

# 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. <b><u>Signature and date is required.</u></b>
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-595-OH	Notice and Consent Form for AIDS (HIV) Testing	Must complete on all cases submitted.  Leave a copy of this form 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. <b><u>Send the Original to the Home Office.</u></b></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](mailto: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](http://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](http://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



**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

\_\_\_\_\_  Replace  Change  
 Policy Number

\_\_\_\_\_  Business  Personal  Other  
 Amount Purpose – Business or Personal Issue Date

b) \_\_\_\_\_  
 Name of Insured Company

\_\_\_\_\_  Replace  Change  
 Policy Number

\_\_\_\_\_  Business  Personal  Other  
 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:<br>(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?<br>(If Yes, complete the appropriate questionnaire.) |                                       |                                       |   |  |
|    | <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?<br>(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?<br>(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>
-------------	---------------------

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?<br>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?<br>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?<br>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?<br>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

## 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: _____ <b>Answer questions (c) and (d) <u>only</u> if this is a replacement:</b> (c) Did you use any pre-printed company approved sales materials? If Yes, List Name or Form Number: _____ (d) Did you use any Company approved, electronically generated, individualized sales materials (such as illustrations or concept materials)? (If Yes, you must provide a copy of these materials with the application.)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <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.

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

*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 FORM FOR HIV TESTING

In order for us to evaluate your eligibility for insurance coverage, we request that you provide a blood or other bodily fluid sample for HIV testing and analysis. The test that will be performed will determine the presence of antibodies to the HIV virus. By signing and dating this form, you agree that the HIV antibody test may be performed on your blood or other bodily fluid sample and that underwriting decisions may be based on the test results. A positive test result will adversely affect your insurance application. It also may result in uninsurability for life, health, or disability insurance for which you may apply in the future.

### HUMAN IMMUNODEFICIENCY VIRUS (HIV)

The HIV virus causes a life-threatening disorder of the immune system called Acquired Immune Deficiency Syndrome (AIDS). Antibodies to HIV are found in the blood and other bodily fluids of people who have been exposed to the virus. You do not have to have AIDS to have antibodies against HIV. The virus is spread by sexual contact with an infected person, by exposure to infected blood (as in needle sharing during intravenous drug use or, rarely, as a result of a blood transfusion), or from an infected mother to her new-born infant.

The HIV antibody test is actually a series of tests performed upon your blood or other bodily fluid sample by a medically accepted procedure which is extremely reliable. The testing will be performed by a licensed laboratory.

### PRE-TESTING CONSIDERATION:

Many public health organizations have recommended that before taking an HIV virus antibody test a person seek counseling to become informed about the implications of such tests. You may wish to consider counseling, at your expense, prior to being tested.

### DISCLOSURE OF TEST RESULTS:

All test results are confidential, except as provided by law. State law requires that the laboratory notify the Ohio Department of Health of positive test results.

The results of the test will be reported to the insurance company named on your application for insurance. The Insurer may not by law, release positive test results except as provided below:

- If your HIV antibody test result is normal (negative), you will not be notified. You will be notified of an abnormal (positive) test result if you indicate that you desire a positive result be made known to you. You may also identify another person to whom you want the positive results released.
- If you want a physician or other health care provider to be notified of an abnormal HIV antibody test result, you must indicate the name and address of that physician or provider.
- Abnormal test results may be disclosed to persons hired by the Insurer who participate in medical underwriting decisions of the Insurer. Abnormal test results may also be disclosed to affiliates of the Insurer who require the result for medical underwriting purposes.
- In addition, if your HIV antibody test is abnormal, a generic code signifying a nonspecific blood, oral fluid (saliva) or urine abnormality may be made known to the MIB, LLC (MIB). The MIB is an organization of life and health insurance companies which operates as an information exchange on behalf of its members. There will be no record with the MIB that you had a positive HIV antibody test; however, there will be a record at the MIB that you have some blood, oral fluid or urine abnormality. If you apply to another MIB member company for life or health insurance coverage, the MIB, upon request, will supply the information on you in its file to that member.

### TEST RESULTS:

While a positive test result does not necessarily mean that you have AIDS, it does mean that you are at a greater risk of developing AIDS or AIDS-related conditions if you do not take appropriate medications. If you are infected with HIV, you are infectious to others. You should seek medical follow-up care with your personal health care provider.

HIV test results are highly reliable but not 100% accurate. If the test gives a positive result you should consider retesting in order to confirm the result. If the test gives a negative result, there is still a small possibility you may be infected with HIV. This is most likely to happen in recently infected persons. It takes at least 4 to 12 weeks for a positive test result to develop after a person is infected, and may take as long as 6 to 12 months.

**OTHER SOURCES OF INFORMATION:**

For more information about HIV or AIDS you may ask a doctor, a nurse, a counselor, or call the Ohio AIDS Hotline at 1-800-332-AIDS (2437). The hotline is a free call.

**CONSENT FOR HIV TESTING:**

I have read and I understand this HIV test informed consent form. I voluntarily consent to the withdrawal of blood or to the providing of another bodily fluid sample, the testing of my blood or other bodily fluid for HIV antibodies, and the disclosure of the test results a described above. I will be given a copy of this form. This consent is valid for ninety (90) days from the day of my signature below. The Insurer agrees to complete testing and provide the authorized notifications, as appropriate, within the 90 (ninety) day period. In addition, Protective Life Insurance Company or its reinsurers will make a brief report of any personal health information to the MIB.

In the event of a positive test result:

Send the result to me at:

Address: \_\_\_\_\_

I authorize Protective Life Insurance Company to send the result to another person:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

I authorize Protective Life Insurance Company to send the result to the following physician or health care provider.

Physician's Name: \_\_\_\_\_

Address: \_\_\_\_\_

**AUTHORIZATION:**

\_\_\_\_\_  
Name of Proposed Insured (Print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Proposed Insured

\_\_\_\_\_  
Signature of Legal Guardian, if any

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Person Obtaining Consent

\_\_\_\_\_  
Date

# PROTECTIVE LIFE INSURANCE COMPANY

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

## INFORMED CONSENT FORM FOR HIV TESTING

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The HIV virus causes a life-threatening disorder of the immune system called Acquired Immune Deficiency Syndrome (AIDS). Antibodies to HIV are found in the blood and other bodily fluids of people who have been exposed to the virus. You do not have to have AIDS to have antibodies against HIV. The virus is spread by sexual contact with an infected person, by exposure to infected blood (as in needle sharing during intravenous drug use or, rarely, as a result of a blood transfusion), or from an infected mother to her new-born infant.

The HIV antibody test is actually a series of tests performed upon your blood or other bodily fluid sample by a medically accepted procedure which is extremely reliable. The testing will be performed by a licensed laboratory.

### PRE-TESTING CONSIDERATION:

Many public health organizations have recommended that before taking an HIV virus antibody test a person seek counseling to become informed about the implications of such tests. You may wish to consider counseling, at your expense, prior to being tested.

### DISCLOSURE OF TEST RESULTS:

All test results are confidential, except as provided by law. State law requires that the laboratory notify the Ohio Department of Health of positive test results.

The results of the test will be reported to the insurance company named on your application for insurance. The Insurer may not by law, release positive test results except as provided below:

- If your HIV antibody test result is normal (negative), you will not be notified. You will be notified of an abnormal (positive) test result if you indicate that you desire a positive result be made known to you. You may also identify another person to whom you want the positive results released.
- If you want a physician or other health care provider to be notified of an abnormal HIV antibody test result, you must indicate the name and address of that physician or provider.
- Abnormal test results may be disclosed to persons hired by the Insurer who participate in medical underwriting decisions of the Insurer. Abnormal test results may also be disclosed to affiliates of the Insurer who require the result for medical underwriting purposes.
- In addition, if your HIV antibody test is abnormal, a generic code signifying a nonspecific blood, oral fluid (saliva) or urine abnormality may be made known to the MIB, LLC (MIB). The MIB is an organization of life and health insurance companies which operates as an information exchange on behalf of its members. There will be no record with the MIB that you had a positive HIV antibody test; however, there will be a record at the MIB that you have some blood, oral fluid or urine abnormality. If you apply to another MIB member company for life or health insurance coverage, the MIB, upon request, will supply the information on you in its file to that member.

### TEST RESULTS:

While a positive test result does not necessarily mean that you have AIDS, it does mean that you are at a greater risk of developing AIDS or AIDS-related conditions if you do not take appropriate medications. If you are infected with HIV, you are infectious to others. You should seek medical follow-up care with your personal health care provider.

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For more information about HIV or AIDS you may ask a doctor, a nurse, a counselor, or call the Ohio AIDS Hotline at 1-800-332-AIDS (2437). The hotline is a free call.

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In the event of a positive test result:

- Send the result to me at:

Address: \_\_\_\_\_

- I authorize Protective Life Insurance Company to send the result to another person:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

- I authorize Protective Life Insurance Company to send the result to the following physician or health care provider.

Physician's Name: \_\_\_\_\_

Address: \_\_\_\_\_

**AUTHORIZATION:**

\_\_\_\_\_  
Name of Proposed Insured (Print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Proposed Insured

\_\_\_\_\_  
Signature of Legal Guardian, if any

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Person Obtaining Consent

\_\_\_\_\_  
Date



**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

## 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.

**Termination and Refund of Premium**

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

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

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

**Effective Date of Coverage**

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

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

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

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

**SIGNATURES:**

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

\_\_\_\_\_  
Proposed Insured’s Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Owner’s Signature (if other than the Proposed Insured)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Joint Owner’s Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Agent’s Signature

\_\_\_\_\_  
Date



# PROTECTIVE LIFE INSURANCE COMPANY

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

## IMPORTANT NOTICE: REPLACEMENT OF LIFE INSURANCE OR ANNUITIES

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

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

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

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

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

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

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing life insurance policy or annuity contract?  Yes  No
2. Are you considering using funds from your existing policies or annuity contracts to pay premiums due on the new life insurance policy or annuity contract?  Yes  No

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

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

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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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.

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	INSURER NAME	ANNUITY CONTRACT OR LIFE INSURANCE POLICY #	INSURED OR ANNUITANT	REPLACED (R) or FINANCING (F)
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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.)

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**PREMIUMS:**

- Are they affordable?
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- New policies usually take longer to build cash values and to pay dividends.
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- 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:**

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- Will a loan be deducted from death benefits?
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**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?



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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	\$	\$
<b>TOTAL</b>	<b>\$</b>	<b>\$</b>

**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.)	\$	\$
<b>Net Worth</b>	<b>\$</b>	<b>\$</b>

**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 <i>(Provide details on how value was determined in "Remarks" section below)</i>	\$ _____
Are other partners being covered? <i>(Provide details in "Remarks" section below)</i>	<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 <i>(how many years?)</i>	
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 <i>(cash, accounts receivable, equipment, inventory, etc.)</i>	\$ _____	\$ _____
Total Liabilities <i>(wages/interest/dividends payable, loans, etc.)</i>	\$ _____	\$ _____
Gross Sales or Revenue	\$ _____	\$ _____
Net Income <i>(before taxes)</i>	\$ _____	\$ _____

**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

<b>Proposed Insured 1</b>				<b>Proposed Insured 2</b>			
Name (First, Middle, Last)				Name (First, Middle, Last)			
Height	Weight	<input type="checkbox"/> Gain	Pounds in past year?	Height	Weight	<input type="checkbox"/> Gain	Pounds in past year?
		<input type="checkbox"/> Loss				<input type="checkbox"/> Loss	
Currently pregnant <input type="checkbox"/> Yes <input type="checkbox"/> No				Currently pregnant <input type="checkbox"/> Yes <input type="checkbox"/> No			
If "Yes," anticipated delivery date				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)	<b>Proposed Insured 1</b>	<b>Proposed Insured 2</b>
	Yes No	Yes No
(a) Any disorder or disease of the <b>brain or nervous system</b> (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 <b>heart, blood vessels, or circulatory system</b> (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 <b>respiratory system</b> (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 <b>stomach, liver, intestines, rectum, pancreas, or abdominal organs</b> .....	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
(e) Any disorder or disease of the <b>genitourinary organs</b> (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 <b>skeletal system</b> (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 <b>eyes, ears, nose or throat</b> .....	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
(h) Any disorder or disease of the <b>blood, skin, thyroid, lymph or other glands</b> (such as anemia, diabetes).....	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
(i) Any <b>psychiatric or mental health</b> disorders or diseases (such as attempted suicide, Bipolar, Obsessive-compulsive).....	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
(j) Any <b>gynecological</b> 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 <b>cancer, tumor, cyst or nodule</b> .....	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
(l) Any <b>sexually transmitted</b> disorders or diseases.....	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
(m) Any disorders or diseases of the <b>immune system</b> <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.					<b>Proposed Insured 1</b> Yes No	<b>Proposed Insured 2</b> 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.	
<b>Proposed Insured 1</b>						
<b>Proposed Insured 2</b>						

**SECTION 7**

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

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

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

_____ Proposed Insured 1 (Sign Name in Full)	_____ Date	_____ Proposed Insured 2 (Sign Name in Full)	_____ Date
_____ Signature of Parent or Guardian	_____ Date	_____ Signature of Witness	_____ Date

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# PROTECTIVE LIFE INSURANCE COMPANY

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

## LIFE INSURANCE ILLUSTRATION CERTIFICATION & ACKNOWLEDGEMENT

- This certification must be submitted with the Application for Life Insurance if a signed illustration is not submitted for one of the reasons set forth below.
- This form must be signed on or before the application signed date 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**

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**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.

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**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.

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