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

POLICY CHANGE APPLICATION – WITH EVIDENCE

SECTION I – Policy and Insured Information

Policy Number:

1. INSURED(S)

Insured 1 Name: (First, Middle, Last)			*Gender*	*Birthdate*	*Birth State*
Marital Status	*Driver's License No. & State*		*Social Security No./Tax ID No.*		
Home Phone Number	*Work Phone Number*		*Cell Phone Number*		
Address: (Street, City, State, Zip Code)		*Years at Residence*	*Email Address*		

Insured 2 Name: (First, Middle, Last)		*Phone Number*
Relationship to Insured	*Social Security No./Tax ID No.*	*Email Address*
Address: (Street, City, State, Zip Code)		

2. EMPLOYMENT

Insured 1 Employer's Name		*Occupation/Duties*
Annual Income	*Household Income*	*Net Worth*
If unemployed, provide details:		

Insured 2 Employer's Name		*Occupation/Duties*
Annual Income	*Household Income*	*Net Worth*
If unemployed, provide details:		

3. OWNER (If other than Insured)

Name		*Birthdate*
Relationship to Insured	*SSN/Tax ID*	*Phone Number*
Address: (Street, City, State, Zip Code)		*Email Address*

SECTION II – Type of Change / Action Being Requested

1. FACE AMOUNT INCREASE – Plan selection may be limited by product face amount ranges and state approval.

OPTION	BY AMOUNT	FOR TOTAL FACE AMOUNT OF	PREMIUM AMOUNT
☐ Increase Base Policy	$	$	$

2. ☐ MORTALITY CLASS IMPROVEMENT

3. ☐ RATE REDUCTION

SECTION III – Non-Medical History

	HAS THE INSURED: *(Must be answered for all Insureds.)*	Insured 1 Yes	Insured 1 No	Insured 2 Yes	Insured 2 No
1.	Used tobacco or nicotine of any kind over the last 5 years? _____ Type _____ Frequency _____ Date Last Used	☐	☐	☐	☐
2.	Consulted a physician or had treatment for the use or possession of: A. Alcohol?	☐	☐	☐	☐
	B. Narcotics, stimulants. sedatives, hallucinogenic drugs?	☐	☐	☐	☐
3.	In the past 5 years, been convicted of (i) two or more moving violations, (ii) driving under the influence of alcohol or other drugs, or (iii) had their driver's license suspended or revoked or do you have charges currently pending against you for driving while under the influence of alcohol?	☐	☐	☐	☐
4.	Have any insureds ever been convicted of, or pled guilty or no contest to a felony, or do they have any such charge pending against them?	☐	☐	☐	☐
5.	Flown as a pilot, student pilot or crew member, or intend to fly as such? If Yes, complete the Aviation Questionnaire.	☐	☐	☐	☐
6.	Been a member of, or applied to be a member of, or received a notice of required service in, the armed forces, reserves or National Guard? *If Yes, please list: branch of service, rank, duties, mobilization category and current duty station.* _____ _____	☐	☐	☐	☐
7.	Engaged in any of the following activities in the past 2 years? If Yes, complete the appropriate questionnaire. ☐ Racing ☐ Scuba Diving ☐ Hang Gliding ☐ Mountain Climbing excluding recreational hiking ☐ Sky Diving ☐ Parachuting	☐	☐	☐	☐
8.	Is/Are the Insured(s): a) A citizen of any country other than the United States or Canada? (If Yes, provide country of citizenship, visa type and expiration date, and length of U.S. Residency.) _____ _____	☐	☐	☐	☐
	b) Intending to travel or reside outside the United States or Canada within the next 12 months? _____ To Where _____ When _____ Why _____ For How Long	☐	☐	☐	☐

	Question #	Details to any Yes answers to non-medical history questions 1-8. *(Must be answered if applicable.)*
Insured 1		
Insured 2		

SECTION IV – Medical Declarations

1.

	Height	Weight	Gain or Loss and number of pounds in past year		Currently pregnant?	If Pregnant, what is the anticipated delivery date?
Insured 1			☐ Gain ☐ Loss	_____lbs	☐ Yes ☐ No	
Insured 2			☐ Gain ☐ Loss	_____lbs	☐ Yes ☐ No	

2.

Has any insured person ever been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for: (**Circle** conditions to which **Yes** answer applies and give details below.)	**Insured 1** Yes	No	**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 the **eyes, ears, nose or throat**……..	☐	☐	☐	☐
(h) Any disorder or disease (excluding HIV) 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** (excluding HIV)……	☐	☐	☐	☐
(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 in questions (a) – (m) above.

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

3.

(**Circle** conditions to which **Yes** answer applies and give details below.)	Insured 1 Yes	Insured 1 No	Insured 2 Yes	Insured 2 No
(a) Has any insured person ever been diagnosed or treated by a member of the medical profession for specified symptoms such as 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) Has any insured person ever been diagnosed or treated by a member of the medical profession for Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS)……	☐	☐	☐	☐

Please provide details for any/all Yes responses.

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

4.

Has any insured person ever: (**Circle** conditions to which **Yes** answer applies and give details below.)	Insured 1 Yes	Insured 1 No	Insured 2 Yes	Insured 2 No
(a) Used narcotics, barbiturates, amphetamines, hallucinogens, marijuana, heroin, cocaine, or other habit forming drugs, except as prescribed by a physician……..	☐	☐	☐	☐
(b) Received medical treatment or counseling for, or been advised by a physician 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
Insured 1				
Insured 2				

5.

The following questions 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 insured person: (**Circle** items or conditions to which **Yes** answer applies and give details below.)	Insured 1 Yes	Insured 1 No	Insured 2 Yes	Insured 2 No
(a) Been treated, examined or advised by a member of the medical profession for any condition other than stated above……	☐	☐	☐	☐
(b) Been advised by a member of the medical profession to get any specified medical care, hospitalization, surgery or diagnostic test, which has not been completed……	☐	☐	☐	☐
(c) Been an inpatient or outpatient in a hospital, clinic, medical facility, or any similar entity……	☐	☐	☐	☐
(d) Had any diagnostic tests: 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, or gender or been confined at home……	☐	☐	☐	☐
(g) Has made a claim for or received benefits, compensation or pension for any injury, sickness, disability or impaired condition……	☐	☐	☐	☐

Please provide details for any/all Yes responses.

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

6. Name, Address and Phone Number of Personal Physician or Medical Facility that is consulted for routine health care or periodic check-ups.

Insured 1	Name:
	Address:
	Phone Number:
	Date and Reason of last consult:
	Name:
	Address:
	Phone Number:
	Date and Reason of last consult:
Insured 2	Name:
	Address:
	Phone Number:
	Date and Reason of last consult:
	Name:
	Address:
	Phone Number:
	Date and Reason of last consult:

7.

For the following Family Medical History question, please provide details 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.	**Insured 1** Yes	No	**Insured 2** Yes	No
Has any insured person 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 at Diagnosis**	**Diagnosis**	**Date Last Treated**	**Age – if still alive and if not alive, age, date, and cause of death.**
Insured 1					
Insured 2					

SECTION V – Existing Coverage and Pending Insurance for Juveniles

Regarding all Insureds under the age of 14 years and 6 months, list amounts of life insurance coverage currently in force or pending.

Name of Insured	Company	Type of Coverage	Amount of Coverage

SECTION VI – Additional Ownership Information

		Insured 1 Yes	Insured 1 No	Insured 2 Yes	Insured 2 No
(1)	**For any policy to be issued as a result of this application, will any portion of the initial or future premiums be paid by anyone other than the Insured, his or her family, or employer?** If Yes, complete the "Statement of Owner Intent" (Application Supplement – Part II) and the "Premium Financing Disclosure and Acknowledgement" form.	☐	☐	☐	☐
(2)	**Will anyone other than persons with a familial or employment relationship with the Proposed Insured obtain any right, title or interest in any policy, or in any trust which is to own the policy, issued on the life of the Insured(s) as a result of this application?** If Yes, complete the "Statement of Owner Intent" (Application Supplement – Part II) and the "Trust Certification" (Application Supplement – Part III.)	☐	☐	☐	☐
(3)	**Is the issue age of any Insured 65 or older AND is the 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.)	☐	☐	☐	☐

SECTION VII - Signatures

No insurance shall take effect unless: (1) the change is issued on this application and delivered to and accepted by the Owner; (2) the first premium, if any, for the change is paid in full while the insured is alive; and (3) there has been no change in health and insurability from that described in this application.

I (We) have read or have had read to me (us) the completed Application before signing below. The above statements and answers are true and complete to the best of my (our) knowledge and belief. I (We) agree that such statements and answers shall be attached to and made part of the application and shall be considered the basis of any insurance issued.

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

_____ _____
Signature of Insured 1 Signature of Insured 2

_____ _____
Signature of Parent or Guardian Signature of Insured if Age 14 ½ or Older

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

SUITABILITY AND BEST INTEREST QUESTIONNAIRE FOR LIFE INSURANCE

This form is an essential part of the application process. It helps your producer assess your insurance needs and financial objectives, and make recommendations appropriate to your situation. The questions to be completed will depend on the type of transaction. The form must be signed by each owner/applicant and the producer.

(FOR USE IN NEW YORK)

TYPE OF TRANSACTION:

☐ **New Business (purchase, exchange, or replacement of a life insurance policy)**

☐ **In Force (increase in death benefit, exercise of contractual right, or purchase of additional benefits, riders, or endorsements)**

Policy Number: _____

PURCHASE INFORMATION:

Premium Amount / Total Estimated Initial Purchase Price: $_____

Plan Type: ☐ Qualified ☐ Non-Qualified

Face Amount: $_____

Product Name: _____

Term Length: _____

Insured Name (if different than owner): _____

Payment Mode: ☐ Annual ☐ Quarterly ☐ Semi-Annual ☐ Monthly ☐ Single Payment

OWNERS/APPLICANTS: *(If the policy will be jointly owned, please provide information for both.)*

_____ _____ _____

Owner/Applicant 1 – First Name **Last Name** **Soc. Sec. No. / Tax I.D. No.**

_____ _____ _____

Age **Trust/Entity (if applicable)** **Trust Date**

_____ _____ _____

Owner/Applicant 2 – First Name **Last Name** **Soc. Sec. No. / Tax I.D. No.**

_____ _____ _____

Age **Trust/Entity (if applicable)** **Trust Date**

FINANCIAL PROFILE: *(If the policy will be jointly owned, the information may be combined for both.)*

1. **What is your gross annual household income?** $ _____

   a. What are your sources of income? *(select all that apply)*

   ☐ Wages/Salary ☐ Rental Income ☐ Investments

   ☐ Pension/Retirement Benefit ☐ SSI ☐ Other _____

   b. Describe your monthly income: ☐ it is stable -or- ☐ it fluctuates

2. **What are your annual household living expenses?** $ _____
   (Includes: housing, food, transportation, insurance, medical care, and property taxes.)

3. **What is the face amount that you have in force for existing life insurance policies?** $ _____

4. **Federal Income Tax Rate:** ☐ 0-10% ☐ 11-20% ☐ 21-30% ☐ 31-36% ☐ 37%+

5. **What is your liquid net worth?** $ _____
(Liquid net worth is the amount that can be easily converted into cash without paying any kind of penalty or surrender charge.)

6. **Is your current income or liquid assets sufficient for living expenses, medical expenses, or any unexpected emergencies?** ☐ Yes ☐ No

If No, please explain: _____

7. **Please provide the details of your household net worth.**

Total ASSETS $_____	**Short-Term Total DEBTS $_____**
(Examples of Assets include: Primary Residence, Rental Properties, Checking Account, Savings Account, Money Market, Stocks, Bonds, Mutual Funds, CDs, Annuity Holdings, Life Insurance Cash Value, Retirement Plans/Pensions, Business Equity.)	*(Short-Term Debt includes financial obligations that are expected to be paid off within a year. Examples of Short-Term Debt include: Bank Loans, Payday Loans, Consumer Loans, Online or Installment Loans, Lines of Credit, Credit Card Debt.)*
	Long-Term Total DEBTS $_____
	(Long-Term Debt includes non-current liabilities that are due after a year or more. Examples of Long-Term Debt include: Primary Mortgage/Rent Payments, Medical Bills, Auto/Vehicle Loans, Student Loans, Unpaid Taxes/Judgements.)
	Short-Term + Long-Term = TOTAL DEBTS $_____

(Total Assets) $_____ — (Total Debts) $_____ = Household Net Worth $_____

8. **What percentage of your gross annual household income is used to pay installment debt?** _____%

9. **After the purchase of this life insurance policy, do you anticipate any material changes to the following?** ☐ Yes ☐ No
(If Yes, please select the option(s) that will be affected and provide an explanation below.)

☐ Monthly Income ☐ Out-of-pocket Medical Expenses ☐ Living Expenses ☐ Liquid Assets

If Yes, please explain: _____

10. **Do you have an emergency fund for unexpected expenses?** ☐ Yes ☐ No

If No, please explain: _____

11. **Do you have a reverse mortgage?** ☐ Yes ☐ No

FINANCIAL OBJECTIVES AND EXPERIENCE:

12. **Intended use of Life Insurance Policy:** *(select all that apply)*

☐ Income Replacement/Family Protection ☐ Estate Planning/Wealth Transfers ☐ Gifting
☐ Cover Burial Expenses/Final Expenses ☐ Retirement Income/Protection ☐ Business Planning/Protection
☐ Non-Qualified Executive Benefit ☐ Build Up Cash Value/Accumulation ☐ Pay off Debts/Liabilities

13. **Which of the following financial products do you own and/or have previously owned and indicate number of years for each?** *(select all that apply)*

☐ Fixed Annuities _____ years ☐ Variable Annuities _____ years ☐ Life Insurance _____ years
☐ Bonds _____ years ☐ Stocks _____ years ☐ Other _____ _____ years

14. **Source of funds for this life insurance purchase?** *(select all that apply)*
(If life insurance policies are being replaced, the replacement questions on this questionnaire and the State required replacement forms will need to be completed.)

☐ Current Income ☐ Life Insurance ☐ IRA/Retirement Plan
☐ Cash/Savings/Checking ☐ Loan/Reverse Mortgage ☐ Stocks/Bonds/Mutual Funds
☐ CDs ☐ Other _____

15. How long do you plan to keep this life insurance policy? *(select one)*

☐ 1-10 years ☐ 11-20 years ☐ 21+ years ☐ Lifetime

16. What is your risk tolerance for this life insurance policy?

☐ Conservative ☐ Moderately Conservative ☐ Moderate ☐ Moderately Aggressive ☐ Aggressive

17. Excluding the current transaction, have you replaced any other life insurance policies within the past 36 months? ☐ Yes ☐ No

If Yes, please explain: _____

18. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer or otherwise terminating existing life insurance policy(ies)? ☐ Yes ☐ No

19. Are you considering using funds from your existing life insurance policy(ies) to pay premiums due on the new life insurance policy? ☐ Yes ☐ No

20. If you answered "Yes" to either of questions 18 or 19, please list each existing life insurance policy you are contemplating replacing, and complete any State required replacement forms:

	Policy 1	***Policy 2***	***Policy 3***
Company Name			
Policy Number			
Name of Insured			
Replace (R) or Change (C)			
Issue Date			
Annual Premium			
Face Amount			
Cash Value (if any)			

21. The reason for replacing the existing life insurance policy(ies) is because:

_____

22. Is there a surrender charge for liquidating the existing life insurance policy(ies)? ☐ Yes ☐ No

If Yes, what is the Surrender Charge? $ _____

23. Please describe what benefit(s) the owner/applicant will achieve by replacing the existing life insurance policy(ies). If the owner/applicant is giving up certain riders or endorsements, please explain why the riders or endorsements are no longer needed.

_____

24. Are you willing to accept non-guaranteed elements in the policy, including variability in premium, death benefit, or fees? ☐ Yes ☐ No
(Non-guaranteed elements include, but are not limited to, expense and benefit charge rates, interest crediting rates, cost of insurance rates, index account parameter, etc.)

25. Please include any other information provided by the owner/applicant that is relevant to the suitability of the transaction.

_____

26. Did the owner/applicant refuse to provide any suitability information requested by the producer? ☐ Yes ☐ No
If Yes, please provide an explanation in this section.

_____

NOTE: **Refusing to provide suitability information affects the producer's ability to determine if purchasing this life insurance policy is suitable and in the owner/applicant's best interest. If we are unable to determine suitability, the application will be rejected.**

OWNER/APPLICANT'S STATEMENT:

I confirm that I provided the information above and that it is true and complete to the best of my knowledge. I discussed my current financial situation, anticipated financial needs, and risk tolerance with my producer. The producer discussed with me the advantages and disadvantages of this life insurance policy, potential consequences of the transaction, and how he or she is compensated for the sale and servicing of the life insurance policy. My producer provided me with a product summary, in the form of the product-specific Disclosure Statement and the Product Summary Disclosure, and explained to me the product features, including, if applicable, the interest crediting elements, the indexes upon which the interest calculation will be based, surrender charges, and other costs relating to the product. I understand the risks associated with this product include fluctuating interest rates and potentially lower returns. I understand and accept that the life insurance policy I am purchasing may include non-guaranteed elements such as changes in interest rates, availability of options, policy value, death benefits, fees, or additional premium limitations. I understand my refusal to provide certain information affects the ability of my producer to determine if purchasing this life insurance policy is suitable and in my best interest.

Please check the box next to *one* of the statements below. The application *will not be accepted* if this section is incomplete.

☐ I provided the necessary information requested by my producer to thoroughly assess my current financial situation and make a recommendation that I believe is suitable and in my best interest according to my financial goals and objectives.

☐ I have selected this product despite a contrary recommendation (or absence of a recommendation) from my producer.

Owner/Applicant 1: _____ **Date:** _____

Owner/Applicant 2: _____ **Date:** _____

PRODUCER'S STATEMENT:

I have made a reasonable effort to obtain the following information about the applicant(s): financial situation, net worth and liquidity, tax status, financial objectives, risk tolerance, time horizon, and financial goals and objectives. I have a reasonable basis to believe that the applicant(s) have the financial ability to meet the financial commitments under this life insurance policy. To the best of my knowledge and belief, the information provided by the applicant on this Suitability and Best Interest Questionnaire for Life Insurance is true, complete, and was obtained prior to the purchase of the life insurance policy. I considered only the interests of the applicant(s) when making the recommendation to purchase this life insurance policy, and the recommendation was not influenced by the amount of compensation or incentive that I or anyone affiliated with me would receive. I completed the product training and believe I am knowledgeable of the life insurance policy that I recommended to the applicant(s). I did not use the title or designation of "financial planner," "financial advisor," or any similar title without being appropriately licensed or certified to provide securities or other non-insurance financial services. I have discussed with the applicant how I am compensated, advantages and disadvantages of this product, potential consequences of the transaction, and I provided them with the basis of my recommendation. Sections a. and b. must be completed to confirm the advantages and disadvantages of this purchase.

a. Advantages of purchasing the proposed life insurance policy: ***(select all that apply)***

☐ Guarantees/Lapse Protection ☐ Temporary Death Benefit Protection ☐ Permanent Death Benefit Protection
☐ Supplemental Retirement Income Needs/Protection ☐ Long-Term Care Protection ☐ Business Needs/Planning
☐ Lower Premiums ☐ Increased Death Benefit Protection ☐ Guaranteed Level Premiums ☐ Reduced/Lower Fees
☐ Cash Value Growth ☐ Other, please explain: _____

b. Disadvantages of purchasing the proposed life insurance policy: ***(select all that apply)***

☐ Surrender Period/Length ☐ Surrender Charges ☐ Reduction in Death Benefit ☐ Loss of Policy Features
☐ Higher Upfront Costs and Expenses/First Year Charges ☐ Chance for Less Gain than Current Product
☐ New Contestable Period ☐ Market Exposure ☐ Other, please explain: _____

Please check the box next to *one* of the statements below. The application *will not be accepted* if this section is incomplete.

☐ Based on the information the applicant(s) provided and according to the applicant's financial goals and objectives, I believe the recommended life insurance policy contract is suitable and in the best interest of the applicant(s).

☐ The applicant(s) selected this product despite a contrary recommendation (or absence of a recommendation) from me.

Producer: _____ **Date:** _____

Protective Life and Annuity Insurance Company, Post Office Box 830619, Birmingham, AL 35283-0619
Toll Free: 800-366-9378; Fax: 205-268-5807

PROTECTIVE LIFE AND ANNUITY INSURANCE COMPANY

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

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

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.

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

PROTECTIVE LIFE AND ANNUITY 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 and Annuity Insurance Company (Protective Life and Annuity) 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 Annuity 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, including but not limited to, 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, including but not limited to 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) and other risk factors 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 and Annuity, 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 and Annuity 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, but are not limited to:

a. tests for cholesterol and related blood lipids, diabetes, liver or kidney disorders, immune disorders (other than HIV/AIDS, see ***SPECIAL REQUIREMENT FOR HIV/AIDS TESTING*** section).
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 and Annuity 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 and Annuity 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 organizations providing services relating to insurance underwriting for Protective Life and Annuity, **MIB** 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 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 and Annuity is declined or if Protective Life and Annuity is unable to offer coverage at an acceptable rate.
d. to the Life Insurance Representative(s) and its staff, affiliated companies and/or entities, insurance companies and their reinsurers representing me on my (our) application for life insurance.

RELEASE OF MEDICAL, NON-HEALTH, NON-MEDICAL AND TESTING INFORMATIION TO REINSURERS

I (we) authorize Protective Life and Annuity 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 reinsurers, to make a brief report of my personal health information to **MIB**.

SPECIAL REQUIREMENT FOR HIV/AIDS TESTING

If Protective Life and Annuity intends to test for the presence of antibodies to the Human Immunodeficiency Virus (HIV), which is the virus that has been associated with Acquired Immune Deficiency Syndrome (AIDS), Protective Life may require a separate authorization. I (we) hereby authorize Protective Life and Annuity:

a. to obtain and use the results of any HIV tests that I (we) separately authorize;
b. (if permitted by law) to disclose the results of any tests to its reinsurers and **MIB**.

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, whichever period is shorter, or, in the event of a claim for benefits, for the duration of such claim.
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 and Annuity 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 redisclosure 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 and Annuity'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.**)

SIGNATURES

Date of Authorization: _____

_____

List Health Care Providers

_____

Proposed Insured 1 (Signature) Print Name of Proposed Insured 1 Birthdate Social Security #

_____

Proposed Insured 2 (Signature) Print Name of Proposed Insured 2 Birthdate Social Security #

_____

If Minor, Print Name Parent or Legal Guardian (Signature) Print Name of Parent or Legal Guardian

PROTECTIVE LIFE AND ANNUITY INSURANCE COMPANY

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

NOTICE AND CONSENT FOR BLOOD TESTING

NOTICE AND CONSENT FOR BLOOD TESTING WHICH MAY INCLUDE AIDS VIRUS (HIV) ANTIBODY/ANTIGEN TESTING AND AUTHORIZATION OF RELEASE OF HIV TEST INFORMATION

EXAMINER: _____

ADDRESS: _____

To determine your insurability, the Insurer named above has requested that you provide a sample of your blood for testing and analysis. All tests will be performed by a licensed laboratory.

1. What tests may be performed?
   Tests which may be performed include: determinations of blood cholesterol and related lipids (fats) and screening for liver or kidney disorders, diabetes, immune disorders, and the presence of HIV antibodies/antigens.

2. What is the HIV Antibody Test?
   The HIV antibody test is a blood test. The test shows if you have antibodies to the virus that causes AIDS. A sample of your blood will be taken from your arm with a needle. If the first test shows that you have antibodies, a different test will then be done on the same blood sample to make sure the first test was right. The HIV antigen test directly identifies AIDS viral particles.

   A positive test result means that you have been exposed to the virus and are infected. It does not mean that you have AIDS or that you will become sick with AIDS in the future; *but it is an indication that you may develop AIDS and may wish to consider further independent testing.*

   A negative test result means that you are probably not infected with the virus. It takes the body time to produce HIV antibodies. If you have been exposed to HIV recently, you need to be retested in several months to make sure you are not infected. Your doctor or counselor will explain this to you.

3. What are the benefits of taking the test?
   If you test negative:
   - You can learn how to protect yourself from getting infected with the virus in the future. Ask your doctor or counselor how.

   If you test positive:
   - You can learn how to avoid giving the virus to others.
   - Knowing that you are infected is important for your health. Your doctor can care for you better.
   - If you are a woman or man who is thinking of having a child, you can learn about the risks of passing the virus to your baby.
   - If you are a woman who is already pregnant, your doctor can provide information on the full range of options and services available to you.

4. Voluntary Testing
   Taking an HIV antibody test is voluntary. You do not have to take the test.
   If you do not wish anyone to know your test results or even that you have been tested, you can go to an anonymous test site. This is a place where you can receive counseling and the HIV test without giving your name or address. You can find the nearest anonymous test site by calling the AIDS Hotline at 1-800-541-2437.

5. Confidentiality of Test Results

If you take the HIV antibody test, your test results are confidential. Under New York State Law, confidential HIV related information can only be given to people you allow to have it by signing this consent and release form, or to those persons included on the back of this form.

By signing this release form, you agree that the test results will be reported by the laboratory to the insurer. When necessary for business reasons in connection with insurance you have or have applied for with the insurer, the insurer may disclose test results to others involved solely in the underwriting process such as its affiliates, reinsurers, employees or contractors. If the insurer is a member of the MIB, LLC, and if the test results for HIV antibodies/antigens are other than normal, the insurer will report to the MIB, LLC, a generic code which signifies only a non-specific blood and/or urine test abnormality. If your HIV test is normal, no report will be made about it to the MIB, LLC. Other test results may be reported to the MIB, LLC, in a more specific manner. The organizations described in this paragraph may maintain the test results in a file or data bank. There will be no other disclosure of test results or even that the tests have been done except as may be required or permitted by law or as authorized by you.

If your HIV test results are normal, no routine notification will be sent to you. If the HIV test results are other than normal, the insurer will contact you. The insurer may also contact you if there are other abnormal test results which, in the insurer's opinion, are significant. The insurer will ask you for the name of a physician, other health care provider, or other designee to whom you may authorize disclosure and with whom you may wish to discuss the results. *If you elect to receive the HIV test results directly, you may call the State Health Department's toll-free number for further information about AIDS, the meaning of HIV test results and the availability and location of HIV counseling services. You should consult your physician about the meaning of and need for counseling, where appropriate, as to the HIV test results.*

6. Risks Involved with Disclosure and Sources of Help

If you test positive, you should be careful about telling others what your test showed. Some HIV positive people have been discriminated against by employers, landlords and others. If you experience discrimination because of release of HIV related information, you may contact the New York State Division of Human Rights at (212) 870-8624 or the New York City Commission of Human Rights at (212) 566-5493. These agencies are responsible for protecting your rights.

7. For More Information

If you have further questions about informed consent for HIV antibody testing, you may contact the New York State Department of Health at (518) 486-1595.

Name and address of facility/provider obtaining release:

Name: _____

Address: _____

Name of person whose HIV related information will be released: _____

Name and address of person signing this form (if other than above):

Name: _____

Address: _____

Relationship to person whose HIV information will be released: _____

Name and address of person who will be given HIV related information:

Name: _____

Address: _____

Reason for release of HIV related information: _____

Time during which release is authorized: From: _____ To: _____

My questions about this form have been answered. I know that I do not have to allow release of HIV related information, and that I can change my mind at any time.

_____ _____

Date Signature

My questions about the HIV test have been answered. I agree to take the HIV antibody test.

_____

Date

_____ _____

Signature of person who will be tested Signature of person authorized to consent for person to be tested

_____ _____

Name of person who will be tested *(Please print)* Name of person authorized to consent *(Please print)*

I have explained the means by which the HIV antibody test is done, the meaning of the results and the possible consequences of disclosure of the test results to the individual above, and have answered any questions she/he had about the test.

_____ _____

Name Title

_____

Facility/Provider Name

PROTECTIVE LIFE AND ANNUITY INSURANCE COMPANY

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

HIV RELATED INFORMATION - NEW YORK

Who Can Receive HIV Related Information?

Under New York State Public Health Law, HIV related information is confidential and may only be given:

a. To you (or a person authorized by law who consented to the test for you);

b. To anyone whom you have specifically authorized to receive such information by signing a written release;

c. To a health care facility (such as a hospital, blood bank, or clinical laboratory) or a health care provider (such as a physician, nurse, or mental health counselor) providing care to you or your child, and anyone working for such a facility or provider who reasonably needs the information to supervise, monitor or administer a health service;

d. To a person who your doctor believes is at significant risk for HIV infection, if you do not notify that person after being counseled to do so;

e. To a committee or organization responsible for reviewing or monitoring a health facility;

f. To a federal, state, country, or local health officer when state or federal law requires disclosure;

g. To a government agency, when the agency needs the information to supervise, monitor or administer a health or social service;

h. To an authorized foster care or adoption agency;

i. To insurance companies and other third party payors such as Medicaid, if necessary for the payment of services to you;

j. To any person to whom a court orders disclosure under limited circumstances set forth by law. Except in an emergency situation, advance notice and an opportunity to oppose the release of such information would be given to you;

k. To the Division of Parole, the Division of Probation, the Commission of Correction, or a medical director of a local correctional facility, as permitted by HIV confidentiality regulations of such organization;

l. By a physician to the person who consents for your health care (parent, guardian, etc.) if disclosure is necessary to provide timely care for you, and you have been counseled regarding the need for disclosure. A physician may not disclose such information if it is against your best interest to do so.

You can ask your doctor if HIV related information about you has been released to anyone listed above.

PROTECTIVE LIFE & ANNUITY INSURANCE COMPANY

P.O. Box 830619 | Birmingham, AL 35283-0619 | Phone: 1-800-366-9378 | Fax: 205-268-5807

NOTIFICATION OF RIGHT TO NAME THIRD PARTY DESIGNEE

New York policyholders have the right to designate a third party designee to receive copies of notices affecting insurance coverage, please provide us with the information below and return this form to us at P.O. Box 830619, Birmingham, Alabama 35283-0619. The designation will be effective no later than 10 business days from the date received by us. New York law requires this form be sent to us by certified mail, return receipt requested. If you do not wish to name a third party designee at this time, simply do not return the form.

If you have any questions about your right to name a third party designee, please call us at 1-800-366-9378, write us at P.O. Box 830619, Birmingham, Alabama 35283-0619, or fax us at 205-268-5807.

Please Print the Following Information:

_____
Policy Number (if known)

_____
Policy Owner's Name

_____
Insured's Name

Third Party Designee:

_____
Name

_____
Street Address or P.O. Box

_____
City, State, Zip Code

_____
Telephone Number

PROTECTIVE LIFE AND ANNUITY 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 and Annuity may receive from doctors and hospitals who have attended you.

Information regarding your insurability will be treated as confidential. Protective Life and Annuity, 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 and Annuity, 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 and Annuity, 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 and Annuity 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

PROTECTIVE LIFE AND ANNUITY 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: