

PROTECTIVE LIFE INSURANCE COMPANY

P.O. Box 830619

Birmingham, AL 35283-0619

Application Part II Statements Made to Examiner

Proposed Insured _____ Birth Date _____
First Name Middle Initial Last Name

1. a. Name and address of your personal physician? (If none, check box) [] None _____
b. Date and reason last consulted? _____
c. What treatment was given or medication prescribed? _____

2. Last use of tobacco in any form?
[] Within 1 year [] 1-3 years [] 3-5 years [] Never
Type: [] cigarettes [] cigars [] chewing tobacco or snuff
[] pipe [] nicotine gum [] nicotine patch
Date last used: _____
Frequency used (Day/Month/Year): _____

6. Have you ever tested positive for exposure to the HIV infection or been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection? Yes No
[] []

3. Have you ever been diagnosed with, or been treated for: Yes No
a. Disorder of eyes, ears, nose or throat? [] []
b. Chest pain, pulse irregularity, high blood pressure, rheumatic fever, heart murmur, heart attack, stroke, or other disorder of the heart or circulatory system? [] []
c. Cancer, tumor, disorders of lymph glands, cyst, or disorder of skin? [] []
d. Diabetes, thyroid or other endocrine disorders? [] []
e. Sugar, albumin, blood or pus in urine; venereal disease; stone or other disorder of kidney, bladder, prostate, reproductive organs or breasts? [] []
f. Pancreatitis, jaundice, intestinal bleeding, ulcer, chronic diarrhea, colitis, diverticulitis, hemorrhoids, recurrent indigestion, or other disorder of the stomach, intestines, liver or gallbladder? [] []
g. Blood spitting, asthma, emphysema, pleurisy, bronchitis, tuberculosis or chronic respiratory disorder? [] []
h. Dizziness, fainting, headache, convulsions, seizures, epilepsy, paralysis, mental or nervous disorder? [] []
i. Allergies, anemia, or other disorder of the blood, or immune system? [] []
j. Rheumatism, arthritis, gout, or disorder of the muscles, bones or joints, including the spine? [] []
k. Deformity, or amputation? [] []

7. a. Are you now under medical treatment or observation? [] []
b. Has your weight changed in the past year? Gain lbs. Loss lbs. Reason _____ [] []

8. Have you ever requested or received a pension, or payment because of an injury, sickness or disability? [] []

9. Do you participate in a regular, supervised exercise program, or any organized sport? [] []

10. a. Do you know if any parent, brother or sister has had Cancer, Heart Disease, Stroke, High Blood Pressure or Diabetes? If yes, please indicate age of onset. _____ [] []
10. b. Did any die prior to age 60 due to any of these conditions? [] []

11. Have you ever had military service deferment, rejection or discharge because of a physical or mental condition? [] []

12. Are you pregnant? [] []

4. Other than above, have you within the past 5 years:
a. Had a checkup, consultation, illness, injury, surgery? [] []
b. Been a patient in a hospital, clinic, sanatorium or other medical facility? [] []
c. Had electrocardiogram, x-ray, other diagnostic test? [] []
d. Been advised to have any diagnostic test, hospitalization, or surgery which was not completed? [] []
e. Had any mental or physical disorder not listed above? [] []

13. DETAILS of "Yes" answers. If additional space is needed, please use the Continuation of Information form.

5. a. Have you ever been advised by a physician that your use of alcohol or drugs was sufficient to impair or possibly impair your health? [] []
b. Have you ever used narcotics, sedatives, depressants, stimulants or hallucinogens, other than under a doctor's prescription and direction? [] []
c. Have you ever been or are you currently a member of any alcohol or drug rehabilitation program? [] []
d. Had more than 2 moving violations in the past 3 years? [] []
e. Been convicted for reckless driving or driving under the influence of alcohol or drugs within the past 7 years? [] []
f. Have you ever been treated for alcohol or drug use? [] []
g. Do you or have you ever smoked marijuana? [] []
h. Do you or have you ever used cocaine? [] []
i. Have you ever been convicted of a felony? [] []

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. Any person who knowingly and with intent to injure, defraud, or deceive any Insurer, files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Signed at _____ (City) _____ (State) Date: _____

Witness _____ (X) _____
Medical Examiner or Interviewer Signature of person proposed for insurance if age 15 or over, or Parent if proposed insured is under age 15

14. a. Height _____ ft. _____ in.
 Weight _____ lbs.
 b. Did you weigh and measure applicant? Yes No
 c. Is appearance unhealthy or older than stated age? Yes No

Chest (Full Inspiration)	Chest (Forced Expiration)	Abdomen, at Umbilicus
in.	in.	in.

Applicant's identity was established by:

Drivers License # _____
 Social Security # _____
 Other _____

15. Blood Pressure (Record all readings) (If Above 140/90 Record Additional Readings.)

	1st	2nd	3rd
Systolic			
Diastolic (5th phase)			

16. Pulse: Exercise if irregular, over 90 or less than 50 per min.

	At Rest	After Exercise	3 Minutes Later
Rate			
Irregularities per min.			

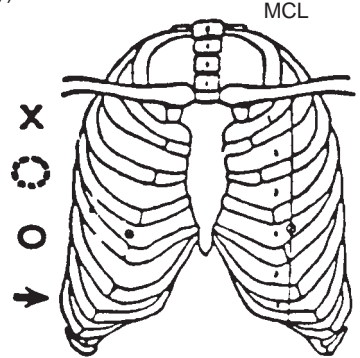
NOTE: DO NOT USE THIS SECTION FOR THE COMPLETION OF QUESTION #13. DETAILS-USE THE CONTINUATION OF INFORMATION FOR PART I AND PART II.

17. Heart: Is there any:

Enlargement Yes No Dyspnea Yes No
 Murmur(s) Yes No Edema Yes No
 (describe below - if more than one, describe separately)

Details of Positive Findings by MD

	Murmur 1.	Murmur 2.	
Location			Indicate:
Constant	<input type="checkbox"/>	<input type="checkbox"/>	Apex by X
Inconstant	<input type="checkbox"/>	<input type="checkbox"/>	Murmur area by ○
Transmitted	<input type="checkbox"/>	<input type="checkbox"/>	Point of greatest intensity by ○
Localized	<input type="checkbox"/>	<input type="checkbox"/>	Transmission by →
Systolic	<input type="checkbox"/>	<input type="checkbox"/>	
Diastolic	<input type="checkbox"/>	<input type="checkbox"/>	
Soft (Gr. 1-2)	<input type="checkbox"/>	<input type="checkbox"/>	
Mod. (Gr. 3-4)	<input type="checkbox"/>	<input type="checkbox"/>	
Loud (Gr. 5-6)	<input type="checkbox"/>	<input type="checkbox"/>	
After exercise:			
Increased	<input type="checkbox"/>	<input type="checkbox"/>	
Absent	<input type="checkbox"/>	<input type="checkbox"/>	
Unchanged	<input type="checkbox"/>	<input type="checkbox"/>	
Decreased	<input type="checkbox"/>	<input type="checkbox"/>	



For comments and your impression?

18. Is there on examination any abnormality of the following: (Circle applicable items and give details)

	Yes	No
(a) Eyes, ears, nose, mouth, pharynx? (If vision or hearing markedly impaired, indicate degree and correction.)	<input type="checkbox"/>	<input type="checkbox"/>
(b) Skin (include scars); lymph nodes; varicose veins or peripheral arteries?	<input type="checkbox"/>	<input type="checkbox"/>
(c) Nervous system (include reflexes, gait, paralysis)?	<input type="checkbox"/>	<input type="checkbox"/>
(d) Respiratory system?	<input type="checkbox"/>	<input type="checkbox"/>
(e) Abdomen (include scars)?	<input type="checkbox"/>	<input type="checkbox"/>
(f) Genitourinary system?	<input type="checkbox"/>	<input type="checkbox"/>
(g) Endocrine system (include thyroid and breasts)?	<input type="checkbox"/>	<input type="checkbox"/>
(h) Musculoskeletal system (include spine, joints, amputations, deformities)?	<input type="checkbox"/>	<input type="checkbox"/>

19. Are you aware of or do you suspect any other medical, alcoholic or drug history? (If yes, please send a confidential report to the Medical Director) Yes No

20. Urinalysis: Albumin _____ Sugar _____ Specific Gravity _____
 In Addition To Performing Above Urinalysis, Please Send Specimen To Lab On ALL Exams.

21. If required, was Blood Sample sent to Lab: Yes No
 If required, was the following sent to the Home Office: EKG Yes No Stress Test Yes No X-Ray Yes No

I certify that I have made this examination with the results recorded on this _____ day of _____ (month), _____ (year)

Examination was made at: My Office Applicant's resident Applicant's place of business
 Person Examined is: Not My Patient My Patient (If patient, please send copies of charts)

 Signature of Examiner Telephone No.

(Legibly print, type or rubber stamp name of examiner and office address below)
 Name _____
 Address _____
 City, State & Zip _____

1. Name of agent requesting exam _____
 2. Name of person examined _____
 Address _____
 City, State & Zip _____

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

Any person who knowingly and with intent to injure, defraud, or deceive any Insurer, files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

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)

Agent's Printed Name Agent's Signature Agent's FL License ID No