

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) <input type="checkbox"/> None _____		
b. Date and reason last consulted? _____		
c. What treatment was given or medication prescribed? _____		
2. Last use of tobacco in any form? <input type="checkbox"/> Within 1 year <input type="checkbox"/> 1-3 years <input type="checkbox"/> 3-5 years <input type="checkbox"/> Never Type: <input type="checkbox"/> cigarettes <input type="checkbox"/> cigars <input type="checkbox"/> chewing tobacco or snuff <input type="checkbox"/> pipe <input type="checkbox"/> nicotine gum <input type="checkbox"/> nicotine patch Date last used: _____ Frequency used (Day/Month/Year): _____	6. Have you been diagnosed by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS) or Aids Related Complex (ARC)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
3. Have you ever had, been told you had, or been treated for: a. Disorder of eyes, ears, nose or throat? <input type="checkbox"/> Yes <input type="checkbox"/> No b. Chest pain, pulse irregularity, high blood pressure, rheumatic fever, heart murmur, heart attack, stroke, or other disorder of the heart or circulatory system? <input type="checkbox"/> Yes <input type="checkbox"/> No c. Cancer, tumor, disorders of lymph glands, cyst, or disorder of skin? <input type="checkbox"/> Yes <input type="checkbox"/> No d. Diabetes, thyroid or other endocrine disorders? <input type="checkbox"/> Yes <input type="checkbox"/> No e. Sugar, albumin, blood or pus in urine; venereal disease; stone or other disorder of kidney, bladder, prostate, reproductive organs or breasts? <input type="checkbox"/> Yes <input type="checkbox"/> No f. Pancreatitis, jaundice, intestinal bleeding, ulcer, chronic diarrhea, colitis, diverticulitis, hemorrhoids, recurrent indigestion, or other disorder of the stomach, intestines, liver or gallbladder? <input type="checkbox"/> Yes <input type="checkbox"/> No g. Blood spitting, asthma, emphysema, pleurisy, bronchitis, tuberculosis or chronic respiratory disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No h. Dizziness, fainting, headache, convulsions, seizures, epilepsy, paralysis, mental or nervous disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No i. Allergies, anemia, or other disorder of the blood, or immune system? <input type="checkbox"/> Yes <input type="checkbox"/> No j. Rheumatism, arthritis, gout, or disorder of the muscles, bones or joints, including the spine? <input type="checkbox"/> Yes <input type="checkbox"/> No k. Deformity, or amputation? <input type="checkbox"/> Yes <input type="checkbox"/> No	7. a. Are you now under medical treatment or observation? <input type="checkbox"/> Yes <input type="checkbox"/> No b. Has your weight changed in the past year? Gain lbs. Loss lbs. Reason _____ <input type="checkbox"/> Yes <input type="checkbox"/> No	
	4. Other than above, have you within the past 5 years: a. Had a checkup, consultation, illness, injury, surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No b. Been a patient in a hospital, clinic, sanatorium or other medical facility? <input type="checkbox"/> Yes <input type="checkbox"/> No c. Had electrocardiogram, x-ray, other diagnostic test? <input type="checkbox"/> Yes <input type="checkbox"/> No d. Been advised to have any diagnostic test, hospitalization, or surgery which was not completed? <input type="checkbox"/> Yes <input type="checkbox"/> No e. Had any mental or physical disorder not listed above? ... <input type="checkbox"/> Yes <input type="checkbox"/> No	8. Have you ever requested or received a pension, or payment because of an injury, sickness or disability? <input type="checkbox"/> Yes <input type="checkbox"/> No
	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? <input type="checkbox"/> Yes <input type="checkbox"/> No b. Have you ever used narcotics, sedatives, depressants, stimulants or hallucinogens, other than under a doctor's prescription and direction? <input type="checkbox"/> Yes <input type="checkbox"/> No c. Have you ever been or are you currently a member of any alcohol or drug rehabilitation program? <input type="checkbox"/> Yes <input type="checkbox"/> No d. Had more than 2 moving violations in the past 3 years? .. <input type="checkbox"/> Yes <input type="checkbox"/> No e. Been convicted for reckless driving or driving under the influence of alcohol or drugs within the past 7 years? <input type="checkbox"/> Yes <input type="checkbox"/> No f. Have you ever been treated for alcohol or drug use? <input type="checkbox"/> Yes <input type="checkbox"/> No g. Do you or have you ever smoked marijuana? <input type="checkbox"/> Yes <input type="checkbox"/> No h. Do you or have you ever used cocaine? <input type="checkbox"/> Yes <input type="checkbox"/> No i. Have you ever been convicted of a felony? <input type="checkbox"/> Yes <input type="checkbox"/> No	9. Do you participate in a regular, supervised exercise program, or any organized sport? <input type="checkbox"/> Yes <input type="checkbox"/> No
		10. a. Do you know if any parent, brother or sister has had Cancer, Heart Disease, Stroke, High Blood Pressure or Diabetes? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please indicate age of onset. _____ 10. b. Did any die prior to age 60 due to any of these conditions? <input type="checkbox"/> Yes <input type="checkbox"/> No
		11. Have you ever had military service deferment, rejection or discharge because of a physical or mental condition? <input type="checkbox"/> Yes <input type="checkbox"/> No
		12. Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No
		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

12. 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 _____

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

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

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

14. Pulse: _____ Exercise if irregular, over 90 or less than 50 per min.
 At Rest After Exercise 3 Minutes Later

Rate _____
 Irregularities per min. _____

Details of Positive Findings by MD

15. 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	<input type="checkbox"/>	<input type="checkbox"/>
Inconstant	<input type="checkbox"/>	<input type="checkbox"/>
Transmitted	<input type="checkbox"/>	<input type="checkbox"/>
Localized	<input type="checkbox"/>	<input type="checkbox"/>
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"/>

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

For comments and your impression?

16. 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"/>

17. 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

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

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

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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)