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

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

1. This authorization to obtain and disclose information complies with HIPAA regulations as they relate to life insurance. I (we) authorize Protective Life and Annuity Insurance Company (Protective Life and Annuity) and its reinsurers to obtain directly through designated third parties and use any information about or relating to me (us) that may affect my (our) insurability. Protective Life and Annuity and its reinsurers may obtain and use health and medical information to include all dates of service, including but not limited to information about chart notes, EKG's, nicotine use, physical and mental diseases and illness, and psychiatric disorders, excluding psychotherapy notes. Protective Life and Annuity and its reinsurers may also obtain and use non-health and non-medical information, including but not limited to financial information, credit reports, consumer reports, driving record, criminal record, and information about avocations and aviation activity. All of this information may be used to evaluate an application for insurance, a claim for insurance benefits, or both. Information relating to communicable diseases and other risk factors relating to me or to my spouse or life partner may be used to evaluate an application for insurance on either me or my spouse or life partner. The Protective Life and Annuity sales agent or regional sales office representing me on my (our) application for insurance may obtain the information described in this paragraph directly from any of the persons or organizations listed in paragraph 2 in order to expedite the delivery of the information to Protective Life and Annuity.

2. I (we) authorize the following persons and organizations to release and disclose the information described in paragraph 1 Protective Life and Annuity, directly through designated third parties or its agents acting on its behalf; (i) my (our) doctor(s); (ii) medical practitioners; (iii) pharmacists and Pharmacy Benefit Managers; (iv) 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; (v) insurers; (vi) reinsurers; (vii) MIB, Inc. (MIB); (viii) my (our) current and previous employers; and (ix) 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 and Annuity. MIB may not release the information described in paragraph 1 to a CRA.

3. I (we) authorize Protective Life and Annuity to release and disclose the information described in paragraph 1 to its affiliates, its reinsurers, persons or organizations providing services relating to insurance underwriting for Protective Life and Annuity, MIB, and as otherwise required by law. I (we) authorize Protective Life and Annuity to release and disclose the information described in paragraph 1 to other duly licensed life insurers if I (we) have applied or apply to the other insurers for insurance. I (we) authorize Protective Life and Annuity Insurance Company, or its reinsurers, to make a brief report of my personal health information to MIB.

4. I (we) authorize Protective Life and Annuity to release and disclose the information described in paragraph 1 to the Agent and their Representative representing me to duly licensed specific life insurers for the purpose of applying for life insurance if my (our) application with Protective Life and Annuity is declined or if Protective Life and Annuity is unable to offer coverage at an acceptable rate.

5. I (we) authorize Protective Life and Annuity to release and disclose the information described in paragraph 1 to the sales agent representing me on my (our) application for insurance if it is necessary to provide an explanation of the reasons for Protective Life and Annuity's decision to impose special underwriting requirements, whenever my application cannot be approved as submitted, or in connection with a claim for benefits.

6. This authorization shall be valid for 24 months from the Date of Authorization shown below.

7. During the evaluation of my (our) insurance application, I (we) understand that I (we) have the right to revoke the authorizations in paragraphs 1 through 5 by writing to Protective Life and Annuity Insurance Company at [P.O. Box 830619 • Birmingham, AL 35283-0619]. If this authorization is revoked, this would result in the file being closed and no coverage provided.

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

9. I (we) understand that information about me (us) may be disclosed under this authorization to persons or organizations that are not subject to the Health Insurance Portability and Accountability Act (HIPAA) and that the information would then no longer be protected by HIPAA and any related regulations.

10. *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 and Annuity's ability to process this application.*

11. ❒ I (we) have been given a copy of this authorization form and Protective Life and Annuity's Description of Information Practices.

❒ I (we) authorize the preparation of an investigative consumer report.

❒ I (we) would like to be interviewed if an investigative consumer report will be made. *(Please check if you wish to be interviewed.)*

THIS AUTHORIZATION MUST BE SIGNED WITHOUT MODIFICATION AND RETURNED WITH THE APPLICATION BEFORE PROCESSING.

_____	_____	Date of Authorization: _____
Proposed Insured 1 (Signature)	Date of Birth	When applicable, print name(s) of minor(s) below:
_____	_____	_____
Print Name (Proposed Insured 1)	Social Security #	
_____	_____	_____
Proposed Insured 2 (Signature)	Date of Birth	
_____	_____	_____
Print Name (Proposed Insured 2)	Social Security #	Health Care Provider
_____		_____
Parent or Legal Guardian (Signature)		Physician Name
		_____
		Physician Name

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