AND OWNER(S) AS THE ABOVE LISTED POLICY(IES).**

I certify that if the above listed policy(ies) is/are not attached to this conditional assignment that it/they has/have been lost or destroyed. I hereby waive all rights and benefits under such policy(ies) and agree to return it/them to you if it/they comes/come into my possession.

I understand and agree that I will be responsible for keeping the above listed policy(ies) in force by paying any premiums as they become due until such time as Protective Life notifies me in writing that I have been issued a new life insurance policy.

I understand that under Section 1035, reporting may be required for federal income tax purposes. The replaced company is required to report all exchanges of insurance contracts on Form 1099-R, including tax-free exchanges under Section 1035 in situations in which a policyholder has an outstanding policy loan at the time of exchange. If there is an outstanding policy loan at the time of the exchange, the transaction may not be characterized as tax-free. In fact, any gain will be taxed to the extent of the outstanding policy loan. Accordingly, I understand that it is advisable when filing my individual federal income tax return that I enclose a copy of the reporting form (Form 1099-R) with an explanation that the policy was exchanged pursuant to Section 1035 or otherwise and that Protective Life has no responsibility for the validity of this Assignment.

Please Check One: ☐ I have enclosed the original policy(ies) to be exchanged. ☐ I certify that the original policy(ies) has/have been lost or destroyed. To the best of my knowledge, the original policy(ies) is/are not in the possession or control of any other person.

_____	_____	_____
Insured(s) Signature(s)	Witness Signature	Date
_____	_____	_____
*Spouse Signature *(For Community Property States Only)*	Witness Signature	Date
_____	_____	_____
Owner(s) Signature(s) ***(Required)***	Witness Signature ***(Required)***	Date
_____	_____	_____
Joint Owner(s) Signature(s)	Witness Signature	Date
_____	_____	_____
Collateral Assignee/Irrevocable Beneficiary Signature, if any	Witness Signature	Date

(If the Owner resides in the Community Property states of AZ, CA, ID, LA, NM, NV, TX, WA or WI we recommend that the Owner's spouse also sign this form. Signatures must be witnessed by a disinterested party of legal age.)*

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PROTECTIVE LIFE INSURANCE COMPANY

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

ASSIGNMENT/TRANSFER OF OWNERSHIP SECTION 1035 EXCHANGE

Insured(s): _____

Owner(s)/Joint Owner(s): ***(REQUIRED)*** _____

Insurer/Existing Insurance Company Name: _____
(Please include Street Address, City, State, and Zip Code) : _____

Policy Number(s):_____

Estimated Cash Surrender Value: $_____ Phone Number(s): _____

For value received, I hereby assign and transfer to Protective Life Insurance Company (Protective Life) all right, title, and interest to the above listed policy(ies) in an exchange intended to qualify under Section 1035 of the Internal Revenue Code. However, this assignment and all other terms and agreements set forth below are conditioned upon Protective Life's underwriting and approving a new life insurance policy on the life of the Insured(s) named above. This conditional assignment will not become effective unless and until Protective Life approves a new life insurance policy.

I understand that if Protective Life approves a new life insurance policy on the life of the Insured(s) named above, then Protective Life will surrender the assigned policy(ies) and it/they will no longer be in force or effect as of the date of surrender. I further understand that, if Protective Life approves the new life insurance policy, Protective Life will collect whatever cash surrender values are available from the existing insurance company on the assigned policy(ies) and apply such amount received as premium on the new life insurance policy. I understand that the cash surrender value of the policy on the actual date of surrender is likely to be different from the cash surrender value of the policy today. This is especially true if the policy to be surrendered is a variable policy, since the cash surrender value of a variable policy fluctuates with the market. I agree that Protective Life assumes no responsibility if the full scheduled cash surrender values of the assigned policy(ies) are not received.

I certify that the above listed policy(ies) is/are currently in force and not subject to any prior assignments, any legal or equitable claims, or liens. I further certify that there is no proceeding in bankruptcy pending against me.

I hereby designate Protective Life as beneficiary of the above listed policy(ies) to the extent of the cash surrender value thereof at the date of death of the Insured(s) named above. All other beneficiary designations under the above listed policy(ies) will remain in effect. **I FURTHER UNDERSTAND THAT THE POLICY(IES) TO BE ISSUED BY PROTECTIVE LIFE WILL HAVE THE SAME DESIGNATED INSURED(S) AND OWNER(S) AS THE ABOVE LISTED POLICY(IES).**

I certify that if the above listed policy(ies) is/are not attached to this conditional assignment that it/they has/have been lost or destroyed. I hereby waive all rights and benefits under such policy(ies) and agree to return it/them to you if it/they comes/come into my possession.

I understand and agree that I will be responsible for keeping the above listed policy(ies) in force by paying any premiums as they become due until such time as Protective Life notifies me in writing that I have been issued a new life insurance policy.

I understand that under Section 1035, reporting may be required for federal income tax purposes. The replaced company is required to report all exchanges of insurance contracts on Form 1099-R, including tax-free exchanges under Section 1035 in situations in which a policyholder has an outstanding policy loan at the time of exchange. If there is an outstanding policy loan at the time of the exchange, the transaction may not be characterized as tax-free. In fact, any gain will be taxed to the extent of the outstanding policy loan. Accordingly, I understand that it is advisable when filing my individual federal income tax return that I enclose a copy of the reporting form (Form 1099-R) with an explanation that the policy was exchanged pursuant to Section 1035 or otherwise and that Protective Life has no responsibility for the validity of this Assignment.

Please Check One: ☐ I have enclosed the original policy(ies) to be exchanged. ☐ I certify that the original policy(ies) has/have been lost or destroyed. To the best of my knowledge, the original policy(ies) is/are not in the possession or control of any other person.

_____	_____	_____
Insured(s) Signature(s)	Witness Signature	Date
_____	_____	_____
*Spouse Signature *(For Community Property States Only)*	Witness Signature	Date
_____	_____	_____
Owner(s) Signature(s) ***(Required)***	Witness Signature ***(Required)***	Date
_____	_____	_____
Joint Owner(s) Signature(s)	Witness Signature	Date
_____	_____	_____
Collateral Assignee/Irrevocable Beneficiary Signature, if any	Witness Signature	Date

(If the Owner resides in the Community Property states of AZ, CA, ID, LA, NM, NV, TX, WA or WI we recommend that the Owner's spouse also sign this form. Signatures must be witnessed by a disinterested party of legal age.)*

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

INDIVIDUAL LIFE INSURANCE APPLICATION – CONFIDENTIAL FINANCIAL STATEMENT

To be signed by the Proposed Insured if Face Amount is $5,000,001 or greater (for Proposed Insured(s) age 0 - 70) and $3,000,001 or greater (for Proposed Insured(s) age 71 and older) or at the discretion of Underwriting. Complete Part 1 for personal coverage and Part 2 for business coverage. This form should be submitted for all estate tax/liquidity, asset maximization and charitable giving cases, and for any bankruptcy in the last 3 years. Additional documentation may be requested by the Company to verify the agreements and financial disclosures made below.

Name of Proposed Insured	Date of Birth	Social Security Number

Part 1

1. Your Income (before taxes):

	Current Year	Prior Year
Salary or Wages	$	$
Bonuses and/or Commissions	$	$
Net Business or Professional Income *(Gross income less business expenses)*	$	$
Other Earned Income – Explain details in "Remarks" below	$	$
Unearned Income *(interest and dividends, net real estate income, retirement income, etc.)* – Explain details in "Remarks" below	$	$
TOTAL	$	$

2. Your Net Worth:

	Current Year	Prior Year
Investment Assets *(cash, mutual funds, stocks, 401k, etc.)*	$	$
Real Estate *(residence, second home, rental properties, etc.)*	$	$
Business Assets – Explain details in "Remarks" below *(cash, accounts receivable, equipment, inventory, etc.)*	$	$
Liabilities *(wages/interest/dividends payable, loans, etc.)*	$	$
Net Worth	$	$

3. Estimated tax liabilities at death - include potential estate taxes, capital gains taxes, income taxes *(both federal and state)*:

4. How was the need and amount of coverage determined?

Remarks *(questions 1-4)*

Part 2

Complete questions 5-8 only if applying for business coverage.

5. Purpose of business coverage:

☐ Key Person ☐ Buy/Sell ☐ Stock Repurchase ☐ Creditor ☐ Deferred Compensation

☐ Other (explain): _____

6. If buy/sell, is a written buy/sell agreement in effect? ***(if Yes, please attach a copy)*** ☐ Yes ☐ No

Percentage of Ownership	_____%
Fair Market Value of Company *(Provide details on how value was determined in "Remarks" section below)*	$_____
Are other partners being covered? *(Provide details in "Remarks" section below)*	☐ Yes ☐ No
Date Business Started	_____ / _____ / _____

7. If Creditor:

Name of Lender	
Amount of Loan	$
Purpose of Loan	
Length of Loan *(how many years?)*	
Will the Loan be Collaterally Assigned?	☐ Yes ☐ No

8. Financial Details of Business:

	Last Year	**Prior Year**
Total Assets *(cash, accounts receivable, equipment, inventory, etc.)*	$	$
Total Liabilities *(wages/interest/dividends payable, loans, etc.)*	$	$
Gross Sales or Revenue	$	$
Net Income *(before taxes)*	$	$

Remarks ***(questions 5-8)***

Part 3

Signatures:

I agree that 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 Proposed Insured Date Signature of Agent

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

INDIVIDUAL LIFE INSURANCE – PART 1A SUPPLEMENTAL APPLICATION – MEDICAL DECLARATIONS

SECTION 1

Proposed Insured 1		
Name (First, Middle, Last)		
Height	*Weight*	☐ *Gain* ☐ *Loss* *Pounds in past year?*
Currently pregnant ☐ *Yes* ☐ *No* *If "Yes," anticipated delivery date*		

Proposed Insured 2		
Name (First, Middle, Last)		
Height	*Weight*	☐ *Gain* ☐ *Loss* *Pounds in past year?*
Currently pregnant ☐ *Yes* ☐ *No* *If "Yes," anticipated delivery date*		

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

SECTION 2

Has any person 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)		Proposed Insured 1 Yes No	Proposed 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 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.

	Question Number	Date of Diagnosis	Diagnosis, Medication or Treatment Prescribed	Medical Professional or Facility
Proposed Insured 1				
Proposed Insured 2				

SECTION 3

Has any person 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)	Proposed Insured 1 Yes No	Proposed 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……..	☐ ☐	☐ ☐
(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
Proposed Insured 1				
Proposed Insured 2				

SECTION 4

Has any person proposed for insurance ever (Circle conditions to which "Yes" answer applies and give details below)	Proposed Insured 1 Yes No	Proposed Insured 2 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
Proposed Insured 1				
Proposed Insured 2				

SECTION 5

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 person proposed for insurance (Circle items or conditions to which "Yes" answer applies and give details below)	Proposed Insured 1 Yes No	Proposed Insured 2 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…...	☐ ☐	☐ ☐
(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
Proposed Insured 1				
Proposed Insured 2				

SECTION 6

For the following Family Medical History question, please provide in section number 8 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.	Proposed Insured 1 Yes No	Proposed Insured 2 Yes No
Has any person proposed for insurance 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 of Diagnosis	Diagnosis	Date Last Treated	Age – if still alive and if not alive, age, date, and cause of death.
Proposed Insured 1					
Proposed Insured 2					

SECTION 7

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

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

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

LIFE INSURANCE ILLUSTRATION CERTIFICATION & ACKNOWLEDGEMENT
• **This certification must be submitted with the Application for Life Insurance if a signed illustration is not submitted for one of the reasons set forth below.** • **This form must be signed on or before the application signed date.**
PROPOSED INSURED *(please print)*
First, Middle, Last Name:
Social Security Number:
Date of Birth *(mm/dd/yyyy)*:
OWNER *(if other than the Proposed Insured)*
First, Middle, Last Name:
AGENT/REPRESENTATIVE *(please print)*
First, Middle, Last Name:
Agent/Representative Number:
BGA Name *(if applicable)*:
ELECTRONIC ILLUSTRATION DATA
Complete this section if an electronic illustration is presented and no corresponding printed copy is provided.
Gender Class:
Date of Birth *(mm/dd/yyyy)*:
Underwriting Class:
Plan Type:
Product Name:
Policy Form Number:
Rider(s):
Initial Death Benefit:
Premium Amount Illustrated:
Premium Mode:
Number of Policy Years Illustrated:
Guaranteed Interest Rate Percentage:
Non-Guaranteed Illustrated Interest Rate Percentage:
Alternate Indexed Interest Rate Percentage *(for Indexed Products)*:

APPLICANT ACKNOWLEDGEMENT

I, the Applicant, hereby acknowledge that *(check only one)*:

☐ No policy illustration was provided to me and I understand that a policy illustration conforming to the policy as issued will be provided no later than the time the policy is delivered.

☐ The policy applied for is different than the policy illustration shown to me, and I understand that a policy illustration conforming to the policy as issued will be provided no later than at the time the policy is delivered.

☐ I viewed a complete electronic illustration which was based on the personal and policy information shown on this form and I understand that a policy illustration conforming to the policy as issued will be provided no later than at the time the policy is delivered. No corresponding printed copy was provided.

Applicant Signature: Date:

AGENT/REPRESENTATIVE CERTIFICATION

I, the Agent/Representative, hereby certify that *(check only one)*:

☐ No illustration was used in the sale of the life insurance applied for.

☐ The life insurance applied for is other than as shown in the policy illustration.

☐ I displayed a complete electronic illustration to the proposed insured that was based on the personal and policy information shown on this form. I further certify that the policy illustration complies with applicable state requirements and that no corresponding printed copy was provided.

Agent/Representative Signature: Date:

A SIGNED COPY MUST BE PROVIDED TO THE APPLICANT AND TO THE COMPANY

See Page 3 for State Specific Disclosures

REQUIRED CALIFORNIA DISCLOSURE – For Universal Life Policies with No-Lapse Guarantee

This policy is guaranteed to stay in force for a specified number of years as long as you meet the requirements of the Policy, including the Minimum Monthly Premium provision found in the policy contract. This provision is also known as a no-lapse guarantee, and a general description of the provision is included in the Narrative Summary section of the Basic Illustration.

While this policy provides a no-lapse guarantee, it may provide nonforfeiture benefits, such as cash surrender values, which are less than those that would be provided if the guarantee were issued as a separate policy, such as a term policy. If a separate term policy has higher nonforfeiture benefits, the premiums for the separate policy might be higher than the premiums for the no-lapse guarantee provided in this policy. Therefore, when considering the purchase of this policy, you should compare the value of higher nonforfeiture benefits, such as cash surrender values, versus the premiums required to keep your insurance coverage in force.

REQUIRED SOUTH CAROLINA DISCLOSURE – For Universal Life Policies with No-Lapse Guarantee

If there is no policy debt or partial surrenders, this policy is guaranteed to stay in force during the no lapse period as long as you have paid the required minimum premiums. This guarantee could be provided by a separate policy (such as a term policy). However, the nonforfeiture benefits (such as cash surrender value) in this policy may be significantly less valuable than those provided by the separate policy. So, if you fail to pay a premium within a specified period of time from its due date or otherwise cause this policy to terminate early, the benefits paid to you upon termination could be much less than would customarily be paid if provided by the separate policy.

When thinking about purchasing this policy, you should consider the tradeoff you may be making between having significantly smaller nonforfeiture benefits (such as a cash surrender value) available to you upon surrender of the policy versus the reduction in premium, if any, you may receive for not having these benefits.

CALIFORNIA FRAUD STATEMENT

For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

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PROTECTIVE LIFE INSURANCE COMPANY

P.O. Box 830619 | Birmingham, AL 35283-0619 | Phone: 1-800-366-9378 | Fax: 205-268-5807

NOTIFICATION OF RIGHT TO NAME THIRD PARTY DESIGNEE

Maine policyholders have the right to designate a third party designee to receive notice of policy lapse or termination for nonpayment of premium. If you would like to make a designation, please complete the information below and return it to us at P.O. Box 830619, Birmingham, Alabama 35283-0619.

If you have any questions about your right to name a third party designee, please call us at 1-800-366-9378, write us at P.O. Box 830619, Birmingham, Alabama 35283-0619, or fax us at 205-268-5807.

Please Print the Following Information:

_____
Policy Number (if known)

_____
Policy Owner's Name

_____
Insured's Name

Third Party Designee:

_____
Name

_____
Street Address or P.O. Box

_____
City, State, Zip Code

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

ELECTRONIC DELIVERY ELECTION FORM

At Protective Life Insurance Company, we're always looking for ways to make your life easier. Receive your policy, related statements and notices faster with electronic delivery, or eDelivery. Some notices may still be shared by first class mail due to regulatory requirements but opting into electronic delivery allows most documents to be accessible online and stored on our secure self-service website at **myaccount.protective.com**.

With an online My Protective account you can:

- View, store, print and download up to 12 months of account documents.
- Conveniently access account communications and statements anytime, anywhere.
- Save time and decrease the amount of paper records you keep at home.
- Update account preferences and profile information, including beneficiary changes.
- Make payments and manage recurring payment information. Your initial payment can be made online by bank draft or credit card.

Register your My Protective account or log in at **myaccount.protective.com**.

By providing my signature and email address, I consent to receive my policy and related statements and notices through electronic delivery from Protective Life Insurance Company. This consent is effective on the date that I affix my signature below. In the event that my email address changes or I determine that there was an error in the information provided, I will notify my representative or the Company of the updates.

CALIFORNIA ONLY - For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

_____ _____
Signature of Proposed Insured Date

_____
Email address for Proposed Insured

_____ _____
Signature of Owner (if other than Proposed Insured) Date

_____
Email address for Owner