

**PROTECTIVE LIFE AND ANNUITY INSURANCE COMPANY**

**P.O. Box 830619**

**Birmingham, AL 35283-0619**

**SUPPLEMENTAL APPLICATION – DRUG AND ALCOHOL USE QUESTIONNAIRE**

Name

Date of Birth

Policy Number

1. Do you presently use alcohol beverages?

Yes  No

a. If No, please provide the date of last usage (if applicable):

Type of Alcohol

Date of Last Usage

|                              |  |
|------------------------------|--|
| Beer (1 serving = 12 oz.)    |  |
| Wine (1 serving = 5 oz.)     |  |
| Liquor (1 serving = 1.5 oz.) |  |

b. If Yes, please provide quantity of drinks below:

Type of Alcohol

Daily

Weekly

Monthly

|                              |  |  |  |
|------------------------------|--|--|--|
| Beer (1 serving = 12 oz.)    |  |  |  |
| Wine (1 serving = 5 oz.)     |  |  |  |
| Liquor (1 serving = 1.5 oz.) |  |  |  |

2. Did you ever use substantially more alcohol in the past?

Yes  No

If Yes, please provide usage details, including dates and alcohol amounts in ounces.

Type of Alcohol

Daily

Weekly

Monthly

Date of Last Usage

|                              |  |  |  |  |
|------------------------------|--|--|--|--|
| Beer (1 serving = 12 oz.)    |  |  |  |  |
| Wine (1 serving = 5 oz.)     |  |  |  |  |
| Liquor (1 serving = 1.5 oz.) |  |  |  |  |

3. Do you presently or did you in the past use any of the following, other than for treatment of a medical condition by a licensed member of the medical profession?

a) Amphetamines e.g. 'Ecstasy', 'Ice', MDMA, 'Speed', 'Uppers'

Yes  No

b) Barbiturates e.g. 'Downers'

Yes  No

c) Cannabis e.g. 'Hashish', Marijuana, 'Pot', THC, 'Edibles'

Yes  No

d) Cocaine e.g. 'Coke', 'Crack', 'Snow'

Yes  No

e) Hallucinogens e.g. 'Acid', 'Angel Dust', 'Haze', LSD, 'Microdots'

Yes  No

f) Opiates e.g. Codeine, Heroin, Methadone, Morphine, Opium, 'Smack'

Yes  No

g) Sedatives e.g. Diazepam, 'Downers', Nitrazepam, 'Tranks'

Yes  No

h) Solvents e.g. Aerosols, Glue

Yes  No

Continued.....

If Yes to any of the above drugs listed, please provide usage details below:

| Name of Drug | Daily | Weekly | Monthly | Date of Last Usage |
|--------------|-------|--------|---------|--------------------|
|              |       |        |         |                    |
|              |       |        |         |                    |
|              |       |        |         |                    |
|              |       |        |         |                    |

**REMARKS (if more space is needed to provide responses)**

I hereby represent that the above statements and answers to all the above questions are complete and true to the best of my knowledge and belief, and I agree that they will be attached to and form a part of the application.

Signed at (City, State): \_\_\_\_\_, \_\_\_\_\_ day of \_\_\_\_\_ (Month), \_\_\_\_\_ (Year).

(X) \_\_\_\_\_  
Signature of Proposed Insured

\_\_\_\_\_  
Witness