

Application Part II
Statements Made to Examiner

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



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): _____

	Yes	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"/>	<input type="checkbox"/>
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"/>	<input type="checkbox"/>
c. Cancer, tumor, disorders of lymph glands, cyst, or disorder of skin?	<input type="checkbox"/>	<input type="checkbox"/>
d. Diabetes, thyroid or other endocrine disorders?	<input type="checkbox"/>	<input type="checkbox"/>
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"/>	<input type="checkbox"/>
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"/>	<input type="checkbox"/>
g. Blood spitting, asthma, emphysema, pleurisy, bronchitis, tuberculosis or chronic respiratory disorder?	<input type="checkbox"/>	<input type="checkbox"/>
h. Dizziness, fainting, headache, convulsions, seizures, epilepsy, paralysis, mental or nervous disorder?	<input type="checkbox"/>	<input type="checkbox"/>
i. Allergies, anemia, or other disorder of the blood, or immune system?	<input type="checkbox"/>	<input type="checkbox"/>
j. Rheumatism, arthritis, gout, or disorder of the muscles, bones or joints, including the spine?	<input type="checkbox"/>	<input type="checkbox"/>
k. Deformity, or amputation?	<input type="checkbox"/>	<input type="checkbox"/>

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?

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"/>	<input type="checkbox"/>
b. Have you ever used narcotics, sedatives, depressants, stimulants or hallucinogens, other than under a doctor's prescription and direction?	<input type="checkbox"/>	<input type="checkbox"/>
c. Have you ever been or are you currently a member of any alcohol or drug rehabilitation program?	<input type="checkbox"/>	<input type="checkbox"/>
d. Had more than 2 moving violations in the past 3 years? ..	<input type="checkbox"/>	<input type="checkbox"/>
e. Been convicted for reckless driving or driving under the influence of alcohol or drugs within the past 7 years?	<input type="checkbox"/>	<input type="checkbox"/>
f. Have you ever been treated for alcohol or drug use?	<input type="checkbox"/>	<input type="checkbox"/>
g. Do you or have you ever smoked marijuana?	<input type="checkbox"/>	<input type="checkbox"/>
h. Do you or have you ever used cocaine?	<input type="checkbox"/>	<input type="checkbox"/>
i. Have you ever been convicted of a felony?	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No
6. Have you been diagnosed by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS)?	<input type="checkbox"/>	<input type="checkbox"/>

7. a. Are you now under medical treatment or observation?	<input type="checkbox"/>	<input type="checkbox"/>
b. Has your weight changed in the past year?	<input type="checkbox"/>	<input type="checkbox"/>
Gain lbs. Loss lbs. Reason _____		

8. Have you ever requested or received a pension, or payment because of an injury, sickness or disability?	<input type="checkbox"/>	<input type="checkbox"/>
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9. Do you participate in a regular, supervised exercise program, or any organized sport?	<input type="checkbox"/>	<input type="checkbox"/>
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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	<input type="checkbox"/>	<input type="checkbox"/>
indicate age of onset. _____		

10. b. Did any die prior to age 60 due to any of these conditions?	<input type="checkbox"/>	<input type="checkbox"/>
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11. Have you ever had military service deferment, rejection or discharge because of a physical or mental condition? ..	<input type="checkbox"/>	<input type="checkbox"/>
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12. Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
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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

11. 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 _____

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

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

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

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

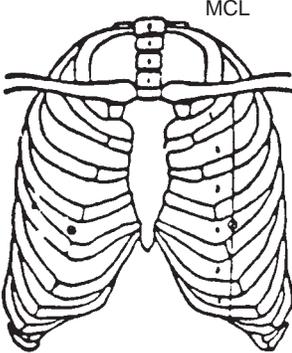
NOTE: DO NOT USE THIS SECTION FOR THE COMPLETION OF QUESTION #13. DETAILS-USE THE CONTINUATION OF INFORMATION FOR PART I AND PART II.

11. 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?

11. 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"/>

1J. 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

[Large empty rectangular box for supplemental information]

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)