PROTECTIVE LIFE INSURANCE COMPANY

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

INDIVIDUAL LIFE INSURANCE APPLICATION PACKET - INSTRUCTIONS

The forms listed on page 1 are required on all cases submitted.
All forms must be dated on or before the application signed date.

FORM NUMBER	FORM NAME	INSTRUCTIONS
PL-DIP	Description of Information Practices	This notice MUST be given to the Proposed Insured on all cases submitted.
PL-400R-FL	Individual Life Insurance Application	Protective Life can only accept or service an application from an applicant who speaks English or Spanish. Spanish speaking applicants must go through our TeleLife process. Complete each question in the Application for Insurance. If completing by hand, please use a pen with black ink. If applying for any riders see instructions for Rider Worksheet on Page 2.
PL-701-FL	Supplement to Life Insurance Application (STOLI)	Must complete on all cases being submitted.
PL-HIPAA3-FL	Authorization to Obtain and Disclose Information (HIPAA)	Must complete on all cases being submitted. Leave a copy of this form with the applicant. **Signature and date is required.**
PLX-408	Broker/Representative Report	The correct Broker/Representative PLICO Contract Number must be included in order to ensure commissions are paid correctly. Include Split Share Percentage.
PL-406A-FL	Continuation of Information	Use this form if additional space is needed for information.
U-422-FL	Notice and Consent Form for AIDS (HIV) Testing	Must complete on all cases submitted. Leave a copy of this form with the applicant.
FL-SA	Notification of Right to Name a Secondary Addressee	Must complete on all cases submitted. Leave a copy of this form with the applicant.
PLX-588	Life Insurance Illustration Certification & Acknowledgement	Only required for illustrated UL products when an illustration is not obtained. Illustrations are required prior to issue.

NOT FOR USE WITH VARIABLE UNIVERSAL LIFE PRODUCTS

The forms listed on page 2 may be required if circumstances apply. Forms are available on MyProtective.com.

FORM NUMBER	FORM NAME	INSTRUCTIONS
PL-403R-FL	Rider Worksheet	If applying for any additional benefits or riders, the Rider Worksheet must be completed. In addition, the following riders require these supplemental application forms, which can be found online at MyProtective.com forms site. Leave a copy of each form with the applicant. If applying for the Children's Term Rider, complete form number PL-404R-FL. If applying for the Chronic Illness Accelerated Death Benefit Rider, provide the applicant with the L652-DSC Disclosure form. The medical examiner will need to complete the Supplemental Underwriting Application form number PL-226R-FL. If applying for the Income Provider Option, complete form number P-U-437R.
PL-104	Pre-Authorized Withdrawal Agreement	Use in cases where the applicant elects to have premium payments drafted from a bank account.
PL-CR	Conditional Receipt Agreement	If payment is submitted with the application, must complete and sign the Conditional Receipt Agreement. Leave a copy of this form with the applicant.
A-1128-FLA and A-1129-FLA	Replacement Forms	Must complete and sign regarding existing coverage. Leave a copy of this form with the Proposed Insured.
F-LAD-277	Assignment/Transfer of Ownership (Section 1035 Exchange)	Must complete on 1035 Exchange/Transfer cases. Leave a copy of this form with the owner. **Send the Original to the Home Office.**
PL-405R-FL	Confidential Financial Statement	To be signed by the Proposed Insured if Face Amount is $5,000,001 or greater (for Proposed Insured(s) age 0-70) and $3,000,001 or greater (for Proposed Insured(s) age 71 and older) or at the discretion of underwriting.
PL-402-FL	Part 1A Supplemental Application (Medical Declarations)	If the Proposed Insured is NOT being examined, this form must be completed.

E-mail Address: NBApps@protective.com
If e-mailing the application, you do not need to send the original application. However, we will need the original 1035 paperwork and assignment forms (if applicable).

Mailing Addresses:

Home Office – Regular Mail
Protective Life Insurance Company
ATTN: New Business
P.O. Box 830619
Birmingham, Alabama 35283-0619
Telephone: (800) 366-9378
Fax: (205) 268-5807

Home Office – Overnight Mail
Protective Life Insurance Company
ATTN: New Business
2801 Highway 280 South
Birmingham, Alabama 35223
Telephone: (800) 366-9378
Fax: (205) 268-5807

PROTECTIVE LIFE INSURANCE COMPANY
P.O. Box 830619
Birmingham, AL 35283-0619

DESCRIPTION OF INFORMATION PRACTICES

(Including MIB, LLC Notice and Fair Credit Reporting Act Notice)

DISCLOSURE OF INFORMATION

In considering your application for insurance, information from various sources must be considered. These include the results of your physical examination, if required, and any reports Protective Life may receive from doctors and hospitals who have attended you.

Information regarding your insurability will be treated as confidential. Protective Life, or its reinsurers, may, however, make a brief report of any personal health information thereon to the MIB, LLC ("MIB"), which operates an information exchange on behalf of insurance companies that are members of MIB Group, Inc. If you apply to another MIB member company for life or health insurance coverage or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 or go to its website at www.mib.com to request disclosure online. If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

Protective Life, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

INVESTIGATIVE CONSUMER REPORT

Furthermore, as part of our procedures for processing your insurance application, an investigative consumer report may be prepared by one or more of the commercial agencies offering this service whereby information is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted. This inquiry includes information as to your insurance risk score, character, general reputation, personal characteristics or behavioral and lifestyle factors, except as may be related directly or indirectly to your sexual orientation. You have the right to be personally interviewed if we order an investigative consumer report. You also have the right to receive a copy of the report by making a written request to Protective Life, within a reasonable period of time, to receive additional detailed information about the nature and scope of this investigation.

YOU CAN REVIEW AND CORRECT YOUR INFORMATION

As a general practice, we will not disclose personal or privileged information about you to anyone else without your consent, unless a legitimate business need exists or disclosure is required or permitted by law. You are entitled, upon request, to receive a more detailed statement of our information practices. You also have the right to access the personal information about you that we have in our records. You may see a copy of the information, or we will send it to you, whichever you prefer. You also have the right to request correction of personal information we may have about you which you think is wrong. To exercise these rights, please write to us at the address appearing at the end of this notice.

Ask our agent/producer for assistance or call or write us at Protective Life Insurance Company, Attention: New Business, P.O. Box 830619, Birmingham, Alabama 35283-0619. Telephone: 800-366-9378

THIS NOTICE MUST BE GIVEN TO THE PROPOSED INSURED

AGENT/PRODUCER COMPENSATION DISCLOSURE

Agents/Producers receive compensation from an insurer or third party, which may differ depending upon the product or insurer. Additional compensation may be received by the Agent/Producer based on other factors including premium volume placed with the company and loss or claim experience.

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PROTECTIVE LIFE INSURANCE COMPANY
P.O. BOX 830619 • BIRMINGHAM, ALABAMA 35283-0619

INDIVIDUAL LIFE INSURANCE APPLICATION

SECTION I: INSURED AND OWNER INFORMATION

1. PROPOSED INSURED

Name (First, Middle, Last) _____ Home Phone _____

Gender _____ Work Phone _____

Date of Birth _____ Cell Phone _____

Birth State _____ Address 1 (Street or P.O. Box Number) _____

Marital Status _____ Address 2 (City, State, Zip Code) _____

Driver's License Number and State _____ Number of Years at Address _____

Social Security Number _____ Email Address _____

2. SURVIVORSHIP PRODUCTS ONLY

(Provide Proposed Insured 2 Name and Date of Birth below. An additional application must be completed for the Proposed Insured 2.)

Proposed Insured 2 Name _____ Proposed Insured 2 Date of Birth _____

3. EMPLOYMENT INFORMATION

Employer's Name _____ Number of Years with Employer _____

Address 1 (Street or P.O. Box Number) _____ Annual Income _____

Address 2 (City, State, Zip Code) _____ Spouse/Domestic Partner Annual Income _____

Occupation _____ Net Worth _____

4. OWNER

(If other than Proposed Insured, must complete information below. If Trust, include Name and Date of Trust.)

Owner's Name or Name of Trust _____ Social Security Number/Taxpayer I.D. Number _____

Date of Trust (if applicable) _____ Address 1 (Street or P.O. Box Number) _____

Birthdate _____ Phone Number _____ Address 2 (City, State, Zip Code) _____

Relationship to Proposed Insured _____ Email Address _____

JOINT OWNER

(If applicable.)

Joint Owner's Name or Name of Trust _____ Social Security Number/Taxpayer I.D. Number _____

Date of Trust (if applicable) _____ Address 1 (Street or P.O. Box Number) _____

Birthdate _____ Phone Number _____ Address 2 (City, State, Zip Code) _____

Relationship to Proposed Insured _____ Email Address _____

5. **SEND PREMIUM NOTICES TO**
(If other than Owner.)

_____ _____ _____
Name Relationship to Proposed Insured Date of Birth

_____ _____
Address Social Security Number/Taxpayer I.D. Number

SECTION II: PLAN OF INSURANCE

1. _____
Plan of Insurance/Name of Product

2. _____
Face Amount

3. If Term or Alternative to Term (Indicate Years):
☐ 10 ☐ 15 ☐ 20 ☐ 25 ☐ 30 ☐ 35 ☐ 40

4. _____
Underwriting Class Quoted
(Protective will issue the best underwriting class.)

5. If Universal Life: ☐ Level Face Amount
☐ Increasing Face Amount

6. Death Benefit Compliance Test: ☐ CVAT ☐ GPT
(Subject to product availability.)

7. Section 1035: ☐ Yes ☐ No

8. 1035 Loan Transfer: ☐ Yes ☐ No

9. If any additional benefits, riders, or child coverage are requested, check here: ☐

(If checked, please complete the Rider Worksheet. If not checked, no additional benefits or riders are included in the policy.)

10. What is the source of Premium Payment?

☐ Current income or savings
☐ The Trust listed as the Owner
☐ A third-party source, such as Premium Financing
☐ Other: Please explain.

_____

11. Premium Payment:

☐ Annual $_____
☐ Quarterly $_____
☐ Semi-Annual $_____
☐ Monthly $_____
(Pre-Authorized Withdrawal Only)
☐ Cash with Application $_____

SECTION III: BENEFICIARY DESIGNATIONS

(If multiple beneficiaries are named, shares will be divided equally among the surviving beneficiaries, unless otherwise specified. The total percentage for each class of beneficiary must equal 100%.)

1.	Primary Beneficiary Name(s)	Address	Telephone	Date of Birth	Social Security No.	Relationship	Percentage

2.	Contingent Beneficiary Name(s)	Address	Telephone	Date of Birth	Social Security No.	Relationship	Percentage

SECTION IV: EXISTING COVERAGE/PENDING INSURANCE AND REPLACEMENT

(If you answer Yes to Questions 1-3 in this section, you will need to complete any state required replacement forms and comparison statements. All questions must be answered completely. If additional space is needed, use Section VII and follow the directions provided.)

1. Does the Proposed Insured have any existing life insurance policies or annuity contracts in force? ☐ Yes ☐ No

a)
_____ _____
Name of Insured Company

_____ _____
Policy Number Replace or Change

_____ _____ _____
Amount Purpose – Business or Personal Issue Date

b)
_____ _____
Name of Insured Company

_____ _____
Policy Number Replace or Change

_____ _____ _____
Amount Purpose – Business or Personal Issue Date

2. Is the policy applied for intended to be a replacement, modification, or discontinuation of any existing life insurance policies or annuity contracts? ☐ Yes ☐ No
(If you intend to replace existing coverage, complete any state required replacement forms and comparison statements.)
3. Is there any application now pending or being considered for other life or health insurance covering the Proposed Insured? (If Yes, provide details below.) ☐ Yes ☐ No

_____ _____ _____ _____
Company Name Amount of Coverage Total Amount to be Placed Purpose of Coverage

4. Has the Proposed Insured had a request for life or health insurance declined, postponed, rated, canceled, or restricted in any way? (If Yes, please explain.) ☐ Yes ☐ No
5. In the next 3 years, will the ownership of the policy or interest in any trust owning the policy be transferred? (If Yes, please explain.) ☐ Yes ☐ No
6. Is someone other than the Proposed Insured responsible for paying premiums? ☐ Yes ☐ No
(If Yes, please explain.)
7. Will anyone unrelated to the Proposed Insured receive any of the policy death benefit? ☐ Yes ☐ No
(If Yes, please explain.)
8. In the last two years has the Proposed Insured or Owner authorized a life expectancy analysis to be performed or has the Proposed Insured or Owner been asked to authorize a life expectancy analysis in the future? ☐ Yes ☐ No
9. Has the Proposed Insured discussed transfer of the policy to be issued, or its death benefits, to a life settlement company, Investor, offshore trust, investment trust, or entity associated with stranger owned or investment owned life insurance (commonly called SOLI or IOLI) or have you considered such a transfer within the next 2 years? (If Yes, please explain.) ☐ Yes ☐ No

SECTION V: PURPOSE OF INSURANCE

(To be answered and completed by the Owner. If additional space is needed, use Section VII and follow the directions provided.)

1. What is the purpose of the insurance?
(Personal – Family Estate Protection, Asset Transfer or Business – Key Man, Buy-Sell, etc.)
(If Business insurance, complete Questions 2-6 below.)
☐ Personal
☐ Business – Key Person
☐ Business – Buy/Sell
☐ Business – Other
2. What percent of business does the Proposed Insured own or control? _____%
3. What is approximate net annual income of business? $_____
4. What is approximate market value of the business? $_____
5. What year was the business established? _____
6. Please complete the information below:

_____ _____ _____
Name/Business Partner Title % of Business Owned

_____ _____
Insurance Company Amount Now Carried or Applied For

SECTION VI: PERSONAL HISTORY

(If additional space is needed, use Section VII and follow the directions provided.)

1. Has the Proposed Insured used tobacco or nicotine of any kind over the last 5 years? ☐ Yes ☐ No

Type	Frequency	Date Last Used

2. Has the Proposed Insured consulted a physician or had treatment for the use or possession of:
(If Yes, complete the appropriate questionnaire for Alcohol and Drug Use.)
   A. Alcohol? ☐ Yes ☐ No
   B. Narcotics, stimulants, sedatives, hallucinogenic drugs? ☐ Yes ☐ No
3. In the past 5 years, has the Proposed Insured been convicted of (I) two or more moving violations, (II) driving under the influence of alcohol or other drugs, or (III) had driver's license suspended or revoked? ☐ Yes ☐ No
4. Has the Proposed Insured ever been convicted of, or pled guilty or no contest to a felony, or had any such charge pending against them? ☐ Yes ☐ No
5. Has the Proposed Insured flown as a pilot, student pilot or crew member, or intend to fly as such within the next 2 years? (If Yes, complete the Aviation Questionnaire.) ☐ Yes ☐ No
6. Has the Proposed Insured been a member of, or applied to be a member of, or received a notice of required service in the armed forces, reserve, or National Guard? (If Yes, provide details below. If on active duty, please complete the Military Questionnaire.) ☐ Yes ☐ No

Branch of Service	Rank	Duties	Mobilization Category	Current Duty Station

7. Has the Proposed Insured engaged in any of the following activities in the past 2 years? ☐ Yes ☐ No
(If Yes, complete the appropriate questionnaire.)
☐ Motor Vehicle Racing ☐ Scuba Diving ☐ Hang Gliding ☐ Mountain/Rock Climbing ☐ Sky Diving ☐ Parachuting
8. Is the Proposed Insured a U.S. citizen? ☐ Yes ☐ No
(If No, provide details below and complete the Foreign National Questionnaire.)

Country of Citizenship	Visa Type	Expiration Date	Length of U.S. Residency

9. Has the Proposed Insured traveled or resided in Afghanistan or Iraq in the past 2 years? ☐ Yes ☐ No
(If Yes, provide details below and complete the Foreign Travel and Residence Supplement.)

Travel Details

10. Does the Proposed Insured intend to travel or reside in Afghanistan or Iraq in the next 12 months? (If Yes, provide details below and complete the Foreign Travel and Residence Supplement.) ☐ Yes ☐ No

To Where	Why

When	For How Long

11. Has the Proposed Insured filed for or declared bankruptcy in the past ten (10) years? ☐ Yes ☐ No
(If Yes, provide details below.)

Type of Bankruptcy (Chapter)	Date Filed	Date of Discharge or Reorganization	Status

SECTION VII: SPECIAL REMARKS AND DETAILS

(For each question that requires additional information, provide the section number, question number, date, details or reason. Where applicable, also include any attending physician, hospital, or medical facility name, address, and phone number.)

DECLARATIONS

I have read or have had read to me the completed application before signing below. I represent that all statements and answers made in all parts of this application are full, complete and true, to the best of my knowledge and belief. It is agreed that:

- All such statements and answers shall be the basis of any insurance issued, and my answers are material to the decision as to whether the risk is accepted by Protective Life.
- No representative or medical examiner can make, alter or discharge any contract, accept risks, or waive Protective Life's rights or requirements.
- Acceptance of a policy by the Owner shall constitute ratification of any changes made by the Company. In those states where it is required, changes as to plan, amount, age at issue, classification or benefits will be made only with the Owner's written consent.
- No insurance shall take effect unless: (I) a policy is delivered to the Owner, (II) the full first premium is paid while the Proposed Insured is alive, and (III) there has been no change in health and insurability from that described in this application. However, if the premium is paid as set forth in the attached Conditional Receipt Agreement or the Temporary Life Insurance Receipt (Collectively known as the "Receipt") and the Receipt is delivered to the Owner, the terms of the Receipt shall apply. No representative or medical examiner has any authority to waive or to alter these terms and conditions or to bind coverage under any other circumstances.
- I have reviewed the attached Receipt and understand and agree that it provides a limited amount of life insurance for a limited period of time, and that such coverage is subject to the terms and conditions set forth in the Receipt.
- The representative taking this application has made no statement or representation different from, contrary to or in addition to these Declarations and the terms and conditions of the attached Receipt.

IMPORTANT INFORMATION ABOUT IDENTIFICATION VERIFICATION

To help the government fight the funding or terrorism and money laundering activities, Federal Law requires all financial institutions to obtain, obtain, verify, and record information of its customers. We may ask for information or identifying documents that will allow us to verify the identity of our customers.

Any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony in the third degree.

Signed at: _____ _____ _____

City State Date

(X)_____ (X)_____

Signature of Proposed Insured Signature of Owner (if other than Proposed Insured)

(X)_____ (X)_____

Signature of Agent Signature of Joint Owner (if applicable)

_____ _____

Printed Name of Agent FL License I.D. Number

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PROTECTIVE LIFE INSURANCE COMPANY
P.O. Box 830619
Birmingham, AL 35283-0619

SUPPLEMENT TO LIFE INSURANCE APPLICATION **APPLICATION SUPPLEMENT – PART I**

The statements and answers to the questions listed below shall become a part of the attached application; shall be subject to the terms of the attached application; and shall become a part of any policy based on this application. In this form, family means the Owner or Insured's spouse and anyone who is related to the Owner or Insured or the Owner's or Insured's spouse by the following degree by blood, marriage, divorce, adoption or operation of law: parents, in-laws, grandparents, siblings, children, grandchildren, aunts, uncles, nephews and nieces.

Print Name of Proposed Insured(s): _____

For any policy to be issued as a result of this application:	**Yes**	**No**
(1) Will anyone other than the Insured, his or her family, or employer/business partner pay any portion of the initial or future premiums or obtain any right, title or interest in this policy within 2 years of the effective date of coverage? If Yes, complete the "Statement of Owner Intent" (Application Supplement – Part II)	☐	☐
(2) Will any portion of the initial or future premiums be borrowed, loaned or otherwise financed? If Yes, complete the "Premium Financing Disclosure" (Disclosure and Acknowledgement)	☐	☐
(3) Will a trust, including family trust, own this policy? If Yes, complete the "Trust Certification" (Application Supplement – Part III)	☐	☐
(4) Is the Proposed Insured age 65 or older AND total coverage applied for across all Protective companies $1,000,000 or more? If Yes, complete the "Statement of Owner Intent" (Application Supplement – Part II)	☐	☐

SIGNATURES

I (We) have read or have had read to me (us) the completed Supplement before signing below. All statements and answers in the Supplement are correctly recorded and are full, complete and true. I (We) understand that the information being provided in this Supplement is being relied upon in considering the application for life insurance.

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Signed in _____, this _____ day of _____, _____.
(State) (Month) (Year)

Signature(s) of Proposed Insured(s): X _____ SIGN HERE

X _____ SIGN HERE

Signature(s) of Owner(s)/Trustee(s): X _____ SIGN HERE
(provide officer's title if policy is owned by a corporation)

X _____ SIGN HERE

Signature of Witness: X _____ SIGN HERE

AGENT CERTIFICATION

By signing below, I hereby certify that to the best of my knowledge and belief, the information provided herein is complete, accurate, and correct and that the life insurance being applied for conforms to the Company's guidelines.

Signed at: _____ _____ _____
(City and State) Date Florida Agent License Number

X _____ SIGN HERE _____
Agent Signature Agent Name (Print)

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Protective Life Insurance Company
P.O. Box 830619
Birmingham, AL 35283-0619

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

This Authorization to Obtain and Disclose Information complies with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") as related to Life Insurance.

USE OF MEDICAL, NON-HEALTH AND NON-MEDICAL INFORMATION

I (we) authorize Protective Life Insurance Company (Protective Life) and its reinsurers to obtain, directly or through designated third parties, and to use any information about or relating to me (us) that may affect my (our) insurability. Protective Life and its reinsurers, Life Insurance Representative(s) or regional sales office representing me on my (our) application for insurance may:

a. obtain and use health and medical information from all dates of service, medical records, prescription drugs, chart notes, electrocardiograms (EKG), and information about the diagnoses and/or treatments relating to Human Immunodeficiency Virus (HIV) infection or Acquired Immunodeficiency Syndrome (AIDS), sexually transmitted diseases, drug use, alcohol use, nicotine or tobacco use, physical and mental diseases and illnesses, and psychiatric disorders (excluding psychotherapy notes);
b. obtain and use non-health and non-medical information, financial information, credit reports, consumer reports, driving record, criminal record, character, general reputation, personal characteristics or behavioral and lifestyle factors and information about avocations and aviation activity;
c. use all of this information to evaluate an application for insurance, a claim for insurance benefits, or both;
d. use any information relating to communicable diseases (e.g., hepatitis A, measles, influenza, tuberculosis) relating to me or to my spouse or life partner to evaluate an application for insurance on either me or my spouse or life partner.

RELEASE AND DISCLOSE INFORMATION FROM THIRD PARTIES

I (we) authorize the following persons and organizations to release and disclose the information described in the ***USE OF MEDICAL, NON-HEALTH AND NON-MEDICAL INFORMATION*** section to Protective Life, directly through the following designated third parties or its representative(s) acting on its behalf:

a. my (our) doctor(s); medical practitioners; pharmacists and Pharmacy Benefit Managers;
b. medical and related facilities, including hospitals, clinics, facilities run by the Veteran's Administration, Kaiser Permanente, The Cleveland Clinic Foundation including all satellite facilities and The Mayo Clinic;
c. insurers; reinsurers;
d. my (our) current and previous employers;
e. MIB, LLC **(MIB)**; and commercial consumer reporting agencies **(CRA).**

All of these persons and organizations other than **MIB** may release the information described above to a **CRA** acting for Protective Life. **MIB** may not release the information described in the ***USE OF MEDICAL, NON-HEALTH AND NON-MEDICAL INFORMATION*** section to a **CRA**.

TESTING OF BLOOD, ORAL FLUIDS AND URINE

I (we) authorize Protective Life to draw and test my (our) blood, and/or oral fluids, and urine as necessary to underwrite my (our) application for insurance. These tests may include:

a. tests for cholesterol and related blood lipids, diabetes, liver or kidney disorders, immune disorders (**other than HIV/AIDS).**
b. tests for the presence of drugs, nicotine, or their metabolites.

This authorization does not include genetic testing. Unless otherwise required by law or regulation, Protective Life may, but is not obligated to, release any of these test results directly to me or to my spouse or life partner.

RELEASE OF MEDICAL, NON-HEALTH, NON-MEDICAL AND TESTING INFORMATION

I (we) authorize Protective Life to release and disclose the information described in the ***USE OF MEDICAL, NON-HEALTH AND NON-MEDICAL INFORMATION*** section and the ***TESTING OF BLOOD, ORAL FLUIDS AND URINE*** section:

a. to its affiliates, its reinsurers, persons or organization providing services relating to insurance underwriting for Protective Life, **MIB, and as otherwise required by law. Such information as it relates to medical tests for HIV infection and AIDS will be released and disclosed as allowed per §627.429(4)(f) of the Florida Statutes.** and as otherwise required by law.
b. to release and disclose the information to other duly licensed life insurers if I (we) have applied or apply to the other insurers for insurance.
c. to its reinsurers, to make a brief report of my personal health information to **MIB**.
d. to the Life Insurance Representative(s) representing me to duly licensed specific life insurers for the purpose of applying for life insurance if my (our) application with Protective Life is declined or if Protective Life is unable to offer coverage at an acceptable rate.
e. to the Life Insurance Representative(s) and its staff, affiliated companies and/or entities, insurance companies and their re-insurers representing me on my (our) application for life insurance.

GENERAL INFORMATION

a. This authorization shall be valid for 24 months from the Date of Authorization shown below, or for the time limit, if any, permitted by applicable law in the state where the policy is delivered or issued for delivery.

b. During the evaluation of my (our) insurance application, I (we) understand that I (we) have the right to revoke the authorizations in the previous sections (above) by writing to Protective Life at P.O. Box 830619 • Birmingham, Alabama 35283-0619. If this authorization is revoked, this would result in the file being closed and no coverage provided.

c. I understand I do not have to sign this authorization in order to obtain **health care benefits (treatment, payment or enrollment).**

d. I (we) understand that any information about me (us) that is disclosed pursuant to this authorization may be subject to re-disclosure and no longer covered by certain federal rules governing privacy and confidentiality of health information. The information contained in these medical and financial records will be held in confidence and may be used only for the purpose of the procurement, or underwriting for the possible procurement or the evaluation of life, health, long term care, or other insurance products.

e. I (we) understand that my (our) personal information, including my (our) protected health information disclosed under this authorization will be incorporated into and made a part of any life and/or disability insurance policy(ies) issued by the Company and that the policy(ies) will be delivered to the policy owner.

f. *I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction. Any modifications to this authorization may preclude Protective Life's ability to process this application.*

AUTHORIZATIONS AND INVESTIGATIVE CONSUMER REPORT

☐ I (we) have been given a copy of this **Authorization to Obtain and Disclose Information** along with the **Description of Information Practices**.

☐ I (we) would like to be interviewed if an investigative consumer report will be made. (Please refer to the **Description of Information Practices** for additional information regarding the interview for an **Investigative Consumer Report**.)

THIS AUTHORIZATION <u>MUST</u> BE SIGNED WITHOUT MODIFICATION AND RETURNED WITH THE APPLICATION BEFORE PROCESSING.

SIGNATURES

Date of Authorization: X_____

_____

List Health Care Providers

X_____	_____	_____	_____
Proposed Insured 1 (Signature)	Print Name of Proposed Insured 1	Birthdate	Social Security Number
X_____	_____	_____	_____
Proposed Insured 2 (Signature)	Print Name of Proposed Insured 2	Birthdate	Social Security Number

_____	X_____	_____
If Minor, Print Name	Parent or Legal Guardian (Signature)	Print Name of Parent or Legal Guardian
_____	X_____	_____
Agent's Printed Name	Agent's Signature	Agent's FL License I.D. Number

Protective Life Insurance Company
P.O. Box 830619
Birmingham, AL 35283-0619

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

This Authorization to Obtain and Disclose Information complies with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") as related to Life Insurance.

USE OF MEDICAL, NON-HEALTH AND NON-MEDICAL INFORMATION

I (we) authorize Protective Life Insurance Company (Protective Life) and its reinsurers to obtain, directly or through designated third parties, and to use any information about or relating to me (us) that may affect my (our) insurability. Protective Life and its reinsurers, Life Insurance Representative(s) or regional sales office representing me on my (our) application for insurance may:

a. obtain and use health and medical information from all dates of service, medical records, prescription drugs, chart notes, electrocardiograms (EKG), and information about the diagnoses and/or treatments relating to Human Immunodeficiency Virus (HIV) infection or Acquired Immunodeficiency Syndrome (AIDS), sexually transmitted diseases, drug use, alcohol use, nicotine or tobacco use, physical and mental diseases and illnesses, and psychiatric disorders (excluding psychotherapy notes);
b. obtain and use non-health and non-medical information, financial information, credit reports, consumer reports, driving record, criminal record, character, general reputation, personal characteristics or behavioral and lifestyle factors and information about avocations and aviation activity;
c. use all of this information to evaluate an application for insurance, a claim for insurance benefits, or both;
d. use any information relating to communicable diseases (e.g., hepatitis A, measles, influenza, tuberculosis) relating to me or to my spouse or life partner to evaluate an application for insurance on either me or my spouse or life partner.

RELEASE AND DISCLOSE INFORMATION FROM THIRD PARTIES

I (we) authorize the following persons and organizations to release and disclose the information described in the ***USE OF MEDICAL, NON-HEALTH AND NON-MEDICAL INFORMATION*** section to Protective Life, directly through the following designated third parties or its representative(s) acting on its behalf:

a. my (our) doctor(s); medical practitioners; pharmacists and Pharmacy Benefit Managers;
b. medical and related facilities, including hospitals, clinics, facilities run by the Veteran's Administration, Kaiser Permanente, The Cleveland Clinic Foundation including all satellite facilities and The Mayo Clinic;
c. insurers; reinsurers;
d. my (our) current and previous employers;
e. MIB, LLC **(MIB)**; and commercial consumer reporting agencies **(CRA).**

All of these persons and organizations other than **MIB** may release the information described above to a **CRA** acting for Protective Life. **MIB** may not release the information described in the ***USE OF MEDICAL, NON-HEALTH AND NON-MEDICAL INFORMATION*** section to a **CRA**.

TESTING OF BLOOD, ORAL FLUIDS AND URINE

I (we) authorize Protective Life to draw and test my (our) blood, and/or oral fluids, and urine as necessary to underwrite my (our) application for insurance. These tests may include:

a. tests for cholesterol and related blood lipids, diabetes, liver or kidney disorders, immune disorders (**other than HIV/AIDS).**
b. tests for the presence of drugs, nicotine, or their metabolites.

This authorization does not include genetic testing. Unless otherwise required by law or regulation, Protective Life may, but is not obligated to, release any of these test results directly to me or to my spouse or life partner.

RELEASE OF MEDICAL, NON-HEALTH, NON-MEDICAL AND TESTING INFORMATION

I (we) authorize Protective Life to release and disclose the information described in the ***USE OF MEDICAL, NON-HEALTH AND NON-MEDICAL INFORMATION*** section and the ***TESTING OF BLOOD, ORAL FLUIDS AND URINE*** section:

a. to its affiliates, its reinsurers, persons or organization providing services relating to insurance underwriting for Protective Life, **MIB, and as otherwise required by law. Such information as it relates to medical tests for HIV infection and AIDS will be released and disclosed as allowed per §627.429(4)(f) of the Florida Statutes.** and as otherwise required by law.
b. to release and disclose the information to other duly licensed life insurers if I (we) have applied or apply to the other insurers for insurance.
c. to its reinsurers, to make a brief report of my personal health information to **MIB**.
d. to the Life Insurance Representative(s) representing me to duly licensed specific life insurers for the purpose of applying for life insurance if my (our) application with Protective Life is declined or if Protective Life is unable to offer coverage at an acceptable rate.
e. to the Life Insurance Representative(s) and its staff, affiliated companies and/or entities, insurance companies and their re-insurers representing me on my (our) application for life insurance.

GENERAL INFORMATION

a. This authorization shall be valid for 24 months from the Date of Authorization shown below, or for the time limit, if any, permitted by applicable law in the state where the policy is delivered or issued for delivery.

b. During the evaluation of my (our) insurance application, I (we) understand that I (we) have the right to revoke the authorizations in the previous sections (above) by writing to Protective Life at P.O. Box 830619 • Birmingham, Alabama 35283-0619. If this authorization is revoked, this would result in the file being closed and no coverage provided.

c. I understand I do not have to sign this authorization in order to obtain **health care benefits (treatment, payment or enrollment).**

d. I (we) understand that any information about me (us) that is disclosed pursuant to this authorization may be subject to re-disclosure and no longer covered by certain federal rules governing privacy and confidentiality of health information. The information contained in these medical and financial records will be held in confidence and may be used only for the purpose of the procurement, or underwriting for the possible procurement or the evaluation of life, health, long term care, or other insurance products.

e. I (we) understand that my (our) personal information, including my (our) protected health information disclosed under this authorization will be incorporated into and made a part of any life and/or disability insurance policy(ies) issued by the Company and that the policy(ies) will be delivered to the policy owner.

f. *I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction. Any modifications to this authorization may preclude Protective Life's ability to process this application.*

AUTHORIZATIONS AND INVESTIGATIVE CONSUMER REPORT

☐ I (we) have been given a copy of this **Authorization to Obtain and Disclose Information** along with the **Description of Information Practices**.

☐ I (we) would like to be interviewed if an investigative consumer report will be made. (Please refer to the **Description of Information Practices** for additional information regarding the interview for an **Investigative Consumer Report**.)

THIS AUTHORIZATION <u>MUST</u> BE SIGNED WITHOUT MODIFICATION AND RETURNED WITH THE APPLICATION BEFORE PROCESSING.

SIGNATURES

Date of Authorization: X_____

_____

List Health Care Providers

X_____	_____	_____	_____
Proposed Insured 1 (Signature)	Print Name of Proposed Insured 1	Birthdate	Social Security Number
X_____	_____	_____	_____
Proposed Insured 2 (Signature)	Print Name of Proposed Insured 2	Birthdate	Social Security Number

_____	X_____	_____
If Minor, Print Name	Parent or Legal Guardian (Signature)	Print Name of Parent or Legal Guardian
_____	X_____	_____
Agent's Printed Name	Agent's Signature	Agent's FL License I.D. Number

PROTECTIVE LIFE INSURANCE COMPANY

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

BROKER / REPRESENTATIVE REPORT

		Yes	No
1.	In what language were the questions on the application asked? *Please remember that Protective Life cannot accept or service any application from an applicant who does not speak English or Spanish. ☐ English ☐ Spanish ☐ Other* **List Other Language* : _____		
2.	Is the Proposed Insured a relative or does the Proposed Insured have a business relationship with you? *If Yes, Details:* _____	☐	☐
3.	(a) Will this policy replace or change existing policy(ies)?	☐	☐
	(b) If replacement of existing insurance is involved, have you complied with all relevant state requirements, including any Disclosure and Comparison Statements? *If No, Explain:* _____	☐	☐
	Answer questions (c) and (d) *only* if this is a replacement:		
	(c) Did you use any pre-printed company approved sales materials? *If Yes, List Name or Form Number:* _____	☐	☐
	(d) Did you use any Company approved, electronically generated, individualized sales materials (such as illustrations or concept materials)? *(If Yes, you must provide a copy of these materials with the application.)*	☐	☐
4.	Have you advised the proposed policyowner or do you know of any advice that has been given to the policyowner to transfer ownership of the policy to be issued, or its death benefits, to a life settlement company, investor, offshore trust, investment trust, or entity associated with stranger owned or investment owned life insurance (commonly called SOLI or IOLI) or are you otherwise aware that the policyowner may be contemplating such a transfer? *If Yes, please explain in Special Requests/Remarks below.*	☐	☐
5.	Has a mortality analysis or life expectancy analysis been performed on the Proposed Insured?	☐	☐
6.	Has a medical examination been ordered? *If Yes, Name of Examiner:* _____ *Date of Exam:* _____	☐	☐
7.	Is Premium Financing involved in this case? (If Yes, please submit a cover letter describing the parameters.)	☐	☐
	I have verified the identity of the Owner by picture I.D. (*Authorized Representative if Business or Trustee if Trust)* *Identification Type:* _____ *Driver's License Number:* _____ Please include Driver's License Number if Owner is an individual and is other than the Proposed Insured. NOTE: Does not apply to direct marketing situations	☐	☐

I certify that:

a) both the Proposed Insured(s) and the Owner(s) read, speak and understand either the English or Spanish language; and
b) each has explicitly told me that they understood each question and item contained in this application; and
c) the answers given in this application are complete and true to the best of my knowledge and belief; and
d) I know of nothing affecting the risk which is not set forth in my representative's report or this life insurance application; and
e) I carefully explained each question before recording each answer and before the application was signed.

Signature of Broker/Representative	*Date*	*PLICO Contract Number*	*Share %*	*Business Phone Number*
Print Name of Above Signature	*Email Address*		*Signed at (City and State)*	
Signature of Additional Broker/Representative	*Date*	*PLICO Contract Number*	*Share %*	*Business Phone Number*
Print Name of Above Additional Signature	*Email Address*		*Signed at (City and State)*	
BGA/Broker Dealer Name	*PLICO Contract Number*			
New Business Key Contact	*Email Address*		*Phone Number*	

Broker/Representative Special Requests/Remarks:

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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

Any person who knowingly and with intent to injure, defraud, or deceive any Insurer, files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

_____ _____ _____ _____
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

_____ _____ _____
Agent's Printed Name | Agent's Signature | Agent's FL License ID No

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PROTECTIVE LIFE INSURANCE COMPANY
P.O. Box 830619
Birmingham, AL 35283-0619

NOTICE AND CONSENT FOR AIDS-RELATED TESTING

To evaluate your insurability, the Insurer named above (the insurer) has requested that you provide a bodily fluid sample for testing and analysis to determine the presence of human immunodeficiency virus (HIV) antibodies. By signing and dating this form you agree that this test may be done and that underwriting decisions will be based on the test result. A series of tests will be performed by a certified laboratory through a medically accepted procedure.

PRE-TESTING CONSIDERATIONS

Many public health organizations have recommended that before taking an AIDS-related test, a person seek counseling to become informed concerning the implications of such a test. You may wish to consider counseling, at your expense, prior to being tested.

MEANING OF POSITIVE TEST RESULT

The test is not a test for AIDS. It is a test for antibodies to the HIV virus, the causative agent for AIDS, and show whether you have been exposed to the virus. A positive test result does not mean that you have AIDS but that you are at significantly increased risk of developing problems with your immune system. The test for HIV antibodies is very sensitive. Errors are rare, but they do occur. Your private physician, a public health clinic, or an AIDS information organization in your city might provide you with further information on the medical implications of a positive test.

Positive HIV antibody test results will adversely affect your application for insurance.

CONFIDENTIALITY OF TEST RESULTS

All test results are required to be treated confidentially. They will be reported by the laboratory to the Insurer. The test results may be disclosed as required by law or may be disclosed to employees of the Insurer who have the responsibility to make underwriting decisions on behalf of the Insurer or to outside legal counsel who needs such information to effectively represent the Insurer in regard to your application. The results may be disclosed to a reinsurer, if the reinsurer is involved in the underwriting process. The test may be released to an insurance medical information exchange under procedures that are designed to assure confidentiality, including the use of general codes that also cover results of tests for other diseases or conditions not related to AIDS, or for the preparation of Statistical reports that do not disclose the identity of any particular person.

NOTIFICATION OF TEST RESULT

A positive test result will be disclosed to a physician you designate. If you do not designate a physician, a positive test result will be disclosed to the Florida Department of Health, Chief, Bureau of STD Prevention and Control, Bin A-19, 4052 Bald Cypress Way, Tallahassee, Florida 32399-1716. Because a trained person should deliver that information so that you can understand clearly what the test result means, please list your private physician so that the Insurer can have him or her tell you the test result and explain its meaning.

Name of physician for reporting a positive test result: _____

Address: _____

CONSENT

I have read and I understand this Notice of Consent for AIDS-Related Testing. I voluntarily consent to the collection of bodily fluids from me, the testing of that sample, and the disclosure of the test results as described above. In addition, I authorize Protective Life Insurance Company or its reinsurers to make a brief report of any personal health information to the MIB.

I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

Name of Proposed Insured: _____

Address: _____

Signature of Proposed Insured
or Parent/Guardian: _____ Date Signed: _____

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PROTECTIVE LIFE INSURANCE COMPANY
P.O. Box 830619
Birmingham, AL 35283-0619

NOTICE AND CONSENT FOR AIDS-RELATED TESTING

To evaluate your insurability, the Insurer named above (the insurer) has requested that you provide a bodily fluid sample for testing and analysis to determine the presence of human immunodeficiency virus (HIV) antibodies. By signing and dating this form you agree that this test may be done and that underwriting decisions will be based on the test result. A series of tests will be performed by a certified laboratory through a medically accepted procedure.

PRE-TESTING CONSIDERATIONS

Many public health organizations have recommended that before taking an AIDS-related test, a person seek counseling to become informed concerning the implications of such a test. You may wish to consider counseling, at your expense, prior to being tested.

MEANING OF POSITIVE TEST RESULT

The test is not a test for AIDS. It is a test for antibodies to the HIV virus, the causative agent for AIDS, and show whether you have been exposed to the virus. A positive test result does not mean that you have AIDS but that you are at significantly increased risk of developing problems with your immune system. The test for HIV antibodies is very sensitive. Errors are rare, but they do occur. Your private physician, a public health clinic, or an AIDS information organization in your city might provide you with further information on the medical implications of a positive test.

Positive HIV antibody test results will adversely affect your application for insurance.

CONFIDENTIALITY OF TEST RESULTS

All test results are required to be treated confidentially. They will be reported by the laboratory to the Insurer. The test results may be disclosed as required by law or may be disclosed to employees of the Insurer who have the responsibility to make underwriting decisions on behalf of the Insurer or to outside legal counsel who needs such information to effectively represent the Insurer in regard to your application. The results may be disclosed to a reinsurer, if the reinsurer is involved in the underwriting process. The test may be released to an insurance medical information exchange under procedures that are designed to assure confidentiality, including the use of general codes that also cover results of tests for other diseases or conditions not related to AIDS, or for the preparation of Statistical reports that do not disclose the identity of any particular person.

NOTIFICATION OF TEST RESULT

A positive test result will be disclosed to a physician you designate. If you do not designate a physician, a positive test result will be disclosed to the Florida Department of Health, Chief, Bureau of STD Prevention and Control, Bin A-19, 4052 Bald Cypress Way, Tallahassee, Florida 32399-1716. Because a trained person should deliver that information so that you can understand clearly what the test result means, please list your private physician so that the Insurer can have him or her tell you the test result and explain its meaning.

Name of physician for reporting a positive test result: _____

Address: _____

CONSENT

I have read and I understand this Notice of Consent for AIDS-Related Testing. I voluntarily consent to the collection of bodily fluids from me, the testing of that sample, and the disclosure of the test results as described above. In addition, I authorize Protective Life Insurance Company or its reinsurers to make a brief report of any personal health information to the MIB.

I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

Name of Proposed Insured: _____

Address: _____

Signature of Proposed Insured
or Parent/Guardian: _____ Date Signed: _____

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PROTECTIVE LIFE INSURANCE COMPANY
P.O. Box 830619
Birmingham, AL 35283-0619

NOTIFICATION OF RIGHT TO NAME A SECONDARY ADDRESSEE

Under Florida law, you have the right to designate a secondary addressee to receive a notice concerning the potential lapse of your policy. The notice to the secondary addressee will be sent when the policy has been in force for at least one year, the insured is 64 years or older, and the policy is in danger of lapsing.

If you wish to name a secondary addressee, please call us at 1-800-366-9378, or fax us at 1-205-268-5807, or write us at P.O. Box 830619, Birmingham, AL 35283-0619

Please Print the Following Information:

_____
Policy Number (if known)

_____
Policy Owner's Name

_____
Insured's Name

Secondary Addressee:

_____
Name

_____
Street Address or P.O. Box

_____
City, State, Zip Code

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PROTECTIVE LIFE INSURANCE COMPANY
P.O. Box 830619
Birmingham, AL 35283-0619

INDIVIDUAL LIFE INSURANCE APPLICATION – RIDER WORKSHEET

Required if applying for additional benefits or riders.

☐ New Business ☐ In Force Protective Policy # :_____

_____ _____
Print Proposed/Primary Insured's Name Proposed/Primary Insured's Social Security No.

**** If applying for Children's Term Rider, Income Provider Option, ExtendCare Rider or Chronic Illness Accelerated Death Benefit, please complete the rider specific supplemental application(s) per application instructions.***

ADDITIONAL BENEFITS

☐ Accidental Death Benefit Rider *(Range $10,000 - $250,000)* $_____

☐ * Children's Term Rider *(1 Unit Equals $1,000 Death Benefit – 25 Units Maximum)* _____ Units

☐ * ExtendCare Rider or Chronic Illness Accelerated Death Benefit

Maximum Monthly Benefit Amount $_____

Elimination Period *(Number of Days)* _____

☐ Guaranteed Insurability Rider $_____

☐ * Income Provider Option

☐ Protected Insurability Rider $_____

☐ Waiver of Premium *(Non-Universal Life Only)*

☐ Waiver of Specified Premium Rider *(Universal Life Only)*

Monthly Benefit Amount $_____

☐ Other _____

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 attached to and made part of the application and shall be considered the basis of any insurance issued.

Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony in the third degree.

Signed at: (City and State) _____ Date _____

_____ _____
Owner Signature Proposed/Primary Insured Signature

_____ _____
Witness to Owner Signature Signature of Parent or Guardian

_____ _____
Agent Name Printed Agent Signature

FL License ID Number: _____

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PROTECTIVE LIFE INSURANCE COMPANY
P.O. Box 830619
Birmingham, AL 35283-0619

PRE-AUTHORIZED WITHDRAWAL AGREEMENT

FOR DRAFTING OF PREMIUM PAYMENTS

The person paying the premium on the life insurance policy listed below must sign this agreement.

I request and authorize Protective Life Insurance Company to draw against the account listed below to pay premiums. I understand that no coverage exists until a policy is issued or I receive a Conditional Receipt/Temporary Life Insurance Receipt.

Policy Number: _____ Name of Insured: _____

Name of Bank: _____

Street Address or P.O. Box: _____

City: _____ State: _____ Zip Code: _____

Type of Account: ☐ Checking ☐ Savings

Routing Number: ____ ____ ____ ____ ____ ____ ____ ____ ____

Account Number: _____

Premium Frequency: ☐ *Monthly (*Only available by bank draft) ☐ Quarterly

☐ Semi-Annually ☐ Annually

☐ **Draft the initial premium** - I understand that authorizing the drafting of the initial premium and providing the account information does not provide any life insurance coverage on myself or any applicant listed on the application for life insurance unless I have signed, dated and met the terms and conditions of the Protective Life Conditional Receipt Agreement/Temporary Life Insurance Receipt.

If the Company receives a Conditional/Temporary Receipt with this form your premium will be drafted immediately and you will be provided with conditional coverage subject to limited terms and conditions.

Variable life insurance premiums will not be deducted unless a policy is issued.

I request future drafts be made on the _____ *(1st - 28th)* day of the month.

_____
Premium Payer - Depositor (Please Print)

_____ _____
Date Signature

PLEASE INCLUDE A VOIDED CHECK WITH APPLICATION. IF THIS IS TO DRAFT FROM A BROKERAGE ACCOUNT, A VOIDED CHECK IS NOT NECESSARY. DO NOT USE STAPLES.

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PROTECTIVE LIFE INSURANCE COMPANY

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

CONDITIONAL RECEIPT AGREEMENT

PREMIUM RECEIPT

This Conditional Receipt Agreement ("Agreement") contains the entire terms regarding conditional coverage. The Agreement provides a limited amount of insurance, for a limited period of time, subject to the terms provided hereafter. No Agent of Protective Life Insurance Company ("Company") can alter or waive any of the provisions of this Agreement. Furthermore, in no event will there be conditional coverage unless the first full premium required by the Company has been paid at the time of application.

Premium Amount Received: $_____

Method of Payment: ☐ Check ☐ Pre-Authorized Withdrawal

☐ Other _____

The amount received is a conditional payment of the first premium for this insurance policy on the life of the following Proposed Insured(s) _____.

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO PROTECTIVE LIFE INSURANCE COMPANY.

DO NOT MAKE CHECKS PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK. CASH, MONEY ORDERS AND CASHIER'S CHECKS WILL NOT BE ACCEPTED.

TERMS AND CONDITIONS

Amount of Coverage

If a premium has been accepted by the Company for an application of insurance and any person proposed for insurance in such application dies while this Agreement is in effect, the Company will pay, subject to the conditions and limitations contained herein, to the beneficiary designated in such application, the lesser of:

(a) The amount of death benefit, if any, which would be payable under the policy covering the life or lives of the Proposed Insured(s) if issued as applied for under such application; or
(b) The greater of (i) $1,000,000 less the amount of death benefits due and payable by virtue of the Proposed Insured's death under any other policy, application, conditional receipt, or temporary life receipt with the Company, or (ii) $50,000.

Date of Conditional Coverage

Conditional coverage will begin when the application is completed, a premium has been accepted, this Agreement has been completed and signed, and all the terms and conditions stated herein have been satisfied.

Limitations

Premium shall not be collected and this Agreement will not be effective if:

(1) The Proposed Insured(s) is under 15 days of age or over age 80;
(2) The Proposed Insured(s), within the past 90 days, has been admitted to a hospital or other medical facility, been advised by a member of the medical profession to be admitted, or had surgery performed or recommended;
(3) Within the past two years, the Proposed Insured(s) has had treatment recommended by a member of the medical profession for heart trouble, stroke or cancer;
(4) The Proposed Insured(s) has been rated or declined for insurance within the past five years; or
(5) The Proposed Insured(s) intends to leave the United States within the next 60 days.

Termination and Refund of Premium

There shall be no insurance coverage under this Agreement and this Agreement shall be void if:

(1) Premium payment is by check, and it is not honored by the drawee bank upon presentation;
(2) Premium payment is by Pre-Authorized Withdrawal, and the deduction is not honored by the drawee bank;
(3) If the application to which this Agreement was attached is not approved as applied for by the Company within ninety days from the date of its receipt;
(4) There is a material misrepresentation in the answers to any questions or statements in the application; or
(5) If any Proposed Insured(s) dies by suicide, while sane or insane.

If any of the above-listed conditions do occur, the Company's liability under this Agreement is limited to a refund of the premium payment made.

Effective Date of Coverage

Insurance issued based on the application will take effect on the latest of:

(a) the date of the application;
(b) the date requested in the application; or
(c) the date of the last of any medical examinations or tests required under the rules and practices of the company.

Full life insurance coverage becomes effective when the policy is delivered and is governed by the policy contract. This Agreement will terminate when the policy contract is delivered.

Notice: **You should retain a copy of this Agreement. The Original will be retained by the Company.**

SIGNATURES:

I have read this agreement and declare that the answers are true to the best of my knowledge and belief. I understand and agree to the terms, conditions, and limitations of this Agreement.

_____ _____
Proposed Insured's Signature Date

_____ _____
Owner's Signature (if other than the Proposed Insured) Date

_____ _____
Joint Owner's Signature Date

_____ _____
Agent's Signature Date

PROTECTIVE LIFE INSURANCE COMPANY

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

CONDITIONAL RECEIPT AGREEMENT

PREMIUM RECEIPT

This Conditional Receipt Agreement ("Agreement") contains the entire terms regarding conditional coverage. The Agreement provides a limited amount of insurance, for a limited period of time, subject to the terms provided hereafter. No Agent of Protective Life Insurance Company ("Company") can alter or waive any of the provisions of this Agreement. Furthermore, in no event will there be conditional coverage unless the first full premium required by the Company has been paid at the time of application.

Premium Amount Received: $_____

Method of Payment: ☐ Check ☐ Pre-Authorized Withdrawal

☐ Other _____

The amount received is a conditional payment of the first premium for this insurance policy on the life of the following Proposed Insured(s) _____.

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO PROTECTIVE LIFE INSURANCE COMPANY.

DO NOT MAKE CHECKS PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK. CASH, MONEY ORDERS AND CASHIER'S CHECKS WILL NOT BE ACCEPTED.

TERMS AND CONDITIONS

Amount of Coverage

If a premium has been accepted by the Company for an application of insurance and any person proposed for insurance in such application dies while this Agreement is in effect, the Company will pay, subject to the conditions and limitations contained herein, to the beneficiary designated in such application, the lesser of:

(a) The amount of death benefit, if any, which would be payable under the policy covering the life or lives of the Proposed Insured(s) if issued as applied for under such application; or
(b) The greater of (i) $1,000,000 less the amount of death benefits due and payable by virtue of the Proposed Insured's death under any other policy, application, conditional receipt, or temporary life receipt with the Company, or (ii) $50,000.

Date of Conditional Coverage

Conditional coverage will begin when the application is completed, a premium has been accepted, this Agreement has been completed and signed, and all the terms and conditions stated herein have been satisfied.

Limitations

Premium shall not be collected and this Agreement will not be effective if:

(1) The Proposed Insured(s) is under 15 days of age or over age 80;
(2) The Proposed Insured(s), within the past 90 days, has been admitted to a hospital or other medical facility, been advised by a member of the medical profession to be admitted, or had surgery performed or recommended;
(3) Within the past two years, the Proposed Insured(s) has had treatment recommended by a member of the medical profession for heart trouble, stroke or cancer;
(4) The Proposed Insured(s) has been rated or declined for insurance within the past five years; or
(5) The Proposed Insured(s) intends to leave the United States within the next 60 days.

Termination and Refund of Premium

There shall be no insurance coverage under this Agreement and this Agreement shall be void if:

(1) Premium payment is by check, and it is not honored by the drawee bank upon presentation;
(2) Premium payment is by Pre-Authorized Withdrawal, and the deduction is not honored by the drawee bank;
(3) If the application to which this Agreement was attached is not approved as applied for by the Company within ninety days from the date of its receipt;
(4) There is a material misrepresentation in the answers to any questions or statements in the application; or
(5) If any Proposed Insured(s) dies by suicide, while sane or insane.

If any of the above-listed conditions do occur, the Company's liability under this Agreement is limited to a refund of the premium payment made.

Effective Date of Coverage

Insurance issued based on the application will take effect on the latest of:

(a) the date of the application;
(b) the date requested in the application; or
(c) the date of the last of any medical examinations or tests required under the rules and practices of the company.

Full life insurance coverage becomes effective when the policy is delivered and is governed by the policy contract. This Agreement will terminate when the policy contract is delivered.

Notice: **You should retain a copy of this Agreement. The Original will be retained by the Company.**

SIGNATURES:

I have read this agreement and declare that the answers are true to the best of my knowledge and belief. I understand and agree to the terms, conditions, and limitations of this Agreement.

_____ _____
Proposed Insured's Signature Date

_____ _____
Owner's Signature (if other than the Proposed Insured) Date

_____ _____
Joint Owner's Signature Date

_____ _____
Agent's Signature Date

PROTECTIVE LIFE INSURANCE COMPANY
P.O. Box 830619
Birmingham, AL 35283-0619

NOTICE TO APPLICANT REGARDING REPLACEMENT OF LIFE INSURANCE

A decision to buy a new policy and discontinue or change an existing policy may be a wise choice or a mistake.

Get all the facts. Make sure you fully understand both the proposed policy and your existing policy or policies. New policies may contain clauses which limit or exclude coverage of certain events in the initial period of the contract, such as the suicide and incontestable clauses which may have already been satisfied in your existing policy or policies.

Your best source for facts on the proposed policy is the proposed company and its agent. The best source on your existing policy is the existing company and its agent.

Hear from both before you make your decision. This way you can be sure your decision is in your best interest.

If you indicate that you intend to replace or change an existing policy, Florida regulations require notification of the company that issued the policy.

Florida regulations give you the right to receive a written Comparative Information Form which summarizes your policy values. Indicate whether or not you wish a Comparative Information Form from the proposed company and your existing insurer or insurers by placing your initials in the appropriate box below.

If **"YES"**, place initials here: _____ If **"NO"**, place initials here: _____

DO NOT TAKE ACTION TO TERMINATE YOUR EXISTING POLICY UNTIL YOUR NEW POLICY HAS BEEN ISSUED AND YOU HAVE EXAMINED IT AND FOUND IT ACCEPTABLE.

SIGNATURES

I have read this notice and received a copy of it.

Applicant's Signature	Date	Agent's Signature	Date
Owner's Signature (if other than Applicant)	Date	Agent's Name Printed or Typed	
Joint Owner's Signature	Date	Agent's Address Printed or Typed	
		Agent's Company Printed or Typed	

INFORMATION ON POLICIES WHICH MAY BE REPLACED

Company Name	Policy Number	Name of Insured

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PROTECTIVE LIFE INSURANCE COMPANY
P.O. Box 830619
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Company Name	Policy Number	Name of Insured

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PROTECTIVE LIFE INSURANCE COMPANY
P.O. Box 830619
Birmingham, AL 35283-0619

COMPARATIVE INFORMATION FORM FOR PROPOSED INSURANCE

Replacing Agent's Name

OWNER/APPLICANT INFORMATION

Name		
Street Address		
City, State, Zip Code		
Telephone Number	*Date of Birth*	*Age*

POLICY INFORMATION

Policy Generic Name		
Policy Number		
Date of Issue	*Issue Age*	*Contestable Period Expires*
Suicide Period Expires	*Policy Loan Rate*	

POLICY/RIDER DESCRIPTION

Policy/Rider Name	*Initial/Continuing Benefit*	*(Age) Benefit From To*	*Initial/Renewal Annual Premium*	*(Age) Payable From To*

Total Initial Annual Premium	*Mode of Payment*	*Amount*	*Total Renewal Annual Premium*	*Amount*
$		*$*	*$*	*$*

COMPOSITE DISCLOSURE OF PROPOSED INSURANCE FOR PRIMARY INSURED

		GUARANTEES				PROJECTIONS *			
YR	AGE	ANNUAL PREMIUM	CUMULATIVE PREMIUM	CASH VALUE	DEATH BENEFIT	ANNUAL PREMIUM	CUMULATIVE PREMIUM	CASH VALUE	DEATH BENEFIT
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									
16									
17									
18									
19									
20									
55									
60									
65									
75									
85									
95									

* Projections include dividends and current interest rates which are not guaranteed.

IMPORTANT NOTICE: The income tax treatment of the benefits illustrated above may significantly affect their magnitude. Competent tax advice should be secured to clarify income tax implications.

PROTECTIVE LIFE INSURANCE COMPANY
P.O. Box 830619
Birmingham, AL 35283-0619

COMPARATIVE INFORMATION FORM FOR PROPOSED INSURANCE

Existing Insurer	*Insurer's Address*

OWNER/APPLICANT INFORMATION

Name		
Street Address		
City, State, Zip Code		
Telephone Number	*Date of Birth*	*Age*

POLICY INFORMATION

Policy Generic Name		
Policy Number		
Date of Issue	*Issue Age*	*Contestable Period Expires*
Suicide Period Expires	*Policy Loan Rate*	

POLICY/RIDER DESCRIPTION

Policy/Rider Name	*Initial/Continuing Benefit*	*(Age) Benefit* *From* *To*	*Initial/Renewal Annual Premium*	*(Age) Payable* *From* *To*

Total Initial Annual Premium	*Mode of Payment*	*Amount*	*Total Renewal Annual Premium*	*Amount*
$		*$*	*$*	*$*

COMPOSITE DISCLOSURE OF PROPOSED INSURANCE FOR PRIMARY INSURED

		GUARANTEES				**PROJECTIONS ***			
YR	AGE	ANNUAL PREMIUM	CUMULATIVE PREMIUM	CASH VALUE	DEATH BENEFIT	ANNUAL PREMIUM	CUMULATIVE PREMIUM	CASH VALUE	DEATH BENEFIT
CURRENT									
2nd									
3rd									
4th									
5th									
6th									
7th									
8th									
9th									
10th									
11th									
12th									
13th									
14th									
15th									
16th									
17th									
18th									
19th									
20th									
55									
60									
65									
75									
85									
95									

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INSTRUCTIONAL NOTES FOR COMPLETION OF COMPARATIVE INFORMATION FORM

1. Existing life insurance must be identified by name of insurer and the policy number. In the event that a policy number has not been assigned by the existing insurer, alternative identification information such as an application or receipt number must be shown.

2. If more than one existing life insurance policy is to be replaced, a separate Comparative Information Form is to be provided for each such policy.

3. In the disclosure of values premiums shall be shown only if they increase the cash value or death benefits for the primary insured.

4. Any benefits for secondary insureds shall be shown on a supplementary exhibit.

5. Values will be shown for each year in which either an initial change in face value or premium payment occurs.

6. Values will be shown in the disclosure for the maximum duration policy guarantees permit. If this benefit extension requires that guaranteed policy options be utilized, the option to be used will be that (those) automatically utilized by the issuing insurer. However, if the policy application provides for applicant election of an alternative option which is binding on the insurer and the applicant elects to make an alternative election, then the extension of benefits must be identified and briefly explained in the "Policy/Rider Description" section of the Comparative Information Form.

7. The dividend option elected by an insured or applicant must be identified and briefly explained in the "Policy/Rider Description" section of the Comparative Information Form. The dividend option elected by the insured or applicant must be employed in completing the disclosure of values.

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PROTECTIVE LIFE INSURANCE COMPANY
P.O. Box 830619
Birmingham, AL 35283-0619

COMPARATIVE INFORMATION FORM FOR PROPOSED INSURANCE

Replacing Agent's Name

OWNER/APPLICANT INFORMATION

Name		
Street Address		
City, State, Zip Code		
Telephone Number	*Date of Birth*	*Age*

POLICY INFORMATION

Policy Generic Name		
Policy Number		
Date of Issue	*Issue Age*	*Contestable Period Expires*
Suicide Period Expires	*Policy Loan Rate*	

POLICY/RIDER DESCRIPTION

Policy/Rider Name	*Initial/Continuing Benefit*	*(Age) Benefit From To*	*Initial/Renewal Annual Premium*	*(Age) Payable From To*

Total Initial Annual Premium	*Mode of Payment*	*Amount*	*Total Renewal Annual Premium*	*Amount*
$		*$*	*$*	*$*

COMPOSITE DISCLOSURE OF PROPOSED INSURANCE FOR PRIMARY INSURED

		GUARANTEES				PROJECTIONS *			
YR	AGE	ANNUAL PREMIUM	CUMULATIVE PREMIUM	CASH VALUE	DEATH BENEFIT	ANNUAL PREMIUM	CUMULATIVE PREMIUM	CASH VALUE	DEATH BENEFIT
1									
2									
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PROTECTIVE LIFE INSURANCE COMPANY
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COMPARATIVE INFORMATION FORM FOR PROPOSED INSURANCE

Existing Insurer	*Insurer's Address*

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Street Address		
City, State, Zip Code		
Telephone Number	*Date of Birth*	*Age*

POLICY INFORMATION

Policy Generic Name		
Policy Number		
Date of Issue	*Issue Age*	*Contestable Period Expires*
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COMPOSITE DISCLOSURE OF PROPOSED INSURANCE FOR PRIMARY INSURED

		GUARANTEES				**PROJECTIONS ***			
YR	AGE	ANNUAL PREMIUM	CUMULATIVE PREMIUM	CASH VALUE	DEATH BENEFIT	ANNUAL PREMIUM	CUMULATIVE PREMIUM	CASH VALUE	DEATH BENEFIT
CURRENT									
2nd									
3rd									
4th									
5th									
6th									
7th									
8th									
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PROTECTIVE LIFE INSURANCE COMPANY

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

ASSIGNMENT/TRANSFER OF OWNERSHIP SECTION 1035 EXCHANGE

Insured(s): _____

Owner(s)/Joint Owner(s): ***(REQUIRED)*** _____

Insurer/Existing Insurance Company Name: _____
(Please include Street Address, City, State, and Zip Code) : _____

Policy Number(s):_____

Estimated Cash Surrender Value: $_____ Phone Number(s): _____

For value received, I hereby assign and transfer to Protective Life Insurance Company (Protective Life) all right, title, and interest to the above listed policy(ies) in an exchange intended to qualify under Section 1035 of the Internal Revenue Code. However, this assignment and all other terms and agreements set forth below are conditioned upon Protective Life's underwriting and approving a new life insurance policy on the life of the Insured(s) named above. This conditional assignment will not become effective unless and until Protective Life approves a new life insurance policy.

I understand that if Protective Life approves a new life insurance policy on the life of the Insured(s) named above, then Protective Life will surrender the assigned policy(ies) and it/they will no longer be in force or effect as of the date of surrender. I further understand that, if Protective Life approves the new life insurance policy, Protective Life will collect whatever cash surrender values are available from the existing insurance company on the assigned policy(ies) and apply such amount received as premium on the new life insurance policy. I understand that the cash surrender value of the policy on the actual date of surrender is likely to be different from the cash surrender value of the policy today. This is especially true if the policy to be surrendered is a variable policy, since the cash surrender value of a variable policy fluctuates with the market. I agree that Protective Life assumes no responsibility if the full scheduled cash surrender values of the assigned policy(ies) are not received.

I certify that the above listed policy(ies) is/are currently in force and not subject to any prior assignments, any legal or equitable claims, or liens. I further certify that there is no proceeding in bankruptcy pending against me.

I hereby designate Protective Life as beneficiary of the above listed policy(ies) to the extent of the cash surrender value thereof at the date of death of the Insured(s) named above. All other beneficiary designations under the above listed policy(ies) will remain in effect. **I FURTHER UNDERSTAND THAT THE POLICY(IES) TO BE ISSUED BY PROTECTIVE LIFE WILL HAVE THE SAME DESIGNATED INSURED(S) AND OWNER(S) AS THE ABOVE LISTED POLICY(IES).**

I certify that if the above listed policy(ies) is/are not attached to this conditional assignment that it/they has/have been lost or destroyed. I hereby waive all rights and benefits under such policy(ies) and agree to return it/them to you if it/they comes/come into my possession.

I understand and agree that I will be responsible for keeping the above listed policy(ies) in force by paying any premiums as they become due until such time as Protective Life notifies me in writing that I have been issued a new life insurance policy.

I understand that under Section 1035, reporting may be required for federal income tax purposes. The replaced company is required to report all exchanges of insurance contracts on Form 1099-R, including tax-free exchanges under Section 1035 in situations in which a policyholder has an outstanding policy loan at the time of exchange. If there is an outstanding policy loan at the time of the exchange, the transaction may not be characterized as tax-free. In fact, any gain will be taxed to the extent of the outstanding policy loan. Accordingly, I understand that it is advisable when filing my individual federal income tax return that I enclose a copy of the reporting form (Form 1099-R) with an explanation that the policy was exchanged pursuant to Section 1035 or otherwise and that Protective Life has no responsibility for the validity of this Assignment.

Please Check One: ☐ I have enclosed the original policy(ies) to be exchanged. ☐ I certify that the original policy(ies) has/have been lost or destroyed. To the best of my knowledge, the original policy(ies) is/are not in the possession or control of any other person.

_____ Insured(s) Signature(s)	_____ Witness Signature	_____ Date
_____ *Spouse Signature *(For Community Property States Only)*	_____ Witness Signature	_____ Date
_____ Owner(s) Signature(s) ***(Required)***	_____ Witness Signature ***(Required)***	_____ Date
_____ Joint Owner(s) Signature(s)	_____ Witness Signature	_____ Date
_____ Collateral Assignee/Irrevocable Beneficiary Signature, if any	_____ Witness Signature	_____ Date

(If the Owner resides in the Community Property states of AZ, CA, ID, LA, NM, NV, TX, WA or WI we recommend that the Owner's spouse also sign this form. Signatures must be witnessed by a disinterested party of legal age.)*

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(Please include Street Address, City, State, and Zip Code) : _____

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_____ Insured(s) Signature(s)	_____ Witness Signature	_____ Date
_____ *Spouse Signature *(For Community Property States Only)*	_____ Witness Signature	_____ Date
_____ Owner(s) Signature(s) ***(Required)***	_____ Witness Signature ***(Required)***	_____ Date
_____ Joint Owner(s) Signature(s)	_____ Witness Signature	_____ Date
_____ Collateral Assignee/Irrevocable Beneficiary Signature, if any	_____ Witness Signature	_____ Date

(If the Owner resides in the Community Property states of AZ, CA, ID, LA, NM, NV, TX, WA or WI we recommend that the Owner's spouse also sign this form. Signatures must be witnessed by a disinterested party of legal age.)*

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PROTECTIVE LIFE INSURANCE COMPANY
P.O. Box 830619
Birmingham, AL 35283-0619

INDIVIDUAL LIFE INSURANCE APPLICATION – CONFIDENTIAL FINANCIAL STATEMENT

To be signed by the Proposed Insured if Face Amount is $5,000,001 or greater (for Proposed Insured(s) age 0 - 70) and $3,000,001 or greater (for Proposed Insured(s) age 71 and older) or at the discretion of Underwriting. Complete Part 1 for personal coverage and Part 2 for business coverage. This form should be submitted for all estate tax/liquidity, asset maximization and charitable giving cases, and for any bankruptcy in the last 3 years. Additional documentation may be requested by the Company to verify the agreements and financial disclosures made below.

Name of Proposed Insured	Date of Birth	Social Security Number

Part 1

1. Your Income (before taxes):

	Current Year	Prior Year
Salary or Wages	$	$
Bonuses and/or Commissions	$	$
Net Business or Professional Income *(Gross income less business expenses)*	$	$
Other Earned Income – Explain details in "Remarks" below	$	$
Unearned Income *(interest and dividends, net real estate income, retirement income, etc.)* – Explain details in "Remarks" below	$	$
TOTAL	$	$

2. Your Net Worth:

	Current Year	Prior Year
Investment Assets *(cash, mutual funds, stocks, 401k, etc.)*	$	$
Real Estate *(residence, second home, rental properties, etc.)*	$	$
Business Assets – Explain details in "Remarks" below *(cash, accounts receivable, equipment, inventory, etc.)*	$	$
Liabilities *(wages/interest/dividends payable, loans, etc.)*	$	$
Net Worth	$	$

3. Estimated tax liabilities at death - include potential estate taxes, capital gains taxes, income taxes *(both federal and state)*:

4. How was the need and amount of coverage determined?

Remarks *(questions 1-4)*

Part 2

Complete questions 5-8 only if applying for business coverage.

5. Purpose of business coverage:

☐ Key Person ☐ Buy/Sell ☐ Stock Repurchase ☐ Creditor ☐ Deferred Compensation

☐ Other (explain): _____

6. If buy/sell, is a written buy/sell agreement in effect? ***(if Yes, please attach a copy)*** ☐ Yes ☐ No

Percentage of Ownership	_____%
Fair Market Value of Company *(Provide details on how value was determined in "Remarks" section below)*	$_____
Are other partners being covered? *(Provide details in "Remarks" section below)*	☐ Yes ☐ No
Date Business Started	_____ / _____ / _____

7. If Creditor:

Name of Lender	
Amount of Loan	$
Purpose of Loan	
Length of Loan *(how many years?)*	
Will the Loan be Collaterally Assigned?	☐ Yes ☐ No

8. Financial Details of Business:

	Last Year	**Prior Year**
Total Assets *(cash, accounts receivable, equipment, inventory, etc.)*	$	$
Total Liabilities *(wages/interest/dividends payable, loans, etc.)*	$	$
Gross Sales or Revenue	$	$
Net Income *(before taxes)*	$	$

Remarks ***(questions 5-8)***

Part 3

I agree that 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.

Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony in the third degree.

_____ _____ _____
Signature of Proposed Insured | Date | Agent's Name Printed

_____ _____ _____
Signature of Agent | Date | FL License ID Number

PROTECTIVE LIFE INSURANCE COMPANY
P.O. Box 830619
Birmingham, AL 35283-0619

INDIVIDUAL LIFE INSURANCE – PART 1A SUPPLEMENTAL APPLICATION – MEDICAL DECLARATIONS

SECTION 1

Proposed Insured 1		
Name (First, Middle, Last)		
Height	*Weight*	☐ *Gain* ☐ *Loss* *Pounds in past year?*
Reason for Weight Gain or Loss		
Currently pregnant ☐ *Yes* ☐ *No* *If "Yes," anticipated delivery date*		

Proposed Insured 2		
Name (First, Middle, Last)		
Height	*Weight*	☐ *Gain* ☐ *Loss* *Pounds in past year?*
Reason for Weight Gain or Loss		
Currently pregnant ☐ *Yes* ☐ *No* *If "Yes," anticipated delivery date*		

Please use the Continuation of Information form if additional space is needed for details listed below.

SECTION 2

Has any person proposed for insurance ever been diagnosed, treated, tested positive for, or been given medical advice by a licensed member of the medical profession for a disease or disorder such as : (Circle conditions to which "Yes" answer applies and give details below)	Proposed Insured 1 Yes No	Proposed Insured 2 Yes No
(a) Any disorder or disease of the brain or nervous system (such as paralysis, epilepsy, stroke, convulsions, chronic headache)……	☐ ☐	☐ ☐
(b) Any disorder or disease of the heart, blood vessels, or circulatory system (such as high blood pressure, heart attack, heart murmur, chest pain)……	☐ ☐	☐ ☐
(c) Any disorder or disease of the respiratory system (such as Asthma, bronchitis, emphysema, tuberculosis)……	☐ ☐	☐ ☐
(d) Any disorder or disease of the stomach, liver, intestines, rectum, pancreas, or abdominal organs……	☐ ☐	☐ ☐
(e) Any disorder or disease of the genitourinary organs (such as kidneys, urinary tract, blood or sugar in the urine, chronic inflammation)……	☐ ☐	☐ ☐
(f) Any disorder or disease of the skeletal system (such as arthritis, osteoporosis, joints, bones, spine, muscles)……	☐ ☐	☐ ☐
(g) Any disorder or disease of eyes, ears, nose or throat ……	☐ ☐	☐ ☐
(h) Any disorder or disease of the blood, skin, thyroid, lymph or other glands (such as anemia, diabetes)……	☐ ☐	☐ ☐
(i) Any psychiatric or mental health disorders or diseases (such as attempted suicide, Bipolar, Obsessive-compulsive)……	☐ ☐	☐ ☐
(j) Any gynecological disorders or diseases (such as irregular Pap Smear, Toxic Shock Syndrome)……	☐ ☐	☐ ☐
(k) Any cancer, tumor, cyst or nodule……	☐ ☐	☐ ☐
(l) Any sexually transmitted disorders or diseases……	☐ ☐	☐ ☐
(m) Any disorders or diseases of the immune system *except those related to the Human Immunodeficiency Virus (AIDS Virus)*……	☐ ☐	☐ ☐

Please provide details for any/all "Yes" responses.

	Question Number	Date of Diagnosis	Diagnosis, Medication or Treatment Prescribed	Medical Professional or Facility
Proposed Insured 1				
Proposed Insured 2				

SECTION 3

Has any person proposed for insurance ever been diagnosed or treated by a licensed member of the medical profession for specified symptoms of: (Circle conditions to which "Yes" answer applies and give details below)	Proposed Insured 1 Yes No	Proposed Insured 2 Yes No
(a) Immune deficiency, anemia, recurrent fever, fatigue or unexplained weight loss, malaise, loss of appetite, diarrhea, fever of unknown origin, severe night sweats; unexplained or unusual infections or skin lesions; unexplained swelling of the lymph glands; Kaposi's Sarcoma or Pneumocystis Carinii Pneumonia……	☐ ☐	☐ ☐
(b) Have you been tested positive for exposure to the HIV (Human Immunodeficiency Virus) infection or been diagnosed as having AIDS (Acquired Immune Deficiency Syndrome) or ARC (AIDS-Related Complex) caused by the HIV infection or other sickness or condition derived from such infection?.....	☐ ☐	☐ ☐

Please provide details for any/all "Yes" responses.

	Question Number	Date of Diagnosis	Diagnosis, Medication or Treatment Prescribed	Medical Professional or Facility
Proposed Insured 1				
Proposed Insured 2				

SECTION 4

Has any person proposed for insurance ever (Circle conditions to which "Yes" answer applies and give details below)	Proposed Insured 1 Yes No	Proposed Insured 2 Yes No
(a) Used narcotics, barbiturates, amphetamines, hallucinogens, marijuana, heroin, cocaine, or other habit forming drugs, except as prescribed by a licensed member of the medical profession……	☐ ☐	☐ ☐
(b) Received medical treatment or counseling for, or been advised by a licensed member of the medical profession to discontinue, the use of alcohol or prescribed or non-prescribed drugs……	☐ ☐	☐ ☐
(c) Been a member of any self-help group such as Alcoholics Anonymous or Narcotics Anonymous……..	☐ ☐	☐ ☐

Please provide details for any/all "Yes" responses.

	Question Number	Date of Diagnosis	Diagnosis, Medication or Treatment Prescribed	Medical Professional or Facility
Proposed Insured 1				
Proposed Insured 2				

SECTION 5

The following questions in Section 5 do not include answers related to the Human Immunodeficiency Virus (AIDS virus) or for minor viruses, injuries, common colds that prevented normal activities for a period of less than five (5) days. Within the past five (5) years, has any person proposed for insurance (Circle items or conditions to which "Yes" answer applies and give details below)	Proposed Insured 1 Yes No	Proposed Insured 2 Yes No
(a) Been treated, examined or advised by a licensed member of the medical profession for any condition other than stated above……	☐ ☐	☐ ☐
(b) Been advised by a licensed member of the medical profession to get specified medical care which has not been completed, such as any hospitalization, surgery or diagnostic test……..	☐ ☐	☐ ☐
(c) Been an inpatient or outpatient in a hospital, clinic, medical facility, or any similar entity……	☐ ☐	☐ ☐
(d) Had any diagnostic tests such as: an electrocardiogram (EKG), MRI, CT-Scan or X-ray……	☐ ☐	☐ ☐
(e) Been on, or advised to be on any prescribed, non-prescribed (over the counter) medication or prescribed diet……	☐ ☐	☐ ☐
(f) Been unable to work, attend school or perform normal activities of life age and gender or been confined at home…...	☐ ☐	☐ ☐
(g) Has made a claim for or received benefits, compensation or pension for any injury, sickness or disability……	☐ ☐	☐ ☐

Please provide details for any/all "Yes" responses.

	Question Number	Date of Diagnosis	Diagnosis, Medication or Treatment Prescribed	Medical Professional or Facility
Proposed Insured 1				
Proposed Insured 2				

SECTION 6

For the following Family Medical History question, please provide in section number 8 below for each parent or sibling: diagnosis, age of diagnosis, date last treated, age – if still alive and if not alive, age, date, and cause of death.	Proposed Insured 1 Yes No	Proposed Insured 2 Yes No
To the best of your knowledge, has any person proposed for insurance had a parent or sibling diagnosed or treated by a member of the medical profession for certain conditions, such as heart or vascular disease, cancer, diabetes, high blood pressure, kidney disease, attempted suicide or mental illness……	☐ ☐	☐ ☐

Please provide details for any/all "Yes" responses.

	Family Member	Age of Diagnosis	Diagnosis	Date Last Treated	Age – if still alive and if not alive, age, date, and cause of death.
Proposed Insured 1					
Proposed Insured 2					

SECTION 7

Name, Address and Phone Number of Personal Physician or Medical Facility that is consulted for routine health care or periodic check-ups.	
Proposed Insured 1	Name:
	Address:
	Phone Number:
	Date and Reason of last consult:
	Name:
	Address:
	Phone Number:
	Date and Reason of last consult:
Proposed Insured 2	Name:
	Address:
	Phone Number:
	Date and Reason of last consult:
	Name:
	Address:
	Phone Number:
	Date and Reason of last consult:

Please use the Continuation of Information form if additional space is needed for details listed above.

Any person who knowingly and with intent to injure, defraud, or deceive any Insurer, files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

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
Agent's Printed Name	Agent's Signature		Date
Agent's FL License ID No.			

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PROTECTIVE LIFE INSURANCE COMPANY

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

LIFE INSURANCE ILLUSTRATION CERTIFICATION & ACKNOWLEDGEMENT

- **This certification must be submitted with the Application for Life Insurance if a signed illustration is not submitted for one of the reasons set forth below.**
- **This form must be signed on or before the application signed date in restricted states.**

1. PROPOSED INSURED *(please print)*

First, Middle, Last Name: _____

Social Security Number: _____ Date of Birth *(mm/dd/yyyy)*: _____

2. OWNER *(if other than Proposed Insured)*

First, Middle, Last Name: _____

3. AGENT/REPRESENTATIVE *(please print)*

First, Middle, Last Name: _____

Agent/Representative Number: _____ BGA Name *(if applicable)*: _____

4. ELECTRONIC ILLUSTRATION DATA – Complete this section if an electronic illustration is presented and no corresponding printed copy is provided.

Gender Class:_____ Initial Death Benefit: _____

Date of Birth *(mm/dd/yyyy)*: _____ Premium Amount Illustrated: _____

Underwriting Class: _____ Premium Mode: _____

Plan Type: _____ Number of Policy Years Illustrated: _____

Product Name: _____ Guaranteed Interest Rate: _____%

Policy Form Number: _____ Non-Guaranteed Illustrated Interest Rate: _____%

Rider(s): _____ Alternate Indexed Interest Rate: _____%
(for Indexed Products)

I, the Applicant, hereby acknowledge that *(check only one)*:

☐ No policy illustration was provided to me and I understand that a policy illustration conforming to the policy as issued will be provided no later than the time the policy is delivered.

☐ The policy applied for is different than the policy illustration shown to me, and I understand that a policy illustration conforming to the policy as issued will be provided no later than at the time the policy is delivered.

☐ I viewed a complete electronic illustration which was based on the personal and policy information shown on this form and I understand that a policy illustration conforming to the policy as issued will be provided no later than at the time the policy is delivered. No corresponding printed copy was provided.

Applicant Signature: X_____ Date: _____

I, the Agent/Representative, hereby certify that *(check only one)*:

☐ No illustration was used in the sale of the life insurance applied for.

☐ The life insurance applied for is other than as shown in the policy illustration.

☐ I displayed a complete electronic illustration to the proposed insured that was based on the personal and policy information shown on this form. I further certify that the policy illustration complies with applicable state requirements and that no corresponding printed copy was provided.

Agent/Representative Signature: X_____ Date: _____

A SIGNED COPY MUST BE PROVIDED TO THE APPLICANT AND TO THE COMPANY
See Page 2 for State Specific Disclosures

REQUIRED CALIFORNIA DISCLOSURE – For Universal Life Policies with No-Lapse Guarantees

This policy is guaranteed to stay in force for a specified number of years as long as you meet the requirements of the Policy, including the Minimum Monthly Premium provision found in the policy contract. This provision is also known as a no-lapse guarantee, and a general description of the provision is included in the Narrative Summary section of the Basic Illustration.

While this policy provides a no-lapse guarantee, it may provide nonforfeiture benefits, such as cash surrender values, which are less than those that would be provided if the guarantee were issued as a separate policy, such as a term policy. If a separate term policy has higher nonforfeiture benefits, the premiums for the separate policy might be higher than the premiums for the no-lapse guarantee provided in this policy. Therefore, when considering the purchase of this policy, you should compare the value of higher nonforfeiture benefits, such as cash surrender values, versus the premiums required to keep your insurance coverage in force.

REQUIRED SOUTH CAROLINA DISCLOSURE – For Universal Life Policies with No-Lapse Guarantees

If there is no policy debt or partial surrenders, this policy is guaranteed to stay in force during the no lapse period as long as you have paid the required minimum premiums. This guarantee could be provided by a separate policy (such as a term policy). However, the nonforfeiture benefits (such as cash surrender value) in this policy may be significantly less valuable than those provided by the separate policy. So, if you fail to pay a premium within a specified period of time from its due date or otherwise cause this policy to terminate early, the benefits paid to you upon termination could be much less than would customarily be paid if provided by the separate policy.

When thinking about purchasing this policy, you should consider the tradeoff you may be making between having significantly smaller nonforfeiture benefits (such as a cash surrender value) available to you upon surrender of the policy versus the reduction in premium, if any, you may receive for not having these benefits.