



INDIVIDUAL LIFE INSURANCE - TOBACCO USE QUESTIONNAIRE

For Mortality Reclassification from Smoker/Tobacco to Non-Smoker/Non-Tobacco

SECTION 1

Form with fields for Name, Mailing Address, City, State, Zip Code, Policy Number(s), Daytime Telephone Number, and Email Address.

SECTION 2

Form with questions (a) and (b) regarding tobacco use and medical treatment. Question (a) includes sub-fields for Type of tobacco or nicotine product used, Frequency of use, and Date last used.

I hereby represent that the statements and answers made in response to the above questions are complete and true. I agree that the Company can rely on these answers in making their decision and that these answers shall be a supplement to and form a part of the application for this policy.

Signed at (City and State): _____ Date Signed: _____

Signature of Insured: _____

Signature of Owner (if other than insured): _____

Signature of Insured if Aged 14 1/2 or Older: _____

Signature of Parent or Guardian: _____

Signature of Agent/Witness: _____



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 information about chart notes, EKG's, nicotine use, physical and mental diseases and illness, 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 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, Inc. (**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 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 insurance if it is necessary to provide an explanation of the reasons for Protective Life and Annuity's decision to impose special underwriting requirements, whenever my application cannot be approved as submitted, or in connection with a claim for benefits.

Home Office – ORIGINAL Applicant - COPY



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- a. obtain and use health and medical information from all dates of service, including but not limited to information about chart notes, EKG's, nicotine use, physical and mental diseases and illness, and psychiatric disorders (excluding psychotherapy notes);
- 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 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;
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- 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 insurance if it is necessary to provide an explanation of the reasons for Protective Life and Annuity's decision to impose special underwriting requirements, whenever my application cannot be approved as submitted, or in connection with a claim for benefits.

Home Office – ORIGINAL Applicant - COPY



Protective Life and Annuity Insurance Company
 Home Office: 2801 Highway 280 South, Birmingham, AL 35223
 P.O. Box 2606, Birmingham, AL 35202-2606
 Administrative Office: P.O. Box 830735, Birmingham, AL 35283
 Telephone: 1-800-265-1545

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, Inc., and if the test results for HIV antibodies/antigens are other than normal, the insurer will report to the MIB, Inc., 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, Inc. Other test results may be reported to the MIB, Inc., 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.



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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



DESCRIPTION OF INFORMATION PRACTICES

(Including MIB, Inc. 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, Inc., (MIB), formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. 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. 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