

# 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)

<i>Insured 1 Name: (First, Middle, Last)</i>		<i>Gender</i>	<i>Birthdate</i>	<i>Birth State</i>
<i>Marital Status</i>	<i>Driver's License No. &amp; State</i>		<i>Social Security No./Tax ID No.</i>	
<i>Home Phone Number</i>	<i>Work Phone Number</i>		<i>Cell Phone Number</i>	
<i>Address: (Street, City, State, Zip Code)</i>		<i>Years at Residence</i>	<i>Email Address</i>	
<i>Insured 2 Name: (First, Middle, Last)</i>			<i>Phone Number</i>	
<i>Relationship to Insured</i>	<i>Social Security No./Tax ID No.</i>		<i>Email Address</i>	
<i>Address: (Street, City, State, Zip Code)</i>				

#### 2. EMPLOYMENT

<i>Insured 1 Employer's Name</i>		<i>Occupation/Duties</i>		
<i>Annual Income</i>	<i>Household Income</i>		<i>Net Worth</i>	
<i>If unemployed, provide details:</i>				
<i>Insured 2 Employer's Name</i>		<i>Occupation/Duties</i>		
<i>Annual Income</i>	<i>Household Income</i>		<i>Net Worth</i>	
<i>If unemployed, provide details:</i>				

#### 3. OWNER (If other than Insured)

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

### 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
<input type="checkbox"/> Increase Base Policy	\$	\$	\$

2.  **MORTALITY CLASS IMPROVEMENT**

3.  **RATE REDUCTION**

**SECTION III – Non-Medical History**

<b>HAS THE INSURED: (Must be answered for all Insureds.)</b>		<b>Insured 1</b>		<b>Insured 2</b>	
		<b>Yes</b>	<b>No</b>	<b>Yes</b>	<b>No</b>
1. Used tobacco or nicotine of any kind over the last 5 years?  Type _____ Frequency _____ Date Last Used _____		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Consulted a physician or had treatment for the use or possession of: A. Alcohol? B. Narcotics, stimulants, sedatives, hallucinogenic drugs?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Flown as a pilot, student pilot or crew member, or intend to fly as such? If Yes, complete the Aviation Questionnaire.		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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? <i>If Yes, please list: branch of service, rank, duties, mobilization category and current duty station.</i>  _____  _____		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Engaged in any of the following activities in the past 2 years? If Yes, complete the appropriate questionnaire. <input type="checkbox"/> Racing <input type="checkbox"/> Scuba Diving <input type="checkbox"/> Hang Gliding <input type="checkbox"/> Mountain Climbing excluding recreational hiking <input type="checkbox"/> Sky Diving <input type="checkbox"/> Parachuting		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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.) _____  _____		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Intending to travel or reside outside the United States or Canada within the next 12 months?  To Where _____ When _____ Why _____ For How Long _____		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<b>Question #</b>	<b>Details to any Yes answers to non-medical history questions 1-8. (Must be answered if applicable.)</b>			
<b>Insured 1</b>					
<b>Insured 2</b>					

**SECTION IV – Medical Declarations**

1.	<b>Height</b>	<b>Weight</b>	<b>Gain or Loss and number of pounds in past year</b>	<b>Currently pregnant?</b>	<b>If Pregnant, what is the anticipated delivery date?</b>
<b>Insured 1</b>			<input type="checkbox"/> Gain <input type="checkbox"/> Loss _____ lbs	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Insured 2</b>			<input type="checkbox"/> Gain <input type="checkbox"/> Loss _____ lbs	<input type="checkbox"/> Yes <input type="checkbox"/> 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: ( <b>Circle</b> conditions to which <b>Yes</b> answer applies and give details below.)	<b>Insured 1</b> Yes No	<b>Insured 2</b> Yes No
(a)	Any disorder or disease of the <b>brain or nervous system</b> (such as paralysis, epilepsy, stroke, convulsions, chronic headache).....	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
(b)	Any disorder or disease of the <b>heart, blood vessels, or circulatory system</b> (such as high blood pressure, heart attack, heart murmur, chest pain).....	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
(c)	Any disorder or disease of the <b>respiratory system</b> (such as asthma, bronchitis, emphysema, tuberculosis).....	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
(d)	Any disorder or disease of the <b>stomach, liver, intestines, rectum, pancreas, or abdominal organs</b> .	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
(e)	Any disorder or disease of the <b>genitourinary organs</b> (such as kidneys, urinary tract, blood or sugar in the urine, chronic inflammation).....	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
(f)	Any disorder or disease of the <b>skeletal system</b> (such as arthritis, osteoporosis, joints, bones, spine, muscles).....	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
(g)	Any disorder or disease of the <b>eyes, ears, nose or throat</b> .....	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
(h)	Any disorder or disease (excluding HIV) of the <b>blood, skin, thyroid, lymph or other glands</b> (such as anemia, diabetes).....	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
(i)	Any <b>psychiatric or mental health</b> disorders or diseases (such as attempted suicide, bipolar, obsessive-compulsive).....	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
(j)	Any <b>gynecological</b> disorders or diseases (such as irregular Pap Smear, Toxic Shock Syndrome).....	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
(k)	Any <b>cancer, tumor, cyst or nodule</b> .....	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
(l)	Any <b>sexually transmitted disorders or diseases</b> (excluding HIV).....	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
(m)	Any disorders or diseases of the <b>immune system</b> <i>except those related to the Human Immunodeficiency Virus (AIDS Virus)</i> .....	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>

**Please provide details for any/all Yes responses in questions (a) – (m) above.**

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

3.	<b>(Circle conditions to which Yes answer applies and give details below.)</b>				<b>Insured 1</b>		<b>Insured 2</b>	
					<b>Yes</b>	<b>No</b>	<b>Yes</b>	<b>No</b>
(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.....				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(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).....				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

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

4.	<b>Has any insured person ever:</b> <b>(Circle conditions to which Yes answer applies and give details below.)</b>				<b>Insured 1</b>		<b>Insured 2</b>	
					<b>Yes</b>	<b>No</b>	<b>Yes</b>	<b>No</b>
(a)	Used narcotics, barbiturates, amphetamines, hallucinogens, marijuana, heroin, cocaine, or other habit forming drugs, except as prescribed by a physician.....				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(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.....				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(c)	Been a member of any self-help group such as Alcoholics Anonymous or Narcotics Anonymous.....				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

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

5.	<b><i>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.</i></b>							
	<b>Within the past five (5) years, has any insured person:</b> <b>(Circle items or conditions to which Yes answer applies and give details below.)</b>				<b>Insured 1</b>		<b>Insured 2</b>	
(a)	Been treated, examined or advised by a member of the medical profession for any condition other than stated above.....				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(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.....				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(c)	Been an inpatient or outpatient in a hospital, clinic, medical facility, or any similar entity.....				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(d)	Had any diagnostic tests: electrocardiogram (EKG), MRI, CT-Scan or X-ray.....				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(e)	Been on, or advised to be on any prescribed, non-prescribed (over the counter) medication or prescribed diet.....				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(f)	Been unable to work, attend school or perform normal activities of life, age, or gender or been confined at home.....				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(g)	Has made a claim for or received benefits, compensation or pension for any injury, sickness, disability or impaired condition.....				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

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

6. Name, Address and Phone Number of Personal Physician or Medical Facility that is consulted for routine health care or periodic check-ups.	
<b>Insured 1</b>	Name:
	Address:
	Phone Number:
	Date and Reason of last consult:
	Name:
	Address:
	Phone Number:
	Date and Reason of last consult:
<b>Insured 2</b>	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.					<b>Insured 1</b>	<b>Insured 2</b>		
					<b>Yes</b>	<b>No</b>	<b>Yes</b>	<b>No</b>
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.....					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Please provide details for any/all Yes responses.</b>								
	<b>Family Member</b>	<b>Age at Diagnosis</b>	<b>Diagnosis</b>	<b>Date Last Treated</b>	<b>Age – if still alive and if not alive, age, date, and cause of death.</b>			
<b>Insured 1</b>								
<b>Insured 2</b>								

**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		Insured 2	
	Yes	No	Yes	No
<p>(1) <b>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?</b> If Yes, complete the "Statement of Owner Intent" (Application Supplement – Part II) and the "Premium Financing Disclosure and Acknowledgement" form.</p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<p>(2) <b>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?</b> If Yes, complete the "Statement of Owner Intent" (Application Supplement – Part II) and the "Trust Certification" (Application Supplement – Part III.)</p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<p>(3) <b>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?</b> If Yes, complete the "Statement of Owner Intent" (Application Supplement – Part II.)</p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**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.

<b>Total ASSETS</b> \$ _____ (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.)	<b>Short-Term Total DEBTS</b> \$ _____ (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.)
	<b>Long-Term Total DEBTS</b> \$ _____ (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.)
	<b>Short-Term + Long-Term = TOTAL DEBTS</b> \$ _____
<b>(Total Assets) \$ _____ – (Total Debts) \$ _____ = Household Net Worth \$ _____</b>	

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

[Empty rectangular box for additional information]

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

**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, 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 and Annuity. **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).
- 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 organization 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 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 and Annuity is declined or if Protective Life and Annuity 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.

**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 and Annuity 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 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 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) authorize the preparation of an investigative consumer report and 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 MUST 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

# 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 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](http://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](http://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

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. <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other* *List Other Language: _____	Yes	No
2. Is the Proposed Insured a relative or does the Proposed Insured have a business relationship with you? If Yes, Details: _____	<input type="checkbox"/>	<input type="checkbox"/>
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) <b>only</b> 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.)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
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.	<input type="checkbox"/>	<input type="checkbox"/>
5. Has a mortality analysis or life expectancy analysis been performed on the Proposed Insured?	<input type="checkbox"/>	<input type="checkbox"/>
6. Has a medical examination been ordered? If Yes, Name of Examiner: _____ Date of Exam: _____	<input type="checkbox"/>	<input type="checkbox"/>
7. Is Premium Financing involved in this case? (If Yes, please submit a cover letter describing the parameters.)	<input type="checkbox"/>	<input type="checkbox"/>
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	<input type="checkbox"/>	<input type="checkbox"/>

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.

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

*Broker/Representative Special Requests/Remarks:*