Protective Life and Annuity Insurance Company

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

SUPPLEMENTAL UNDERWRITING APPLICATION

PROPOSED INSURED:

First Name	M.I.	Last Name	Date of Birth:

Important! For ALL QUESTIONS ANSWERED YES, please provide details including: Name of physician, date diagnosed, medications, and current condition. If additional space is needed, please use the Additional Details or Comments section of this form or the Continuation of Information form.

1. **Has the Proposed Insured been diagnosed with or been treated within the past 10 years for:** Yes No

a) Alzheimer's disease or dementia, memory loss, Mild Cognitive Impairment (MCI), or organic brain syndrome? ☐ ☐

DETAILS: ____________________

b) Connective Tissue, Lupus or other auto-immune disorder? ☐ ☐

DETAILS: ____________________

c) Nervous disorders such as seizures, fainting spells, Parkinson's disease, tremor, ALS, Multiple Sclerosis, Aphasia or other disorders of the brain or nervous system? ☐ ☐

DETAILS: ____________________

d) Fractures or falls? ☐ ☐

DETAILS: ____________________

2. **Has the Proposed Insured been:**

a) Declined, refused, rated or turned down for life insurance, long-term care insurance, medical or disability insurance? ☐ ☐

DETAILS: ____________________

b) Required to have home care, nursing home care, or adult care for any reason within the past 12 months? ☐ ☐

DETAILS: ____________________

3. Has the Proposed Insured been advised to enter, or is the Proposed Insured planning to reside in, or is the Proposed Insured currently residing in a nursing home, assisted care living facility, or other custodial facility? ☐ ☐

DETAILS: ____________________

4. Does the Proposed Insured currently attend or have plans to attend adult day care? ☐ ☐

DETAILS: ____________________

	Yes	No
5. **Does the Proposed Insured:**		
a) Use one of the following medical devices: walker; wheelchair; hospital bed; quad cane; oxygen; stair lift; or dialysis? (If Yes, provide type of device and date usage began) **DETAILS:** ______________________________	☐	☐
b) Participate in any type of exercise program? (If Yes, provide type and frequency) **DETAILS:** ______________________________	☐	☐
c) Drive a motor vehicle? (If Yes, provide the number of miles driven in the past 12 months. If No, what date did the Proposed Insured last drive and why did the Proposed Insured stop driving?) **DETAILS:** ______________________________	☐	☐
d) Manage finances, including paying bills, writing checks and balancing the check book? (If No, identify what activities require assistance, who provides it and why it is needed.) **DETAILS:** ______________________________	☐	☐
e) Perform regular household tasks including cooking, cleaning, laundry, shopping, yard work? (If No, identify what activities require assistance, who provides it and why it is needed.) **DETAILS:** ______________________________	☐	☐
f) Live alone? (If No, who does the Proposed Insured live with?) **DETAILS:** ______________________________	☐	☐
6. **Does ANYONE help the Proposed Insured** with getting around inside the home, getting into and out of bed or a chair, bathing, dressing, toileting or eating? (If Yes, identify the helper and give details of help required) **DETAILS:** ______________________________	☐	☐
7. **The Proposed Insured:**		
a) Is the Proposed Insured's activity limited by shortness of breath, debility, gait/ambulation disturbance or pain? **DETAILS:** ______________________________	☐	☐
b) How far can the Proposed Insured walk comfortably without the issue(s) in 7a causing him or her to stop? **DETAILS:** ______________________________		
8. **Additional details or comments:**		

I have read or have had read to me the completed Supplemental Underwriting 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/State): ______________________ **Date:** ______________________

______________________ ______________________

Signature of Examiner as Witness   Signature of Proposed Insured