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

The applicant does not have to disclose an HIV (AIDS Virus) test which was administered: (1) to a criminal offender or crime victim as a result of a crime that was reported to the police; (2) to a patient who received the services of emergency medical services personnel at a hospital or medical care facility; (3) to emergency medical personnel who were tested as a result of performing emergency medical services. The applicant should be referred to the definition of "emergency medical personnel" as defined on the Authhorzation to Obtain and Disclose Information.

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): _____

3. Have you been medically diagnosed or treated by a medical professional 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?	☐	☐

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?	☐	☐

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, or stimulants 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. Been convicted of 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 5 years?	☐	☐
f. Have you ever been treated for alcohol or drug use?	☐	☐
g. Do you or have in the last 5 years used illegal drugs?	☐	☐
h. Have you ever been convicted of a felony?	☐	☐

	Yes	No
6. Have you been diagnosed by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS)?	☐	☐
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?	☐	☐

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

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.

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.

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

b. Did you weigh and measure applicant? ☐ Yes ☐ No
c. Is appearance unhealthy or older than stated age? ☐ Yes ☐ No

Applicant's identity was established by:

☐ Drivers License # _____
☐ Social Security # _____
☐ Other _____

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

(Record all 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.

Details of Positive Findings by MD

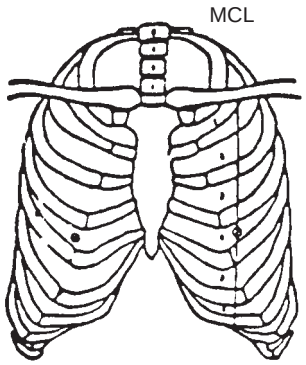
17. Heart: Is there any:

Enlargement ☐ Yes ☐ No Dyspnea ☐ Yes ☐ No
Murmur(s) ☐ Yes ☐ No Edema ☐ Yes ☐ No

(describe below – if more than one, describe separately)

	Murmur 1.	Murmur 2.
Location		
Constant	☐	☐
Inconstant	☐	☐
Transmitted	☐	☐
Localized	☐	☐
Systolic	☐	☐
Diastolic	☐	☐
Soft (Gr. 1-2)	☐	☐
Mod. (Gr. 3-4)	☐	☐
Loud (Gr. 5-6)	☐	☐
After exercise:		
Increased	☐	☐
Absent	☐	☐
Unchanged	☐	☐
Decreased	☐	☐

Indicate:
Apex by X
Murmur area by ◌
Point of greatest intensity by O
Transmission by →



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.)	☐	☐
(b) Skin (include scars); lymph nodes; varicose veins or peripheral arteries?	☐	☐
(c) Nervous system (include reflexes, gait, paralysis)?	☐	☐
(d) Respiratory system?	☐	☐
(e) Abdomen (include scars)?	☐	☐
(f) Genitourinary system?	☐	☐
(g) Endocrine system (include thyroid and breasts)?	☐	☐
(h) Musculoskeletal system (include spine, joints, amputations, deformities)?	☐	☐

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) ☐ ☐

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 _____

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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) *(if other than Proposed Insured)*	Date		