Protective Life 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 Continuation of Information form.

	Yes	No
1. **Has the Proposed Insured been diagnosed with or been treated within the past 10 years for:**		
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) Any history of 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: _____		
c) Advised to enter, planning to reside in, or currently residing in a nursing home, assisted care living facility, or other custodial facility, or attending adult day care?	☐	☐
DETAILS: _____		

3. **Does the Proposed Insured:** **Yes** **No**

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 you last drive and why did you 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 do you live with?) ☐ ☐

DETAILS: _____

4. **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: _____

5. **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 5a causing him or her to stop?

DETAILS: _____

6. **Additional details or comments:**

The above statements and answers are true and complete to the best of my knowledge and belief.

CALIFORNIA ONLY - For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

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

_____ _____

Signature of Examiner as Witness Signature of Proposed Insured