

PROTECTIVE LIFE INSURANCE COMPANY

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

INDIVIDUAL LIFE INSURANCE APPLICATION PACKET - INSTRUCTIONS

***The forms listed on page 1 are required on all cases submitted.
All forms must be dated on or before the application signed date.***

FORM NUMBER	FORM NAME	INSTRUCTIONS
PL-DIP	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.
ICC21-HIPAA3	Authorization to Obtain and Disclose Information (HIPAA)	Must complete on all cases being submitted. Leave a copy of this form with the applicant. <u>Signature and date is required.</u>
L628-TiD1-MT	Summary Disclosure Statement for Accelerated Death Benefit	Must complete on all cases submitted. Leave a copy of this form with the applicant.
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-465 and U-466	Notice and Consent Form for AIDS (HIV) Testing	Must complete on all cases submitted. Leave a copy of this form with the applicant.
MT-SA	Notification of Right to Name a Secondary Addressee	Must complete on all cases being submitted. Leave a copy of this notice 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.

NOT FOR USE WITH VARIABLE UNIVERSAL LIFE PRODUCTS

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

FORM NUMBER	FORM NAME	INSTRUCTIONS
ICC20-403R	Rider Worksheet	<p>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 MyProtective.com forms site.</p> <p>Leave a copy of each form with the applicant.</p> <p>If applying for the Children's Term Rider, complete form number ICC17-404R.</p> <p>If applying for the Chronic Illness Accelerated Death Benefit Rider, provide the applicant with the L652-DSC Disclosure form. The medical examiner will need to complete the Supplemental Underwriting Application form number ICC13-P226.</p> <p>If applying for the Pre-determined Death Benefit Payout Endorsement (IPO), complete form number ICC18-437R.</p>
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	<p>If payment is submitted with the application, must complete and sign the Conditional Receipt Agreement.</p> <p>Leave a copy of this form with the applicant.</p>
A-2043-N	Replacement Form	<p>Must complete and sign regarding existing coverage.</p> <p>Leave a copy of this form with the applicant.</p>
F-LAD-277	Assignment/Transfer of Ownership (Section 1035 Exchange)	<p>Must complete on 1035 Exchange/Transfer cases.</p> <p>Leave a copy of this form with the owner. <u>Send the Original to the Home Office.</u></p>
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.

E-mail Address: NBApps@protective.com

If e-mailing 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
 Telephone: (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
 Telephone: (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, Attention: New Business, P.O. Box 830619, Birmingham, Alabama 35283-0619. Telephone: 800-366-9378

THIS NOTICE MUST BE GIVEN TO THE PROPOSED INSURED

AGENT/PRODUCER COMPENSATION DISCLOSURE

Agents/Producers receive compensation from an insurer or third party, which may differ depending upon the product or insurer. Additional compensation may be received by the Agent/Producer based on other factors including premium volume placed with the company and loss or claim experience.

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INDIVIDUAL LIFE INSURANCE APPLICATION

SECTION I: INSURED AND OWNER INFORMATION

1. PROPOSED INSURED

Name (First, Middle, Last)

Home Phone

Gender

Work Phone

Date of Birth

Cell Phone

Birth State

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

Marital Status

Address 2 (City, State, Zip Code)

Driver's License Number and State

Number of Years at Address

Social Security Number

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

Number of Years with Employer

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

Annual Income

Address 2 (City, State, Zip Code)

Spouse/Domestic Partner Annual Income

Occupation

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

Social Security Number/Taxpayer I.D. Number

Date of Trust (if applicable)

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

Birthdate

Phone Number

Address 2 (City, State, Zip Code)

Relationship to Proposed Insured

Email Address

JOINT OWNER

(If applicable.)

Joint Owner's Name or Name of Trust

Social Security Number/Taxpayer I.D. Number

Date of Trust (if applicable)

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

Birthdate

Phone Number

Address 2 (City, State, Zip Code)

Relationship to Proposed Insured

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

10. What is the source of Premium Payment?

2. _____
Face Amount

Current income or savings

The Trust listed as the Owner

3. If Term or Alternative to Term (Indicate Years):

A third-party source, such as Premium Financing

10 15 20 25 30 35 40

Other: Please explain.

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

11. Premium Payment:

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

Annual \$ _____

Quarterly \$ _____

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

Semi-Annual \$ _____

7. Section 1035: Yes No

Monthly
(Pre-Authorized Withdrawal Only)

8. 1035 Loan Transfer: Yes No

Cash with Application \$ _____

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.)

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%.)

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

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.)			<input type="checkbox"/> Yes <input type="checkbox"/> 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.)			<input type="checkbox"/> Yes <input type="checkbox"/> No
6.	Is someone other than the Proposed Insured responsible for paying premiums? (If Yes, please explain.)			<input type="checkbox"/> Yes <input type="checkbox"/> No
7.	Will anyone unrelated to the Proposed Insured receive any of the policy death benefit? (If Yes, please explain.)			<input type="checkbox"/> Yes <input type="checkbox"/> No
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?			<input type="checkbox"/> Yes <input type="checkbox"/> 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.)			<input type="checkbox"/> Yes <input type="checkbox"/> 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
 (Personal – Family Estate Protection, Asset Transfer or Business – Key Man, Buy-Sell, etc.) Business – Key Person
 (If Business insurance, complete Questions 2-6 below.) 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

- | | <u>Type</u> | <u>Frequency</u> | <u>Date Last Used</u> |
|----|---|------------------|--|
| 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? | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | B. Narcotics, stimulants, sedatives, hallucinogenic drugs? | | <input type="checkbox"/> Yes <input type="checkbox"/> 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? | | |
| | | | <input type="checkbox"/> Yes <input type="checkbox"/> 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? | | |
| | | | <input type="checkbox"/> Yes <input type="checkbox"/> 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.) | | |
| | | | <input type="checkbox"/> Yes <input type="checkbox"/> 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.) | | |
| | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |

- | | <u>Branch of Service</u> | <u>Rank</u> | <u>Duties</u> | <u>Mobilization Category</u> | <u>Current Duty Station</u> |
|----|---|---------------------------------------|---------------------------------------|---|--|
| 7. | Has the Proposed Insured engaged in any of the following activities in the past 2 years?
(If Yes, complete the appropriate questionnaire.) | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | <input type="checkbox"/> Racing | <input type="checkbox"/> Scuba Diving | <input type="checkbox"/> Hang Gliding | <input type="checkbox"/> Mountain/Rock Climbing | <input type="checkbox"/> Sky Diving |
| | | | | | <input type="checkbox"/> Parachuting |
| 8. | Is the Proposed Insured a U.S. citizen?
(If No, provide details below and complete the Foreign National Questionnaire.) | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |

- | | <u>Country of Citizenship</u> | <u>Visa Type</u> | <u>Expiration Date</u> | <u>Length of U.S. Residency</u> | |
|----|---|------------------|------------------------|---------------------------------|--|
| 9. | Has the Proposed Insured traveled or resided outside of the United States in the past 2 years?
(If Yes, provide details below and complete the Foreign Travel and Residence Supplement.) | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |

- 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

<u>To Where</u>	<u>Why</u>
-----------------	------------

<u>When</u>	<u>For How Long</u>
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11. Has the Proposed Insured filed for or declared bankruptcy in the past ten (10) years? Yes No
(If Yes, provide details below.)

<u>Type of Bankruptcy (Chapter)</u>	<u>Date Filed</u>	<u>Date of Discharge or Reorganization</u>	<u>Status</u>

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:

- | | Yes | No |
|---|--------------------------|--------------------------|
| (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?
If Yes, complete the "Statement of Owner Intent" (Application Supplement – Part II) | <input type="checkbox"/> | <input type="checkbox"/> |
| (2) Will any portion of the initial or future premiums be borrowed, loaned or otherwise financed?
If Yes, complete the "Premium Financing Disclosure" (Disclosure and Acknowledgement) | <input type="checkbox"/> | <input type="checkbox"/> |
| (3) Will a trust, including family trust, own this policy?
If Yes, complete the "Trust Certification" (Application Supplement – Part III) | <input type="checkbox"/> | <input type="checkbox"/> |
| (4) Is the Proposed Insured age 65 or older AND total coverage applied for across all Protective companies \$1,000,000 or more?
If Yes, complete the "Statement of Owner Intent" (Application Supplement – Part II) | <input type="checkbox"/> | <input type="checkbox"/> |


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 _____, this _____ day of _____, _____.
(State) (Month) (Year)


Signature(s) of Proposed Insured(s): X _____ 

X _____ 

Signature(s) of Owner(s)/Trustee(s): X _____ 

(provide officer's title if policy
is owned by a corporation)

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.

Signed at: _____ Date _____
(City and State)

X _____  _____
Producer Signature Producer Name (Print)

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AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

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

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

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

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

RELEASE AND DISCLOSE INFORMATION FROM THIRD PARTIES

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

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

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

TESTING OF BLOOD, ORAL FLUIDS AND URINE

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

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

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

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

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

- a. to its affiliates, its reinsurers, persons or organization providing services relating to insurance underwriting for Protective Life, **MIB** and as otherwise required by law.
- b. to release and disclose the information to other duly licensed life insurers if I (we) have applied or apply to the other insurers for insurance.
- c. to its reinsurers, to make a brief report of my personal health information to **MIB**.
- d. to the Life Insurance Representative(s) representing me to duly licensed specific life insurers for the purpose of applying for life insurance if my (our) application with Protective Life is declined or if Protective Life is unable to offer coverage at an acceptable rate.
- e. to the Life Insurance Representative(s) and its staff, affiliated companies and/or entities, insurance companies and their re-insurers representing me on my (our) application for life insurance.

SPECIAL REQUIREMENT FOR HIV/AIDS TESTING

If Protective Life intends to test for the presence of antibodies to the Human Immunodeficiency Virus (HIV), which is the virus that has been associated with Acquired Immune Deficiency Syndrome (AIDS), Protective Life may require a separate authorization. I (we) hereby authorize Protective Life:

- a. to obtain and use the results of any HIV tests that I (we) separately authorize.
- b. (if permitted by law) to disclose the results of any tests to its reinsurers and **MIB**.

GENERAL INFORMATION

- a. This authorization shall be valid for 24 months from the Date of Authorization shown below, or for the time limit, if any, permitted by applicable law in the state where the policy is delivered or issued for delivery, whichever period is shorter, or, in the event of a claim for benefits, for the duration of such claim.
- b. During the evaluation of my (our) insurance application, I (we) understand that I (we) have the right to revoke the authorizations in the previous sections (above) by writing to Protective Life at P.O. Box 830619 • Birmingham, Alabama 35283-0619. If this authorization is revoked, this would result in the file being closed and no coverage provided.
- c. I understand I do not have to sign this authorization in order to obtain **health care benefits (treatment, payment or enrollment)**.
- d. I (we) understand that any information about me (us) that is disclosed pursuant to this authorization may be subject to re-disclosure and no longer covered by certain federal rules governing privacy and confidentiality of health information. The information contained in these medical and financial records will be held in confidence and may be used only for the purpose of the procurement, or underwriting for the possible procurement or the evaluation of life, health, long term care, or other insurance products.
- e. I (we) understand that my (our) personal information, including my (our) protected health information disclosed under this authorization will be incorporated into and made a part of any life and/or disability insurance policy(ies) issued by the Company and that the policy(ies) will be delivered to the policy owner.
- f. *I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction. Any modifications to this authorization may preclude Protective Life's ability to process this application.*

AUTHORIZATIONS AND INVESTIGATIVE CONSUMER REPORT

- I (we) have been given a copy of this **Authorization to Obtain and Disclose Information** along with the **Description of Information Practices**.
- I (we) would like to be interviewed if an investigative consumer report will be made. (Please refer to the **Description of Information Practices** for additional information regarding the interview for an **Investigative Consumer Report**.)

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

SIGNATURES

Date of Authorization: X _____

List Health Care Providers

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

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

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

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

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

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

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

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

RELEASE AND DISCLOSE INFORMATION FROM THIRD PARTIES

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

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

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

TESTING OF BLOOD, ORAL FLUIDS AND URINE

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

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

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

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

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

- a. to its affiliates, its reinsurers, persons or organization providing services relating to insurance underwriting for Protective Life, **MIB** and as otherwise required by law.
- b. to release and disclose the information to other duly licensed life insurers if I (we) have applied or apply to the other insurers for insurance.
- c. to its reinsurers, to make a brief report of my personal health information to **MIB**.
- d. to the Life Insurance Representative(s) representing me to duly licensed specific life insurers for the purpose of applying for life insurance if my (our) application with Protective Life is declined or if Protective Life is unable to offer coverage at an acceptable rate.
- e. to the Life Insurance Representative(s) and its staff, affiliated companies and/or entities, insurance companies and their re-insurers representing me on my (our) application for life insurance.

SPECIAL REQUIREMENT FOR HIV/AIDS TESTING

If Protective Life intends to test for the presence of antibodies to the Human Immunodeficiency Virus (HIV), which is the virus that has been associated with Acquired Immune Deficiency Syndrome (AIDS), Protective Life may require a separate authorization. I (we) hereby authorize Protective Life:

- a. to obtain and use the results of any HIV tests that I (we) separately authorize.
- b. (if permitted by law) to disclose the results of any tests to its reinsurers and **MIB**.

GENERAL INFORMATION

- a. This authorization shall be valid for 24 months from the Date of Authorization shown below, or for the time limit, if any, permitted by applicable law in the state where the policy is delivered or issued for delivery, whichever period is shorter, or, in the event of a claim for benefits, for the duration of such claim.
- b. During the evaluation of my (our) insurance application, I (we) understand that I (we) have the right to revoke the authorizations in the previous sections (above) by writing to Protective Life at P.O. Box 830619 • Birmingham, Alabama 35283-0619. If this authorization is revoked, this would result in the file being closed and no coverage provided.
- c. I understand I do not have to sign this authorization in order to obtain **health care benefits (treatment, payment or enrollment)**.
- d. I (we) understand that any information about me (us) that is disclosed pursuant to this authorization may be subject to re-disclosure and no longer covered by certain federal rules governing privacy and confidentiality of health information. The information contained in these medical and financial records will be held in confidence and may be used only for the purpose of the procurement, or underwriting for the possible procurement or the evaluation of life, health, long term care, or other insurance products.
- e. I (we) understand that my (our) personal information, including my (our) protected health information disclosed under this authorization will be incorporated into and made a part of any life and/or disability insurance policy(ies) issued by the Company and that the policy(ies) will be delivered to the policy owner.
- f. *I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction. Any modifications to this authorization may preclude Protective Life's ability to process this application.*

AUTHORIZATIONS AND INVESTIGATIVE CONSUMER REPORT

- I (we) have been given a copy of this **Authorization to Obtain and Disclose Information** along with the **Description of Information Practices**.
- I (we) would like to be interviewed if an investigative consumer report will be made. (Please refer to the **Description of Information Practices** for additional information regarding the interview for an **Investigative Consumer Report**.)

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

SIGNATURES

Date of Authorization: X _____

List Health Care Providers

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

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

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

PROTECTIVE LIFE INSURANCE COMPANY

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

SUMMARY DISCLOSURE STATEMENT for ACCELERATED DEATH BENEFIT

Benefit:

Subject to the terms of this Benefit, we will pay a portion of the death benefit upon receiving proof that the insured is terminally ill. An accelerated death benefit can only be paid one time.

Consequences of Receiving Accelerated Death Benefit:

The receipt of an accelerated death benefit may be considered a taxable event under the Internal Revenue Code. The receipt of an accelerated death benefit may also affect eligibility to receive, or continue to receive Medicaid benefits, or other state or federal government benefits and entitlements. Before you elect to receive any accelerated benefits, you should consult with your tax advisor.

Amount You May Elect:

You may elect the amount of the accelerated death benefit to be paid. The limits are outlined in the Benefit but are generally limited to the lesser of 60% of the death benefit of the policy or \$1,000,000.

When Eligible for Payment of Benefit:

You are entitled to receive the accelerated death benefit when we have determined that the insured is terminally ill and has a life expectancy of 6 months or less.

Notice and Proof of Qualifying Event:

We will require proof that the insured is terminally ill. The diagnosis must be made by a physician as defined in the Benefit. Any diagnosis must be the result of clinical, radiological, histological, or laboratory evidence of the terminal illness. We may require a second medical opinion by a physician of our choice at our expense. If there is a conflict of opinion, we reserve the right to make the final determination.

Effect of an Accelerated Death Benefit:

When you elect to receive an accelerated death benefit, it will be treated as a lien against your policy. We will charge you interest on the accelerated death benefit paid to you. The Accelerated Death Benefit does not have an effect on the Premium and/or Cost of Insurance Charges of the base policy.

The maximum interest rate we may charge you is the greater of:

1. The interest rate charged on policy loans; or
2. the current 90 day U.S. Treasury Bill rate in effect on the date that the accelerated death benefit is paid.

The maximum interest rate we will charge on the portion of the lien which is equal to the cash surrender value of the policy at the time the accelerated death benefit is requested will be no greater than the rate we charge on policy loans.

The accelerated death benefit will first be used to repay any outstanding policy loans and any unpaid accrued interest thereon. Your access to the cash surrender value of your policy, if any, will be limited to the excess of the cash surrender value over the lien. The death benefit will also be reduced by the amount of the lien. There will be no effect on any benefits not used to determine the accelerated death benefit.

Any irrevocable beneficiaries or assignees must send us a written consent to the accelerated death benefit payment. The written request must be in a form satisfactory to us.

PROTECTIVE LIFE INSURANCE COMPANY

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

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You are entitled to receive the accelerated death benefit when we have determined that the insured is terminally ill and has a life expectancy of 6 months or less.

Notice and Proof of Qualifying Event:

We will require proof that the insured is terminally ill. The diagnosis must be made by a physician as defined in the Benefit. Any diagnosis must be the result of clinical, radiological, histological, or laboratory evidence of the terminal illness. We may require a second medical opinion by a physician of our choice at our expense. If there is a conflict of opinion, we reserve the right to make the final determination.

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The maximum interest rate we may charge you is the greater of:

1. The interest rate charged on policy loans; or
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The maximum interest rate we will charge on the portion of the lien which is equal to the cash surrender value of the policy at the time the accelerated death benefit is requested will be no greater than the rate we charge on policy loans.

The accelerated death benefit will first be used to repay any outstanding policy loans and any unpaid accrued interest thereon. Your access to the cash surrender value of your policy, if any, will be limited to the excess of the cash surrender value over the lien. The death benefit will also be reduced by the amount of the lien. There will be no effect on any benefits not used to determine the accelerated death benefit.

Any irrevocable beneficiaries or assignees must send us a written consent to the accelerated death benefit payment. The written request must be in a form satisfactory to us.

PROTECTIVE LIFE INSURANCE COMPANY

P.O. Box 830619

Birmingham, AL 35283-0619

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. <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other* *List Other Language : _____	Yes	No
2. Is the Proposed Insured a relative or does the Proposed Insured have a business relationship with you? If Yes, Details: _____	<input type="checkbox"/>	<input type="checkbox"/>
3. (a) Will this policy replace or change existing policy(ies)? (b) If replacement of existing insurance is involved, have you complied with all relevant state requirements, including any Disclosure and Comparison Statements? If No, Explain: _____	<input type="checkbox"/>	<input type="checkbox"/>
Answer questions (c) and (d) <u>only</u> if this is a replacement: (c) Did you use any pre-printed company approved sales materials? If Yes, List Name or Form Number: _____	<input type="checkbox"/>	<input type="checkbox"/>
(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.)	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you advised the proposed policyowner or do you know of any advice that has been given to the policyowner to transfer ownership of the policy to be issued, or its death benefits, to a life settlement company, investor, offshore trust, investment trust, or entity associated with stranger owned or investment owned life insurance (commonly called SOLI or IOLI) or are you otherwise aware that the policyowner may be contemplating such a transfer? If Yes, please explain in Special Requests/Remarks below.	<input type="checkbox"/>	<input type="checkbox"/>
5. Has a mortality analysis or life expectancy analysis been performed on the Proposed Insured?	<input type="checkbox"/>	<input type="checkbox"/>
6. Has a medical examination been ordered? If Yes, Name of Examiner: _____ Date of Exam: _____	<input type="checkbox"/>	<input type="checkbox"/>
7. Is Premium Financing involved in this case? (If Yes, please submit a cover letter describing the parameters.)	<input type="checkbox"/>	<input type="checkbox"/>
I have verified the identity of the Owner by picture I.D. (Authorized Representative if Business or Trustee if Trust) Identification Type: _____ Driver's License Number: _____ Please include Driver's License Number if Owner is an individual and is other than the Proposed Insured. NOTE: Does not apply to direct marketing situations	<input type="checkbox"/>	<input type="checkbox"/>

I certify that:

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

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

Broker/Representative Special Requests/Remarks:

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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

I have read or have had read to me the completed Supplemental Application before signing below. The above statements and answers are true and complete to the best of my knowledge and belief. I agree that such statements and answers shall be part of the application and shall be considered the basis of any insurance issued.

Proposed Insured 1 (Sign Name in Full) Date Proposed Insured 2 (Sign Name in Full) Date

Signature of Parent or Guardian Date Signature of Witness Date

Signature of Owner (Sign Name in Full) Date
(if other than Proposed Insured)

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PROTECTIVE LIFE INSURANCE COMPANY

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

INFORMED CONSENT FOR THE HUMAN IMMUNODEFICIENCY VIRUS (HIV) ANTIBODY TEST

If you want to be tested to see if you have been infected with HIV, the virus that causes AIDS, please read the following and ask for an oral explanation of anything that you do not understand.

Purpose of Test: This test shows if you have antibodies to the Human Immunodeficiency Virus (HIV) that causes AIDS; if there are antibodies, you have been infected with HIV and can pass the virus on to others. This test can not determine if you have AIDS.

Blood Drawing: This HIV antibody test is a blood and/or a urine test. A sample of blood and/or urine will be collected from you and then analyzed by a laboratory to determine if it contains HIV antibodies.

Limitations: As with many laboratory tests, there is a possibility of inaccurate results. For instance, a false negative result could occur if you have recently been exposed to the virus but have not yet developed antibodies.

Potential Uses of Test: If your HIV antibody test results are known, it may help your doctor determine the medical care you need. It may also help you make personal decisions, such as whether to have children and how best to avoid the risk behaviors that transmit the virus. Your results are reported to the Montana Department of Health and Environmental Sciences (DHES), but only positives or negatives; no name is attached. If testing for insurance, refer to insurance company testing section.

Counseling: At a minimum, counseling in the form of written materials developed by the DHES must be given to you before you consent to have the HIV antibody test performed and additional written materials from DHES must be provided to you after you receive the test results from your health care provider or designee.

Voluntary and Anonymous Testing: Taking an HIV antibody test is voluntary; you do not have to take the test. If you prefer, anonymous testing in which your name is not known to those performing the test, is available at several locations established by the DHES in Montana. These locations can be obtained from the DHES, your local health department or calling 1-800-233-6668. (Refer to insurance section.)

Withdrawal of Consent: You may withdraw your consent from the HIV test at any time until the blood and/or urine lab specimen is collected.

Confidentiality: Your test result is a confidential medical record and is protected by Montana law, which states that medical information can be released only with your consent, or under conditions specified by the Uniform Health Care Act (Title 50, Chapter 16, Part 5, MCA) or by the Government Health Care Act (Title 50, Chapter 16, Part 6, MCA). When authorizing a health care provider to release information you may specify which part of your medical records you want released and to whom. Signing a medical information release consent form does not waive your legal rights.

Local Health Department and Insurance Company Testing: If the test is being performed as part of an application for insurance, results will be reported to the health care provider designated by you, if it is positive. A negative test may be obtained from your insurance company. (If there is no health care provider designated, a positive test, result may be reported to the local health department for post-test counseling.) A positive test result may have an effect on your ability to obtain insurance. Ask your insurance representative about who receives and has access to your HIV antibody test results.

Unconscious or Otherwise Mentally Incapacitated: If the patient is 1) unconscious or otherwise mentally incapacitated, 2) there is no legal guardian, 3) there are medical indications of an HIV-related condition, 4) the test is advisable in order to determine the proper course of treatment then the patient's next of kin (parent, adult child, grandparent, adult sibling, or legal spouse); or the patient's significant other (individual living in a current spousal relationship with another individual but who is not legally a spouse of that individual) may receive pretest counseling and provide written informed consent. If circumstances in 1-4 above exist and the patient is in a hospital, then the person designated in the patient's medical records may receive pretest counseling and provide written informed consent on behalf of the patient. If circumstances in 1-4 above exist and the patient is in a hospital, and none of the persons listed above are available; the health care faculty may within a reasonable time order a HIV test.

STATEMENT OF CONSENT: By signing below, I certify that:

- (1) I have read and understand the above explanation of the HIV antibody test, including an explanation of the nature of the test, what the test results mean, counseling requirements, the test is voluntary and test results are confidential;
- (2) I have received and read written pre-test counseling materials drafted by the DHES;
- (3) I understand that anonymous testing, if I desire it, is available at one of the counseling/testing sites established by the DHES or elsewhere;
- (4) I agree to have a sample of my blood or urine tested for the presence of the HIV antibody, and authorize

Name of Health Care Provider: _____

Address: _____

to receive and inform me of the results of the test. Post-test counseling is to be given, at minimum in the form of written materials developed by the DHES.

- (5) I understand that when tested for insurance purposes that a positive test result will be given to the designated health care provider (listed above). If desired, I can seek results of a negative test from the insurance company.
- (6) I authorize Protective Life Insurance Company or its reinsurers to make a brief report of any personal health information to the MIB.

Date

Signature of person to be tested or that subject's representative (as defined under section "Unconscious or Otherwise Mentally Incapacitated"). Initials or other identifier if testing anonymously.

Print Name of Signatory

PROTECTIVE LIFE INSURANCE COMPANY

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

INFORMED CONSENT FOR THE HUMAN IMMUNODEFICIENCY VIRUS (HIV) ANTIBODY TEST

If you want to be tested to see if you have been infected with HIV, the virus that causes AIDS, please read the following and ask for an oral explanation of anything that you do not understand.

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Blood Drawing: This HIV antibody test is a blood and/or a urine test. A sample of blood and/or urine will be collected from you and then analyzed by a laboratory to determine if it contains HIV antibodies.

Limitations: As with many laboratory tests, there is a possibility of inaccurate results. For instance, a false negative result could occur if you have recently been exposed to the virus but have not yet developed antibodies.

Potential Uses of Test: If your HIV antibody test results are known, it may help your doctor determine the medical care you need. It may also help you make personal decisions, such as whether to have children and how best to avoid the risk behaviors that transmit the virus. Your results are reported to the Montana Department of Health and Environmental Sciences (DHES), but only positives or negatives; no name is attached. If testing for insurance, refer to insurance company testing section.

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Voluntary and Anonymous Testing: Taking an HIV antibody test is voluntary; you do not have to take the test. If you prefer, anonymous testing in which your name is not known to those performing the test, is available at several locations established by the DHES in Montana. These locations can be obtained from the DHES, your local health department or calling 1-800-233-6668. (Refer to insurance section.)

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Local Health Department and Insurance Company Testing: If the test is being performed as part of an application for insurance, results will be reported to the health care provider designated by you, if it is positive. A negative test may be obtained from your insurance company. (If there is no health care provider designated, a positive test, result may be reported to the local health department for post-test counseling.) A positive test result may have an effect on your ability to obtain insurance. Ask your insurance representative about who receives and has access to your HIV antibody test results.

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- (2) I have received and read written pre-test counseling materials drafted by the DHES;
- (3) I understand that anonymous testing, if I desire it, is available at one of the counseling/testing sites established by the DHES or elsewhere;
- (4) I agree to have a sample of my blood or urine tested for the presence of the HIV antibody, and authorize

Name of Health Care Provider: _____

Address: _____

to receive and inform me of the results of the test. Post-test counseling is to be given, at minimum in the form of written materials developed by the DHES.

- (5) I understand that when tested for insurance purposes that a positive test result will be given to the designated health care provider (listed above). If desired, I can seek results of a negative test from the insurance company.
- (6) I authorize Protective Life Insurance Company or its reinsurers to make a brief report of any personal health information to the MIB.

Date

Signature of person to be tested or that subject's representative (as defined under section "Unconscious or Otherwise Mentally Incapacitated"). Initials or other identifier if testing anonymously.

Print Name of Signatory

PROTECTIVE LIFE INSURANCE COMPANY

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

HIV ANTIBODY TEST

Materials provided by the Department of Health and Environmental Sciences - STATE OF MONTANA BEFORE YOU TAKE THE HIV ANTIBODY TEST

THE HIV VIRUS

Human immunodeficiency virus (HIV) is the virus that causes Acquired Immune Deficiency Syndrome (AIDS). The virus injures your immune (infection-fighting) system. If your immune system becomes so weakened by the virus that you can't fight off other diseases on your own, you have developed AIDS.

THE HIV ANTIBODY TEST

When you have an HIV infection, your body produces antibodies. The HIV antibody test is a test for those antibodies. This test is voluntary. You do not have to take the test.

A **POSITIVE TEST** means that you are infected with HIV. You can pass the virus to other people through certain behaviors. A positive test doesn't mean you have AIDS.

A **NEGATIVE TEST** means that you probably don't have HIV infection. However, because it takes time for the body to make antibodies some people may have a negative test and still be infected with the virus. If the test is done between the time the virus enters your body and the time antibodies are made, the test will be negative. You would still be able to transmit the virus to others.

Even if you have a negative test, you can still get the virus.

HOW HIV IS SPREAD

HIV is not spread by common everyday contact, but by certain risky activities. These risky activities are called **RISK BEHAVIORS**. These behaviors involve passing semen, vaginal secretions, and/or blood from an infected person to someone else. You can get the virus when an infected person's semen, vaginal secretions, or blood enters your body. Open sores make it easier for the virus to enter someone's body. Having sexually transmitted diseases like herpes or syphilis could cause open sores. These sexually transmitted diseases are treatable. See your doctor or nearest health department.

A woman who is carrying HIV may transmit the virus to her unborn child. She may also transmit the virus through her milk to a nursing infant.

THESE ARE RISK BEHAVIORS:

Sexual Contacts

- penis in or around vagina
- penis in or around rectum
- tongue or mouth in or around rectum
- tongue or mouth in or around vagina
- tongue or mouth on or around penis

Sharing Needles or Syringes

Perinatal

- infected mother to unborn child

NOTE: Since blood and blood products used in transfusions have been tested for HIV antibodies since 1985, the risk of getting HIV infection through a blood transfusion is extremely low. There is no risk in donating blood.

HOW YOU CAN PROTECT YOURSELF

The virus is in the semen, vaginal secretions and/or blood of an infected person. You can protect yourself by shielding yourself from these body fluids.

RISK REDUCING BEHAVIORS

(Safest listed first)

- Don't have sex (abstinence)
- Have only one sex partner (monogamy); both must be HIV free
- Use latex condoms (rubbers)
- Don't share needles or syringes
- Use clean needles or syringes

The sex act is risky. Latex condoms reduce the risk. Natural fiber condoms do not reduce the risk. Latex condoms must be used throughout the sexual activity and you must use them in the right way. Don't be afraid to ask your pre-test counselor for demonstrations. The spermicide nonoxynol-9 is also recommended, but only when used with a condom. Do not use oil-based lubricants with a condom.

If you are a person who engages in risk behaviors, do not donate blood. Avoid pregnancy until you are certain you and your partner are HIV free.

REASONS TO TAKE THE TEST

The test will tell you if you have the virus. It will allow your doctor to begin treatment sooner. New drugs can help maintain your health if you have the virus. Risk reducing behaviors can prevent the spread of HIV.

CONCERNS ABOUT TAKING THE TEST

Finding out you have an HIV infection is frightening. You may develop AIDS. You may transmit the virus to someone else. Having the virus can affect your entire life. It is important to consider who is available to talk to you about your test. This is not information to share casually.

Free and anonymous testing is available at Counseling and Testing Sites. A list of Counseling and Testing Sites is available by calling the Montana AIDS HOTLINE at 1-800-233-6668, or your nearest health department.

CONFIDENTIALITY (PRIVACY)

The professionals performing and recording this test value the necessity of keeping your test results confidential. You may be concerned about the possibility of friends, employers, neighbors or your insurance company finding out your test result. Discuss confidentiality policies with your pre-test counselor to find out under what circumstances others might have access to the result.

PARTNER NOTIFICATION

If your test is positive, sex and needle-sharing partner(s) need to be notified and given the opportunity to receive counseling and testing. This is a very sensitive task. Public health personnel can either tell your partner(s) or help you in how to tell your partner(s). By law, public health personnel cannot tell your partner(s) the time or place of possible infection or your identity.

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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) _____

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

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.

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- (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.

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- (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.

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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.				

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

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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.				
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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
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*Spouse Signature (For Community Property States Only)	Witness Signature	Date
--	-------------------	------

Owner(s) Signature(s) (Required)	Witness Signature (Required)	Date
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Joint Owner(s) Signature(s)	Witness Signature	Date
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Collateral Assignee/Irrevocable Beneficiary Signature, if any	Witness Signature	Date
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(* 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

	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

	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)	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No

8. Financial Details of Business:**Last Year****Prior Year**

	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			Proposed Insured 2		
Name (First, Middle, Last)			Name (First, Middle, Last)		
Height	Weight	<input type="checkbox"/> Gain Pounds in past year? <input type="checkbox"/> Loss	Height	Weight	<input type="checkbox"/> Gain Pounds in past year? <input type="checkbox"/> Loss
Currently pregnant <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," anticipated delivery date			Currently pregnant <input type="checkbox"/> Yes <input type="checkbox"/> 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	Proposed Insured 2
	Yes No	Yes No
(a) Any disorder or disease of the brain or nervous system (such as paralysis, epilepsy, stroke, convulsions, chronic headache).....	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
(b) Any disorder or disease of the heart, blood vessels, or circulatory system (such as high blood pressure, heart attack, heart murmur, chest pain).....	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
(c) Any disorder or disease of the respiratory system (such as Asthma, bronchitis, emphysema, tuberculosis).....	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
(d) Any disorder or disease of the stomach, liver, intestines, rectum, pancreas, or abdominal organs	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
(e) Any disorder or disease of the genitourinary organs (such as kidneys, urinary tract, blood or sugar in the urine, chronic inflammation).....	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
(f) Any disorder or disease of the skeletal system (such as arthritis, osteoporosis, joints, bones, spine, muscles).....	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
(g) Any disorder or disease of eyes, ears, nose or throat	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
(h) Any disorder or disease of the blood, skin, thyroid, lymph or other glands (such as anemia, diabetes).....	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
(i) Any psychiatric or mental health disorders or diseases (such as attempted suicide, Bipolar, Obsessive-compulsive).....	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
(j) Any gynecological disorders or diseases (such as irregular Pap Smear, Toxic Shock Syndrome).....	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
(k) Any cancer, tumor, cyst or nodule	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
(l) Any sexually transmitted disorders or diseases.....	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
(m) Any disorders or diseases of the immune system <i>except those related to the Human Immunodeficiency Virus (AIDS Virus)</i>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>

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

	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.....				<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>	
(b) Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS).....				<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>	
<i>Please provide details for any/all "Yes" responses.</i>							
	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.....				<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>	
(b) Received medical treatment or counseling for, or been advised by a physician to discontinue, the use of alcohol or prescribed or non-prescribed drugs.....				<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>	
(c) Been a member of any self-help group such as Alcoholics Anonymous or Narcotics Anonymous.....				<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>	
<i>Please provide details for any/all "Yes" responses.</i>							
	Question Number	Date of Diagnosis	Diagnosis, Medication or Treatment Prescribed	Medical Professional or Facility			
Proposed Insured 1							
Proposed Insured 2							

SECTION 5

<i>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.</i>							
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.....				<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>	
(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.....				<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>	
(c) Been an inpatient or outpatient in a hospital, clinic, medical facility, or any similar entity.....				<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>	
(d) Had any diagnostics test, electrocardiogram (EKG), MRI, CT-Scan or X-ray.....				<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>	
(e) Been on, or advised to be on any prescribed, non-prescribed (over the counter) medication or prescribed diet.....				<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>	
(f) Been unable to work, attend school or perform normal activities of life age and gender or been confined at home.....				<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>	
(g) Has made a claim for or received benefits, compensation or pension for any injury, sickness, disability or impaired condition.....				<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>	
<i>Please provide details for any/all "Yes" responses.</i>							
	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.....					<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
<i>Please provide details for any/all "Yes" responses.</i>						
	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**

NOTIFICATION OF RIGHT TO NAME A SECONDARY ADDRESSEE

Under Montana law, you have the right to designate a secondary addressee to receive a notice concerning the potential lapse of your policy. The notice to the secondary addressee will be sent when the policy is in danger of lapsing.

If you wish to name a secondary addressee, please call us at 1-800-366-9378, or fax us at 1-205-268-5807, or write us at P.O. Box 830619, Birmingham, Alabama 35283-0619.

Please Print the Following Information:

Policy Number (if known)

Policy Owner's Name

Insured's Name

Secondary Addressee:

Name

Street Address or P.O. Box

City, State, Zip Code

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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 in restricted states.

1. PROPOSED INSURED *(please print)*

First, Middle, Last Name: _____

Social Security Number: _____ Date of Birth (mm/dd/yyyy): _____

2. OWNER *(if other than Proposed Insured)*

First, Middle, Last Name: _____

3. AGENT/REPRESENTATIVE *(please print)*

First, Middle, Last Name: _____

Agent/Representative Number: _____ BGA Name *(if applicable)*: _____

4. ELECTRONIC ILLUSTRATION DATA – Complete this section if an electronic illustration is presented and no corresponding printed copy is provided.

Gender Class: _____ Initial Death Benefit: _____

Date of Birth (mm/dd/yyyy): _____ Premium Amount Illustrated: _____

Underwriting Class: _____ Premium Mode: _____

Plan Type: _____ Number of Policy Years Illustrated: _____

Product Name: _____ Guaranteed Interest Rate: _____ %

Policy Form Number: _____ Non-Guaranteed Illustrated Interest Rate: _____ %

Rider(s): _____ Alternate Indexed Interest Rate: _____ %
(for Indexed Products)

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: X _____ Date: _____

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: X _____ Date: _____

A SIGNED COPY MUST BE PROVIDED TO THE APPLICANT AND TO THE COMPANY
See Page 2 for State Specific Disclosures

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

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 Guarantees

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.
