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

Information regarding your insurability will be treated as confidential. Protective Life, 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, 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, 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 Insurance Company, P.O. Box 830619, Birmingham, Alabama 35283-0619. Telephone: 800-366-9378.

AGENT/PRODUCER COMPENSATION DISCLOSURE

Agents/Producers receive compensation from an insurer or third party, which may differ depending upon the product or insurer. Additional compensation may be received by the Agent/Producer based on other factors including premium volume placed with the company and loss or claim experience.

THIS NOTICE MUST BE GIVEN TO THE PROPOSED INSURED

Policy Number: _____

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

INDIVIDUAL LIFE INSURANCE APPLICATION (PART I)

1. Proposed Insured

a. Title	
b. First Name	
c. Middle Initial	
d. Last Name	
e. Suffix	
f. Gender	
g. Birthdate	
h. Birth State	
i. Birth Country	
j. Marital Status	
k. Phone Number(s)	
l. Driver's License Number and State	
m. Social Security or Tax ID Number	
n. Email Address	
o. Residential Address	
p. Length of Time at Residence	

2. Employment Information

a. Employer's Name	
b. Employer's Address	
c. Number of Years Employed	
d. Annual Income	
e. Net Worth	

3. a) Owner *(If other than Proposed Insured)*

1. Name	
2. Date of Trust	
3. Birthdate	
4. Relationship to Proposed Insured	
5. Social Security or Tax ID Number	
6. Email Address	
7. Residential Address	

b) Joint Owner *(If applicable)*

1. Name	
2. Date of Trust	
3. Birthdate	
4. Relationship to Proposed Insured	
5. Social Security or Tax ID Number	
6. Email Address	
7. Residential Address	

4. **Beneficiary Designations** – If multiple beneficiaries are named, shares will be divided equally among the surviving beneficiaries, unless otherwise specified.

a) Primary Beneficiary(ies):

1. Name	
2. Address	
3. Phone Number	
4. Birthdate	
5. Social Security Number	
6. Relationship to Insured	
7. Percentage	

b) Contingent Beneficiary(ies):

1. Name	
2. Address	
3. Phone Number	
4. Birthdate	
5. Social Security Number	
6. Relationship to Insured	
7. Percentage	

5. **Plan of Insurance**

a. Product Name:	
b. Face Amount:	
c. If Term or Alternative to Term, Indicate Years:	
d. Underwriting Class Quoted: *(Protective will issue the best underwriting class.)*	
e. If Applicable, Death Benefit:	Level / Increasing
f. Section 1035:	Yes / No
g. 1035 Loan Transfer :	Yes / No
h. If Applicable, Death Benefit Compliance Test:	Cash Value Accumulation Test / Guideline Premium Test
i. Is Proposed Insured Requesting Additional Benefits, Riders, or Child Coverage?	Yes / No
j. Premium Payment Mode and Amount: *(Cash payment with application, Annual, Quarterly, Semi-Annual Payments; or Monthly Pre-Authorized Withdrawal)*	

6. Regarding the Proposed Insured:

a) Should this application be considered a potential replacement or modification of any existing life insurance or annuity? | Yes / No

b) **List all life insurance information for any policy(ies) in force on your life, whether owned by you or not. If None, insert None.**

1. Company:	
2. Policy Number:	
3. Replace:	Yes / No
4. Amount:	
5. Insurance Type:	
6. Issue Date:	

Remarks and Explanations to any Yes answers.

DECLARATIONS

I have read or have had read to me the completed Application before signing below. I represent that all statements and answers made in all parts of this application are full, complete and true, to the best of my knowledge and belief and I have not withheld any material information that may influence the assessment or acceptance of this application. I agree to inform Protective Life Insurance Company of any material changes before the insurance goes into effect. It is agreed that:

1. All such statements and answers shall be the basis of any insurance issued, and my (our) answers are material to the decision as to whether the risk is accepted by Protective Life.
2. No representative or medical examiner can make, alter or discharge any contract, accept risks, or waive Protective Life's rights or requirements.
3. Acceptance of a policy by the Owner shall constitute ratification of any changes made by the Company. In those states where it is required, changes as to plan, amount, age at issue, classification or benefits will be made only with the Owner's written consent.
4. No insurance shall take effect unless: (1) a policy is delivered to the Owner; (2) the full first premium is paid while the proposed insured(s) is (are) alive; **and** (3) there has been no change in health and insurability from that described in this application. However, if the premium is paid as set forth in the Conditional Receipt Agreement, if any, and the Conditional Receipt Agreement is delivered to the Owner, the terms of the Conditional Receipt Agreement shall apply. No representative or medical examiner has any authority to waive or to alter these terms and conditions or to bind coverage under any other circumstances.
5. I have reviewed the Conditional Receipt Agreement, if any, and understand and agree that it provides a **limited** amount of life insurance for a **limited** period of time, and that such coverage is subject to the terms and conditions set forth in the Conditional Receipt Agreement.
6. The representative taking this application, if any, has made no statement or representation different from, contrary to or in addition to these Declarations and the terms and conditions of the attached Conditional Receipt Agreement.

IMPORTANT INFORMATION ABOUT IDENTIFICATION VERIFICATION

To help the government fight the funding of terrorism and money laundering activities, Federal Law requires all financial institutions to obtain, verify, and record information of its customers. We may ask for information or identifying documents that will allow us to verify the identity of our customers.

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Signatures:

Proposed Insured Signature

Proposed Insured City State Date

Owner Signature (If Owner is other than the Proposed Insured)

Owner City State Date

Joint Owner Signature (If applicable)

Joint Owner City State Date

Legal Guardian Signature (If applicable)

Legal Guardian City State Date

AGENT / BROKER ATTESTATION:

Will this policy replace or change any existing life insurance policy(ies) or annuity(ies)? Yes / No

What is your relationship to the Proposed Insured? _____

I hereby certify that my electronic approval was provided and serves as my signature for legal and regulatory purposes for this application.

Electronic Signature of _____
Agent Full Name

Was obtained on _____
Signature Timestamp

_____
Agent Number

_____
Agent Phone Number

_____
Broker Dealer or Broker General Agent (If applicable)

Protective Life Insurance Company

P.O. Box 830619

Birmingham, AL 35283-0619

SUPPLEMENTAL APPLICATION (PART II)

Proposed Insured Name: _____ Policy Number: _____

1. Do you speak and read English or Spanish? Yes/No

2. Which most accurately describes your employment status?

   - ☐ Child/Student
   - ☐ Unemployed
   - ☐ Self-employed
   - ☐ Owner
   - ☐ Disabled
   - ☐ Homemaker/Stay-at-home parent
   - ☐ Retired
   - ☐ Military
   - ☐ Actively Employed (Enter occupation)

3. Have you filed for or declared bankruptcy in the past 10 years? Yes/No

4. Is there any application for any other life insurance on your life now pending or being considered with Protective or any other company? Yes/No

5. What is the purpose of the insurance?

   - ☐ Personal coverage
   - ☐ Business coverage

6. Have you ever had a request for life or health insurance declined, postponed, or offered other than as applied for? Yes/No

7. Are you a U.S. citizen? Yes/No

8. Do you plan to **reside** outside the U.S. or Canada for a total of 6 or more months within the next 12 months? Yes/No

9. Do you plan to **travel** outside the U.S. or Canada in the next 12 months? Yes/No

10. Have you engaged in any of the following activities in the past 2 years? (check all that apply)

- ☐ Automobile racing
- ☐ Aviation or aerial activities
- ☐ Hang gliding
- ☐ Motorboat racing
- ☐ Motorcycle racing
- ☐ Parachuting
- ☐ Rock or mountain climbing
- ☐ SCUBA diving
- ☐ Skydiving
- ☐ I do not participate in any of these sports or activities

11. Have you plead guilty to or been convicted of any traffic violations in the past 5 years, such as: speeding, failure to yield, reckless driving, or driving under the influence of alcohol or drugs? Yes/No

12. Have you ever been convicted or are you awaiting trial for a felony or misdemeanor other than a traffic violation? Yes/No

13. When did you last use tobacco or nicotine products of any kind? (check the one that applies)

- ☐ In the past month
- ☐ More than a month ago but within the past year
- ☐ Between 1-2 years ago
- ☐ Between 2-5 years ago
- ☐ More than 5 years ago
- ☐ Never

14. When did you last use cannabis (marijuana) products of any kind? (check the one that applies)

- ☐ In the past month
- ☐ More than a month ago but within the past year
- ☐ Between 1-2 years ago
- ☐ Between 2-5 years ago
- ☐ More than 5 years ago
- ☐ Never

15. When did you last drink alcohol? (check the one that applies)

- ☐ Today
- ☐ Within the last week
- ☐ Within the last month
- ☐ Within the last 6 months
- ☐ Within the last year
- ☐ More than a year ago
- ☐ Never

16. Have you ever received medical treatment or counseling for, or been advised by a medical provider to discontinue or reduce your consumption of alcohol? Yes/No

17. Have you ever used narcotics (except as prescribed by a medical provider), barbiturates, amphetamines, hallucinogens, heroin, cocaine, or other recreational drugs? Yes/No

18. Have you ever received medical treatment, counseling for, or been advised by a medical provider to discontinue your use of narcotics, barbiturates, amphetamines, hallucinogens, heroin, cocaine, or other recreational drugs? Yes/No

19. What is your current height and weight?

20. Overall, how has your weight changed in the <u>past 12 months</u>? (check the one that applies)

Increased by…

- ☐ 1-10 lbs
- ☐ 11-20 lbs
- ☐ 21+ lbs

Decreased by…

- ☐ 1-10 lbs
- ☐ 11-20 lbs
- ☐ 21+ lbs

☐ No weight change

21. Have any of your natural parents or siblings ever been diagnosed or treated by a medical provider for heart disease, such as:

- ☐ Coronary artery disease
- ☐ Heart attack
- ☐ Bypass or stent procedure
- ☐ Other heart disease
- ☐ I do not have a family history of heart disease

22. Have any of your natural parents or siblings ever been diagnosed or treated by a medical provider for cancer? (Check all that apply)
    - ☐ Breast
    - ☐ Colon or rectal
    - ☐ Lung
    - ☐ Melanoma
    - ☐ Ovarian
    - ☐ Prostate
    - ☐ Other Cancer
    - ☐ I do not have a family history of cancer

23. Do you have a primary medical provider? Yes/No

24. What was the reason for your last visit or consultation with your primary medical provider?
    - ☐ Routine annual exam
    - ☐ Other (enter reason)
    - ☐ I do not have a primary medical provider

25. Other than your primary medical provider, what was the reason for your last visit with any medical provider?
    - ☐ Enter reason
    - ☐ I only see my primary medical provider
    - ☐ Not applicable

26. Are you pregnant? Yes/No

27. Have you ever been diagnosed, treated, tested positive for, or advised by a medical provider for:
    a. Any disorder or disease of the brain, spinal cord, or nervous system, such as: (check all that apply)
        - ☐ Alzheimer's disease
        - ☐ Amyotrophic lateral sclerosis (ALS)
        - ☐ Chronic headaches
        - ☐ Dementia
        - ☐ Epilepsy or seizures
        - ☐ Fainting
        - ☐ Motor neuron disease
        - ☐ Multiple sclerosis (MS)
        - ☐ Muscular dystrophy
        - ☐ Paralysis

- ☐ Parkinson's disease
- ☐ Sleep disorder
- ☐ Stroke
- ☐ Transient ischemic attack (TIA)
- ☐ Tremors
- ☐ Other
- ☐ No disorder or disease of the brain, spinal cord, or nervous system

b. Any disorder or disease of the heart, blood vessels, or circulatory system, such as: (check all that apply)

- ☐ Chest pain
- ☐ Coronary artery disease
- ☐ Enlarged heart
- ☐ Heart attack
- ☐ Heart failure
- ☐ Heart murmur
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Irregular heartbeat
- ☐ Other
- ☐ No disorder or disease of the heart, blood vessels, or circulatory system

c. Any disorder or disease of the respiratory system, such as: (check all that apply)

- ☐ Asthma
- ☐ Bronchitis
- ☐ Chronic cough
- ☐ Chronic hoarseness
- ☐ Chronic obstructive pulmonary disease (COPD)
- ☐ Emphysema
- ☐ Pneumonia
- ☐ Sarcoidosis
- ☐ Shortness of breath
- ☐ Sleep apnea
- ☐ Tuberculosis (TB)
- ☐ Other
- ☐ No disorder or disease of the respiratory system

d. Any disorder or disease of the stomach, liver, gall bladder, pancreas, abdominal organs, or rectum, such as: (check all that apply)

- ☐ Barrett's esophagus
- ☐ Chronic abdominal pain
- ☐ Colitis
- ☐ Crohn's disease
- ☐ Diverticulitis
- ☐ Hepatitis
- ☐ Intestinal bleeding
- ☐ Polyp
- ☐ Ulcer
- ☐ Other
- ☐ No disorder or disease of the stomach, liver, gall bladder, pancreas, abdominal organs, or rectum

e. Any disorder or disease of the urinary organs, including kidneys, bladder, or urinary tract, such as: (check all that apply)

- ☐ Blood in the urine
- ☐ Chronic inflammation
- ☐ Difficult urination
- ☐ Painful urination
- ☐ Protein in the urine
- ☐ Sugar in the urine
- ☐ Other
- ☐ No disorder or disease of the urinary organs, including kidneys, bladder, or urinary tract

f. Any disorder or disease of the skeletal system, joints, bones, spine, or muscles, such as: (check all that apply)

- ☐ Amputation
- ☐ Arthritis
- ☐ Chronic pain
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Osteoporosis
- ☐ Rheumatoid arthritis
- ☐ Other
- ☐ No disorder or disease of the skeletal system, joints, bones, spine, or muscles

g. Any disorder or disease of the eyes, ears, nose, or throat, such as: (check all that apply)

- ☐ Allergies
- ☐ Difficulty swallowing
- ☐ Myasthenia gravis
- ☐ Retinopathy
- ☐ Tinnitus
- ☐ Other
- ☐ No disorder or disease of the eyes, ears, nose, or throat

h. Any disorder or disease of the endocrine system, thyroid, lymph, or other glands, such as: (check all that apply)

- ☐ Addison's disease
- ☐ Cushing syndrome
- ☐ Diabetes
- ☐ Overactive thyroid
- ☐ Thyroid nodules
- ☐ Underactive thyroid
- ☐ Other
- ☐ No disorder or disease of the endocrine system, thyroid, lymph, or other glands

i. Any disorder or disease of the skin, such as: (check all that apply)

- ☐ Cyst
- ☐ Growth
- ☐ Lump
- ☐ Mole
- ☐ Psoriasis
- ☐ Other
- ☐ No disorder or disease of the skin

j. Any psychiatric, nervous, emotional, or mental disorder or disease, such as: (check all that apply)

- ☐ ADD/ADHD
- ☐ Anxiety
- ☐ Bipolar
- ☐ Depression
- ☐ Eating disorder
- ☐ Obsessive-compulsive
- ☐ Personality disorder
- ☐ Psychosis

- ☐ PTSD
- ☐ Suicidal thoughts
- ☐ Suicide attempt
- ☐ Other
- ☐ No psychiatric, nervous, emotional, or mental disorder or disease

k. Any disease of the reproductive system, uterus, cervix, ovaries, or breasts, such as: (check all that apply)

Question not required by Company

- ☐ Abnormal mammogram
- ☐ Abnormal menstrual bleeding
- ☐ Abnormal pap smear
- ☐ Fibroids
- ☐ Ovarian cysts
- ☐ Polycystic ovary syndrome
- ☐ Sexually transmitted infection
- ☐ Other
- ☐ No disease of the reproductive system, uterus, cervix, ovaries, or breasts

l. Any disease of the reproductive system or prostate, such as: (check all that apply)

Question not required by Company

- ☐ Benign prostatic hypertrophy
- ☐ High PSA
- ☐ Prostatitis
- ☐ Sexually transmitted infection
- ☐ Other
- ☐ No disease of the reproductive system or prostate

m. Any cancer, tumor, nodule, melanoma, skin cancer, or any other malignant disorder, such as: (check all that apply)

- ☐ Breast cancer
- ☐ Colon cancer
- ☐ Lung cancer
- ☐ Melanoma
- ☐ Nodule
- ☐ Prostate cancer
- ☐ Skin cancer
- ☐ Tumor
- ☐ Other
- ☐ No cancer, tumor, nodule, melanoma, skin cancer, or any other malignant disorder

n. Any blood transfusions, being refused as a donor, or disorder of the blood or immune system (excluding Human Immunodeficiency Virus), such as: (check all that apply)

- ☐ Anemia
- ☐ Being refused as a donor
- ☐ Bleeding disorder
- ☐ Blood clots
- ☐ Immune deficiency
- ☐ Leukemia
- ☐ Lymphoma
- ☐ Transfusions
- ☐ Other
- ☐ No history of blood transfusions, being refused as a donor, or disorders of the blood or immune system

28. Have you been diagnosed or treated by a medical provider within the <u>past 10 years</u> for: (check all that apply) Yes/No

- ☐ Diarrhea
- ☐ Fatigue
- ☐ Fever of unknown origin
- ☐ Immune deficiency
- ☐ Loss of appetite
- ☐ Recurrent fever
- ☐ Severe night sweats
- ☐ Unexplained conditions
- ☐ Unexplained infections
- ☐ Unexplained pain
- ☐ Unexplained skin lesions
- ☐ Unexplained weight loss
- ☐ I have not been diagnosed or treated by a medical provider for any of these conditions

29. Have you been diagnosed or treated by a medical provider within the <u>past 10 years</u> for:

- ☐ Acquired Immune Deficiency Syndrome (AIDS)
- ☐ Human Immunodeficiency Virus (HIV)
- ☐ I have not been diagnosed or treated by a medical provider for any of these conditions

30. Excluding HIV, minor injuries, minor viruses, or common colds, within the <u>past 5 years</u>, have you:

a. Been advised, examined, or treated by a medical provider for any conditions other than as previously stated? Yes/No

b. Been advised by a medical provider to undergo specified medical care, hospitalization, surgery, or diagnostic test, except those tests related to the AIDS virus, which has not been completed? Yes/No

c. Been an inpatient in a hospital, clinic, medical facility, rehabilitation center, or any similar entity? Yes/No

d. Had any surgery, biopsy, diagnostic test (except those related to the AIDS virus), CT scan, electrocardiogram (EKG), MRI, or x-ray, other than as previously stated? Yes/No

e. Been unable to work, attend school, perform normal activities, or been confined at home? Yes/No

f. Made a claim for or received benefits, compensation, or pension for any injury, illness, disability, or impaired condition? Yes/No

31. Has anyone other than the proposed insured answered or assisted with answering any part of this application? Yes/No

I declare that the answers I have given are true and complete to the best of my knowledge and belief and that I have not withheld any material information that may influence the assessment or acceptance of this application. I agree to inform Protective Life Insurance Company of any material changes before the insurance is in effect.

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Signatures:

_____

Proposed Insured Signature

_____

Proposed Insured City State Date

_____

Legal Guardian Signature if Proposed Insured is under age 15

_____

Legal Guardian City State Date

PROTECTIVE LIFE 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 Insurance Company (Protective Life) 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 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, 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 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 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 organizations providing services relating to insurance underwriting for Protective Life, **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 is declined or if Protective Life 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 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 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:

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 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'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 INSURANCE COMPANY
P.O. Box 830619
Birmingham AL 35283-0619

SUPPLEMENT TO LIFE INSURANCE APPLICATION – APPLICATION SUPPLEMENT PART I

The statements and answers to the questions listed below shall become a part of the attached application; shall be subject to the terms of the attached application; and shall become a part of any policy based on this application.

Print Name of Proposed Insured(s):

For any policy to be issued as a result of this application:

(1) **Will anyone other than the Insured, his or her family, or employer/business partner pay any portion of the initial or future premiums or obtain any right, title or interest in this policy?** ☐ Yes ☐ No
If Yes, complete the "Statement of Owner Intent" (Application Supplement Part II)

(2) **Will any portion of the initial or future premiums be borrowed, loaned or otherwise financed?** ☐ Yes ☐ No
If Yes, complete the "Premium Financing Disclosure" (Disclosure and Acknowledgement)

(3) **Will a trust, including family trust, own this policy?** ☐ Yes ☐ No
If Yes, complete the "Trust Certification" (Application Supplement Part III)

(4) **Is the Proposed Insured age 65 or older AND total coverage applied for across all Protective companies $1,000,000 or more?** ☐ Yes ☐ No
If Yes, complete the "Statement of Owner Intent" (Application Supplement Part II)

SIGNATURES:

I (We) have read or have had read to me (us) the completed Supplement before signing below. All statements and answers in the Supplement are correctly recorded and are full, complete and true to the best of my (our) knowledge and belief. I (We) understand that the information being provided in this Supplement is being relied upon in considering the application for life insurance and is subject to the applicable Fraud Statement as provided in the Application for Life Insurance.

Signed in (City/State)_____ this ____ day of (Month) _____, (Year) _____.

Signature(s) of Owner(s)/Trustees(s): X_____
(provide officer's title if policy is owned by a corporation) X_____

Signature(s) of Proposed Insured(s): X_____

X_____

X_____

Signature of Witness: X_____

PRODUCER CERTIFICATION

By signing below, I hereby certify that to the best of my knowledge and belief, the information provided herein is complete, accurate, and correct and that the life insurance being applied for conforms to the Company's guidelines.

Producer Signature: X_____

Producer Name (Print): _____

Date: _____

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

CONDITIONAL RECEIPT AGREEMENT

PREMIUM RECEIPT

This Conditional Receipt Agreement ("Agreement") contains the entire terms regarding conditional coverage. The Agreement provides a limited amount of insurance, for a limited period of time, subject to the terms provided hereafter. No Agent of Protective Life Insurance Company ("Company") can alter or waive any of the provisions of this Agreement. Furthermore, in no event will there be conditional coverage unless the first full premium required by the Company has been paid at the time of application.

Premium Amount Received: $_____

Method of Payment: ☐ Check ☐ Pre-Authorized Withdrawal

☐ Other _____

The amount received is a conditional payment of the first premium for this insurance policy on the life of the following Proposed Insured(s) _____.

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO PROTECTIVE LIFE INSURANCE COMPANY.

DO NOT MAKE CHECKS PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK. CASH, MONEY ORDERS AND CASHIER'S CHECKS WILL NOT BE ACCEPTED.

TERMS AND CONDITIONS

Amount of Coverage

If a premium has been accepted by the Company for an application of insurance and any person proposed for insurance in such application dies while this Agreement is in effect, the Company will pay, subject to the conditions and limitations contained herein, to the beneficiary designated in such application, the lesser of:

(a) The amount of death benefit, if any, which would be payable under the policy covering the life or lives of the Proposed Insured(s) if issued as applied for under such application; or
(b) The greater of (i) $1,000,000 less the amount of death benefits due and payable by virtue of the Proposed Insured's death under any other policy, application, conditional receipt, or temporary life receipt with the Company, or (ii) $50,000.

Date of Conditional Coverage

Conditional coverage will begin when the application is completed, a premium has been accepted, this Agreement has been completed and signed, and all the terms and conditions stated herein have been satisfied.

Limitations

Premium shall not be collected and this Agreement will not be effective if:

(1) The Proposed Insured(s) is under 15 days of age or over age 80;
(2) The Proposed Insured(s), within the past 90 days, has been admitted to a hospital or other medical facility, been advised by a member of the medical profession to be admitted, or had surgery performed or recommended;
(3) Within the past two years, the Proposed Insured(s) has had treatment recommended by a member of the medical profession for heart trouble, stroke or cancer;
(4) The Proposed Insured(s) has been rated or declined for insurance within the past five years; or
(5) The Proposed Insured(s) intends to leave the United States within the next 60 days.

Termination and Refund of Premium

There shall be no insurance coverage under this Agreement and this Agreement shall be void if:

(1) Premium payment is by check, and it is not honored by the drawee bank upon presentation;
(2) Premium payment is by Pre-Authorized Withdrawal, and the deduction is not honored by the drawee bank;
(3) If the application to which this Agreement was attached is not approved as applied for by the Company within ninety days from the date of its receipt;
(4) There is a material misrepresentation in the answers to any questions or statements in the application; or
(5) If any Proposed Insured(s) dies by suicide, while sane or insane.

If any of the above-listed conditions do occur, the Company's liability under this Agreement is limited to a refund of the premium payment made.

Effective Date of Coverage

Insurance issued based on the application will take effect on the latest of:

(a) the date of the application;
(b) the date requested in the application; or
(c) the date of the last of any medical examinations or tests required under the rules and practices of the company.

Full life insurance coverage becomes effective when the policy is delivered and is governed by the policy contract. This Agreement will terminate when the policy contract is delivered.

Notice: **You should retain a copy of this Agreement. The Original will be retained by the Company.**

SIGNATURES:

I have read this agreement and declare that the answers are true to the best of my knowledge and belief. I understand and agree to the terms, conditions, and limitations of this Agreement.

_____	_____
Proposed Insured's Signature	Date
_____	_____
Owner's Signature (if other than the Proposed Insured)	Date
_____	_____
Joint Owner's Signature	Date
_____	_____
Agent's Signature	Date

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

PRE-AUTHORIZED WITHDRAWAL AGREEMENT

FOR DRAFTING OF PREMIUM PAYMENTS

The person paying the premium on the life insurance policy listed below must sign this agreement.

I request and authorize Protective Life Insurance Company to draw against the account listed below to pay premiums. I understand that no coverage exists until a policy is issued or I receive a Conditional Receipt/Temporary Life Insurance Receipt.

Policy Number: _____ Name of Insured: _____

Name of Bank: _____

Street Address or P.O. Box: _____

City: _____ State: _____ Zip Code: _____

Type of Account: ☐ Checking ☐ Savings

Routing Number: ___ ___ ___ ___ ___ ___ ___ ___ ___

Account Number: _____

Premium Frequency: ☐ *Monthly (*Only available by bank draft) ☐ Quarterly

☐ Semi-Annually ☐ Annually

☐ **Draft the initial premium** - I understand that authorizing the drafting of the initial premium and providing the account information does not provide any life insurance coverage on myself or any applicant listed on the application for life insurance unless I have signed, dated and met the terms and conditions of the Protective Life Conditional Receipt Agreement/Temporary Life Insurance Receipt.

If the Company receives a Conditional/Temporary Receipt with this form your premium will be drafted immediately and you will be provided with conditional coverage subject to limited terms and conditions.

Variable life insurance premiums will not be deducted unless a policy is issued.

I request future drafts be made on the _____ *(1st - 28th)* day of the month.

_____
Premium Payer - Depositor (Please Print)

_____ _____
Date Signature

PLEASE INCLUDE A VOIDED CHECK WITH APPLICATION. IF THIS IS TO DRAFT FROM A BROKERAGE ACCOUNT, A VOIDED CHECK IS NOT NECESSARY. DO NOT USE STAPLES.

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

INDIVIDUAL LIFE INSURANCE APPLICATION – RIDER WORKSHEET

Required if applying for additional benefits or riders.

☐ New Business ☐ In Force Protective Policy # :_____

Print Proposed/Primary Insured's Name _____ Proposed/Primary Insured's Social Security No. _____

**** If applying for Children's Term Rider, Income Provider Option, ExtendCare Rider or Chronic Illness Accelerated Death Benefit, please complete the rider specific supplemental application(s) per application instructions.***

ADDITIONAL BENEFITS

☐ Accidental Death Benefit Rider *(Range $10,000 - $250,000)* $_____

☐ * Children's Term Rider *(1 Unit Equals $1,000 Death Benefit – 25 Units Maximum* _____ Units

☐ * ExtendCare Rider or Chronic Illness Accelerated Death Benefit

Maximum Monthly Benefit Amount $_____

Elimination Period *(Number of Days)* _____

☐ Conversion Choice Rider with ExtendCare *(ClassicChoice Term Only)*

☐ Guaranteed Insurability Rider $_____

☐ * Income Provider Option

☐ Protected Insurability Rider $_____

☐ Waiver of Premium *(Non-Universal Life Only)*

☐ Waiver of Specified Premium Rider *(Universal Life Only)*

Monthly Benefit Amount $_____

☐ Other _____

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.

Signed at: (City and State) _____ Date _____

_____ Owner Signature

_____ Proposed/Primary Insured Signature

_____ Witness to Owner Signature

_____ Signature of Parent or Guardian

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

NOTICE REGARDING REPLACEMENT OF LIFE INSURANCE OR ANNUITY

REPLACING YOUR LIFE INSURANCE OR ANNUITY?

Are you thinking about buying a new life insurance policy or annuity and discontinuing or changing an existing one? If you are, your decision could be a good one - or a mistake. You will not know for sure unless you make a careful comparison of your existing benefits and the proposed benefits.

Make sure you understand the facts. You should ask the insurance producer or company that sold you your existing policy to give you information about it.

Hear both sides before you decide. This way you can be sure you are making a decision that is in your best interest.

We are required by law to notify your existing company that you may be replacing their policy.

List below the identification of policies which are involved in the replacement transaction:

Contract Number

SIGNATURE

Insurance Producer's Signature

Date

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

NOTICE REGARDING PROPOSED REPLACEMENT OF LIFE INSURANCE OR ANNUITY

Name of Existing Insurer

Address

City, State, Zip Code

GREETINGS

You are herewith given notice that we are in receipt of application(s) for life insurance or annuity(ies) for an individual presently insured with your company.

IDENTIFICATION

Name of Insured

Address

City, State, Zip Code

Contract Number _____ _____

Contract Number _____ _____

Contract Number _____ _____

SIGNATURE

This notice is given pursuant to 50 Ill. Adm. Code 917.70 (c).

Insurance Producer's Signature _____ Date _____

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

WRITTEN INFORMED CONSENT FOR HIV ANTIBODY TESTING

(Conventional Testing – Not for Use with a Rapid HIV Test)

Test Subject or Number: _____ Date: _____

Time: _____

I hereby grant my permission for a test to detect whether I have antibodies to HIV (Human Immunodeficiency Virus) in my body.

HIV Testing is voluntary and requires your consent in writing. The purpose of HIV antibody testing is to show whether you are infected with HIV, the virus that causes AIDS.

Any test result that indicates that antibodies for HIV are present is considered positive for HIV infection.

Before you consent to be tested for HIV, your healthcare provider should speak to you about:

- How HIV is passed from person to person and mother to baby;
- Steps to take that may prevent the transmission of HIV; and
- The meaning of an HIV antibody test result.

If you agree with the following statements and want to consent to HIV testing, please sign this form.

I have been counseled about the benefits of having an HIV test and understand that:

- Human Immunodeficiency Virus (HIV) is the virus that causes AIDS,
- HIV is spread by sexual intercourse, so all sexually active persons are potentially at risk for HIV infection;
- HIV can be passed from a mother to her baby during pregnancy, at delivery, and through breastfeeding; and
- HIV antibody test results are confidential, and the law protects me from discrimination.

I understand that a positive result does not mean I have AIDS, but indicates that I have HIV infection. I understand that if my test results are positive, I will be offered HIV counseling.

I understand that test results may indicate that a person has HIV antibodies when the person does not have the antibodies (a false positive result) or the test may fail to detect that a person has antibodies to the virus when the person does in fact have these antibodies (a false negative result).

If my HIV antibody test result is negative, no further testing will be done at this time. A negative HIV antibody test result most likely means that I am not infected with HIV, but it may not detect recent infection.

If my HIV antibody test result is positive, this means that antibodies to the virus were detected and that I am HIV infected.

Confidentiality of HIV Information:
If you take the rapid HIV test, your test results are confidential. Under Illinois law, confidential HIV information can be given only to people whom you allow it to be given by your written approval, to people who need to know your HIV status in order to provide medical care and services, including: an authorized agent or employee of a health facility or a healthcare provider if the health facility or provider is authorized to obtain test results; those who are exposed to blood/body fluids in the course of their employment; and organizations that review the services you receive.

The law also allows your confirmed HIV test results to be released: to public health officials as required by law; for payment for care and treatment; to a temporary caretaker of children taken into protective custody by the Illinois Department of Children and Family Services; and to any other entity permitted by the AIDS Confidentiality Act.

I understand that my test results will be kept confidential to the extent provided by law. In addition, I understand that I may withdraw from the testing at any point in time prior to the completion of laboratory tests. I understand that my testing is voluntary.

I agree to be tested and I agree that I may be told my test results.

I agree that if the result of my HIV test is positive I may be referred to another healthcare provider for follow-up testing and care.

I authorize Protective Life Insurance Company or its reinsurers to make a brief report of any personal health information to the MIB.

I have been advised about the purpose, potential uses, limitations and meaning of the test results; the voluntary nature of the test; the right to withdraw consent at any time prior to the completion of laboratory tests; and the confidentiality protections under the law. The information presented above has been completely and clearly explained to me, and all of my questions have been answered. I hereby authorize my physician or facility to collect an oral or blood specimen and perform an HIV antibody test on that specimen.

_____	_____
Patient/Client Signature or Signature of Legally Authorized Representative	Date
_____	_____
Facility/Provider Witness	Date

PROTECTIVE LIFE INSURANCE COMPANY

P.O. Box 830619

Birmingham, AL 35283-0619

SUPPLEMENTAL APPLICATION (PART II)

Child or Minor Name:

Policy Number:

Height:

Weight:

Gender/Sex:

Age:

Date of Birth:

Place of Birth:

Social Security Number:

Relationship of the child or minor proposed for insurance to the Owner:

Has the child or minor proposed for insurance ever been diagnosed, treated, tested positive for, or been given medical advice by a licensed member of the medical profession for:

Any disorder or disease of the brain or nervous system (such as seizure, epilepsy, stroke, convulsions, paralysis)?	Yes No
Any disorder or disease of the heart, blood vessels, or circulatory system (such as heart murmur, heart attack, chest pain, high blood pressure)?	Yes No
Any disorder or disease of the respiratory system (such as asthma, bronchitis, emphysema, tuberculosis)?	Yes No
Any disorder or disease of the stomach, liver, intestines, rectum, pancreas, or abdominal organs?	Yes No
Any disorder or disease of the genitourinary organs, kidneys or urinary tract (such as blood or sugar in urine, chronic inflammation)?	Yes No
Any disorder or disease of the skeletal system, joints, bones, spine or muscles (such as arthritis, osteoporosis)?	Yes No
Any disorder or disease of the eyes, ears, nose or throat?	Yes No
Any disorder or disease of the endocrine system, lymph, blood, or other glands (such as diabetes, thyroid disorder, anemia)?	Yes No
Any psychiatric or mental health disease or disorder (such as attention deficit disorder (ADD), eating disorder, depression, anxiety, obsessive-compulsive disorder, bipolar, behavioral disorder, autism)?	Yes No
Any cancer, tumor, cyst or nodule?	Yes No
Any disorders or diseases of the immune system except those related to the Human Immunodeficiency Virus (AIDS Virus)?	Yes No

Has the child or minor proposed for insurance ever been diagnosed or treated by a licensed member of the medical profession for:

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? Yes No

Excluding Human Immunodeficiency Virus (AIDS virus), minor injuries, minor virus or common colds, within the past five (5) years, has any child or minor proposed for insurance:

Been treated, examined or advised by a member of the medical profession for any condition other than as previously stated? Yes No

Been advised by a member of the medical profession to get specified medical care, hospitalization, surgery or diagnostic test (except those related to the AIDS virus), which has not been completed? Yes No

Been an inpatient or outpatient in a hospital, clinic, medical facility, or any similar entity (excluding the E.R.)? Yes No

Had any diagnostic test (except those related to the AIDS virus), surgery, biopsy, electrocardiogram (EKG), MRI, CT-Scan or X-ray? Yes No

Been on or advised by a member of the medical profession to be on any prescribed, non-prescribed (over the counter) medication or prescribed diet? Yes No

Been unable to work, unable to attend school, unable to perform normal activities (including eating, toileting, transferring, bathing, dressing, and continence), or been confined at home? Yes No

Has the child or minor age [15 through 18] proposed for insurance ever:

Used alcohol, barbiturates, narcotics, amphetamines, hallucinogens, heroin, cocaine, or other habit-forming drugs, except as prescribed by a physician? Yes No

Used tobacco, nicotine, or marijuana (cannabis) (such as vaping, e-cigarettes, chewing tobacco)? Yes No

Personal Physician Information (provide physician's name, address, and contact information):

Last Medical Consultation (provide date and reason for the visit and/or consultation):

SIGNATURES

I declare that the answers I have given are true to the best of my knowledge and belief and that I have not withheld any material information that may influence the assessment or acceptance of this application. I agree to inform Protective Life Insurance Company of any material changes before the insurance is in effect.

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Signed at: _____ _____ _____.
City State Mo Day Year

X_____
Signature of Parent or Guardian

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

SUPPLEMENTAL UNDERWRITING APPLICATION

PROPOSED INSURED:

First Name	M.I.	Last Name	Date of Birth:

Important! For ALL QUESTIONS ANSWERED YES, please provide details including: Name of physician, date diagnosed, medications, and current condition. If additional space is needed, please use the Continuation of Information form.

	Yes	No
1. **Has the Proposed Insured been diagnosed with or been treated within the past 10 years for:**		
a) Alzheimer's disease or dementia, memory loss, Mild Cognitive Impairment (MCI), or organic brain syndrome?	☐	☐
DETAILS: _____		
b) Systematic Lupus Erythematosis, Polymyositis, Dermatomyositis, Scleroderma, Progressive Systemic Sclerosis, CREST syndrome, mixed connective tissue disease, undifferentiated connective tissue disease, rheumatic or psoriatic arthritis, celiac disease, ulcerative colitis, Crohn's disease, Ankylosing spondylitis?	☐	☐
DETAILS: _____		
c) Seizures, fainting spells, Parkinson's disease, tremor, ALS (Lou Gehrig's Disease), Multiple Sclerosis, Aphasia, stroke, tumor or growth, transient ischemic attack (TIA), or Huntington's Disease?	☐	☐
DETAILS: _____		
d) Any history of fractures or falls?	☐	☐
DETAILS: _____		
2. **Has the Proposed Insured been:**		
a) Declined, refused, rated or turned down for life insurance, long-term care insurance, medical or disability insurance?	☐	☐
DETAILS: _____		
b) Required to have home care, nursing home care, or adult care for any reason within the past 12 months?	☐	☐
DETAILS: _____		
c) Advised to enter, planning to reside in, or currently residing in a nursing home, assisted care living facility, or other custodial facility, or attending adult day care?	☐	☐
DETAILS: _____		

3. **Does the Proposed Insured:**	**Yes**	**No**
a) Use one of the following medical devices: walker; wheelchair; hospital bed; quad cane; oxygen; stair lift; or dialysis? (If Yes, provide type of device and date usage began)	☐	☐
DETAILS: _____		
b) Participate in any type of exercise program? (If Yes, provide type and frequency)	☐	☐
DETAILS: _____		
c) Drive a motor vehicle? (If Yes, provide the number of miles driven in the past 12 months. If No, what date did you last drive and why did you stop driving?)	☐	☐
DETAILS: _____		
d) Manage finances, including paying bills, writing checks and balancing the check book? (If No, identify what activities require assistance, who provides it and why it is needed.)	☐	☐
DETAILS: _____		
e) Perform regular household tasks including cooking, cleaning, laundry, shopping, yard work? (If No, identify what activities require assistance, who provides it and why it is needed.)	☐	☐
DETAILS: _____		
f) Live alone? (If No, who do you live with?)	☐	☐
DETAILS: _____		
4. **Does ANYONE help the Proposed Insured** with getting around inside the home, getting into and out of bed or a chair, bathing, dressing, toileting or eating? (If Yes, identify the helper and give details of help required)	☐	☐
DETAILS: _____		
5. T**he Proposed Insured:**		
a) Is the Proposed Insured's activity limited by shortness of breath, debility, gait/ambulation disturbance or pain?	☐	☐
DETAILS: _____		
b) How far can the Proposed Insured walk comfortably without the issue(s) in 5a causing him or her to stop?		
DETAILS: _____		
6. **Additional details or comments:**		

The above statements and answers are true and complete to the best of my knowledge and belief.

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Signed at (City/State): _____ **Date:** _____

_____ _____

Signature of Examiner as Witness **Signature of Proposed Insured**

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

IMPORTANT NOTICE REGARDING "SAVE-AGE" DATING OF POLICY

Policy Number: _____

Proposed Insured: _____

Proposed Owner: _____

Proposed Joint Owner: _____

Your Protective Life Policy has been dated to **"save-age"**. This means that we have issued your Policy with a Policy Date that results in a lower premium rate than if you had not dated back to "save-age." Premiums will be payable from this "save-age" Policy Date, even though the Policy Date will be earlier than the date the Policy is delivered to you. Whether or not you select this option, coverage begins only when the Policy is delivered and the first premium is paid, unless you have obtained temporary coverage under our Conditional Receipt Agreement or our Temporary Life Insurance Receipt.

In exchange for the lower premium rate you receive with "save-age" dating, you will pay premiums for the period between the Policy Date and the date of delivery of your Policy, **which is a period in which you receive no insurance coverage**. The amount of premiums you will pay for this non-covered period depends on how long it took to approve, issue, and deliver the Policy to you.

Should you have any questions about this dating, however, you should consult with your Agent or call our Policyholder Services Department at 1-800-265-1545 to discuss this.

You are free to accept or decline this option of having your Policy dated to "save-age".

____ **Accept** "save-age" dating of Policy.

____ **Decline** "save-age" dating of Policy. (**Please contact your Agent for any Revised Premium Quote**.)

Complete and sign below to indicate your choice. Once you complete the form, please return the original to us and keep a copy for your records.

Signed at: _____ (City & State) _____ (Date).

_____ _____
Signature of Proposed Insured Signature of Proposed Owner (if other than Proposed Insured)

_____
Signature of Proposed Joint Owner (if applicable)

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

IUL - SUPPLEMENT TO APPLICATION

INITIAL ALLOCATION OF PREMIUMS

PREMIUM PAYMENT ALLOCATION: Select the allocation for your premium payment(s). The total allocations must be in whole percentages and the total of all allocations must equal 100%. If no designated allocation is made, all premiums will be allocated to the Fixed Account.

Account	Allocation Percentage
Fixed Account	_____**%**
Indexed Account	_____**%**
Total Allocation Percentage	**100%**

CERTIFICATION:
The person who signs below acknowledges that he/she has reviewed and approved the Premium Payment Allocation above.

Any person who knowingly with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties, according to state law.

Signed at: _____, _____, _____.
(City) (State) (Zip Code)

_____ _____ _____
Signature of Owner/Applicant Owner/Applicant Name (Print) Date

_____ _____ _____
Signature of Witness Witness Name (Print) Date

PROTECTIVE LIFE INSURANCE COMPANY
P.O. Box 830619
Birmingham, AL 35283-0619
800-866-3555

POLICY SUMMARY SHEET

Policy Number: _____

Plan Name: _____

Initial Face Amount: _____

Mode of Payment: _____

Initial Premium: _____

Policy Effective Date: _____

Mortality Class: _____

Owner Name: _____

Insured Name: _____

Insured Age at Issue: _____

Gender: _____

Initial Death Benefit Option: _____

Rider Information: _____

Owner Signature: _____

Date: _____

A copy of this Policy Summary Sheet should be stored with your financial planning documents.

PROTECTIVE LIFE INSURANCE COMPANY
P.O. BOX 830619
BIRMINGHAM, ALABAMA 35283-0619

SUMMARY DISCLOSURE STATEMENT for TERMINAL ILLNESS ACCELERATED DEATH BENEFIT

Protective Life Insurance Company:
"We, us, our".

Accelerated Death Benefit (the "Benefit"):
Subject to the terms of this Benefit, we will pay a portion of the death benefit upon receiving proof that the insured is terminally ill. An accelerated death benefit can only be paid one time. The Benefit is not intended as long-term care insurance.

Consequences of Receiving Accelerated Death Benefit:
The Benefit is intended to qualify for favorable tax treatment under Section 101g of the Internal Revenue Code. **The receipt of an accelerated death benefit may be considered a taxable event under the Internal Revenue Code. The receipt of an accelerated death benefit may also affect eligibility to receive, or continue to receive Medicaid benefits, or other state or federal government benefits and entitlements**. Before you elect to receive any accelerated benefits, you should consult with your tax advisor.

Amount You May Elect:
You may elect the amount of the accelerated death benefit to be paid. The limits are outlined in the Benefit but are generally limited to the lesser of 60% of the death benefit of the policy or $1,000,000. We will charge an administrative fee of not more than $300, deducted from any payment made. Upon request to accelerate the death benefit and upon payment of the Benefit, you and any irrevocable beneficiary will be provided a statement demonstrating the effect of the accelerated death benefit.

When Eligible for Payment of Benefit:
You are entitled to receive the accelerated death benefit when we have determined that the insured is terminally ill and has a life expectancy of 6 months or less.

Notice and Proof of Qualifying Event:
We will require proof that the insured is terminally ill. The diagnosis must be made by a physician as defined in the Benefit. Any diagnosis must be the result of clinical, radiological, histological, or laboratory evidence of the terminal illness. We may require a second medical opinion by a physician of our choice at our expense. If there is a conflict of opinion, a determination will be made by a third Physician who is acceptable by both us and the Insured.

Effect of an Accelerated Death Benefit:
When you elect to receive an accelerated death benefit, it will be treated as a lien against your policy. We will charge you interest on the accelerated death benefit paid to you. Interest on the lien is due on each Policy anniversary date. The Accelerated Death Benefit does not have an effect on the Premium and/or Cost of Insurance Charges of the base policy.

The maximum lien interest rate we may charge you is the greater of:

1. The policy loan interest rate stated in the Policy or 8% if a policy loan interest rate is not stated in the Policy; or

2. the current 90 day U.S. Treasury Bill rate in effect on the date that the accelerated death benefit is paid.

Interest accruing on the portion of the lien which is equal in amount to the Policy Value of the Policy, if applicable, on the Accelerated Death Benefit payment date shall be no more than the policy loan interest rate stated in the Policy.

The death benefit will be reduced by the amount of the lien. Your access to the cash surrender value of your policy, if any, will be limited to the excess of the cash surrender value over the lien.

Any irrevocable beneficiaries or assignees must send us a written consent to the accelerated death benefit payment. The written request must be in a form satisfactory to us.

Premiums: There are no premiums for this benefit, however, you will need to continue to pay any premium payments due under the Policy if the death benefit is accelerated.

Acknowledgement: I acknowledge that I have received and read the Summary and Disclosure Statement for Accelerated Death Benefit which was furnished to me prior to signing the application.

_____

Proposed Insured Signature

_____

Proposed Insured City State Date

_____

Owner Signature (If Owner is other than the Proposed Insured)

_____

Owner City State Date

_____

Joint Owner Signature (If applicable)

_____

Joint Owner City State Date

_____

Signature of Agent/Broker

SUMMARY AND DISCLOSURE STATEMENT FOR CHRONIC ILLNESS ACCELERATED DEATH BENEFIT RIDER

This disclosure form provides a brief description of the important features of the rider. This is not an insurance contract. Only the rider contains the governing contractual provisions setting forth in detail the rights and obligations of both the Owner and the Company.

NOTICE: This rider is intended to provide an accelerated death benefit which will qualify for tax treatment under Section 101 (g)(1)(B) of the Code except as provided in Section 101 (g)(5) of the Code. Accelerated benefit payments due to chronic illness are subject to limits imposed by the federal government and any amounts received in excess of these limits are includible in gross income. This rider is not intended to be a Qualified Long Term Care Insurance contract under section 7702B of the Code nor is it intended to be a Non-Qualified Long Term Care contract. Accelerated benefits under this rider may be taxable as income. There may be tax consequences of accepting an amount above the amount that would be tax qualified under the Code. As with all tax matters, the Owner should consult a personal legal or tax advisor to assess the impact of any benefit received under this rider.

Any benefit received under this rider may impact the recipient's eligibility for Medicaid or other government benefits. Benefits under this rider do not pay or reimburse for expenses including those set forth in 101(g)(3)(A)(ii)(I) of the Code.

Any benefit paid under this rider will impact the policy. Face amount, Policy Values and loan values will be reduced if an accelerated death benefit is paid. The impact on the policy is discussed in the Impact on the Policy section of this rider.

Subject to the terms of the rider, we will pay a portion of the policy's death benefit each benefit period upon receiving Written Certification or Written Re-certification, as applicable, that the Insured is Chronically Ill. The amount we pay is called the Monthly Benefit.

DEFINITIONS

Activities of Daily Living: Means six basic human functions necessary for a person to live independently. Specifically they include: eating, toileting, transferring, bathing, dressing, and continence.

Chronically Ill: Means that the Insured has been certified, within the preceding 12 months, by a Licensed Healthcare Practitioner as: being unable to perform, without Substantial Assistance from another individual, at least two Activities of Daily Living for 90 consecutive days due to a loss of functional capacity; or, Requiring Substantial Supervision to protect the Insured from threats to health and safety due to Severe Cognitive Impairment.

Written Certification: Means written documentation from a Licensed Health Care Practitioner certifying that the Insured is Chronically Ill. The initial Written Certification shall be provided at the Owner's or Insured's expense. Written Certification, after the first shall be at our expense and will not count against the Lifetime Maximum Benefit.

BENEFIT

The Monthly Benefit is subject to a maximum chosen by the Insured. An amount less than then Maximum Monthly Benefit may be requested. You may also choose to receive the accelerated death benefit payment as a present value lump sum. All payments are subject to the Lifetime Maximum Benefit as described in the rider.

ELIGIBILITY

The Insured will become eligible, each Benefit Period, for the Benefit payments during the life of the Insured when each of the following conditions are met: (1) We receive Your written request for the Benefit; (2) We receive Written Certification; (3) The Policy and this Rider are in force; (4) We receive written consent from any irrevocable beneficiaries or assignee of record named in the policy; (5) The Elimination Period has expired; and (6) The benefit payment is made in respect to a month when the insured is Chronically Ill.

We reserve the right to independently assess the Insured's Chronic Illness and benefit eligibility. As part of this assessment we have the right to require that the Insured be examined by a Licensed Health Care Practitioner chosen by us. We will pay for this examination. The Insured must be certified as Chronically Ill for the entire period in which benefits are being paid.

IMPACT ON THE POLICY

Each Monthly Benefit payment will reduce certain current values by a proportional amount. This proportion will equal the Monthly Benefit payment, before reduction for repayment of Policy Debt, divided by the death benefit immediately before the payment. The current values that will be reduced by this provision are: (1) Policy Value; (2) Face amount; (3) Surrender Charges, if any; (4) Values and premiums required to maintain lapse protection, if any; (5) Cumulative premiums paid to date; and (6) Policy Debt, if any.

An amount equal to Policy Debt reduction will be applied to repay Policy Debt, and thus will reduce the net amount of proceeds distributable as an accelerated death benefit. Future charges for the policy will be reduced to the rates that would apply had the policy been issued at the reduced face amount.

Below is a **sample illustration** to demonstrate the effect of an accelerated death benefit payment on a policy. This guaranteed-basis illustration shows the effect on the face amount of the policy before the accelerated death benefit is elected, immediately after the election is made and 12 months after the election is made (assuming the insured is still living). This illustration also assumes:

1. The insured is a Male issue age 35;
2. The face amount is $100,000;
3. A $5000 monthly benefit payment is required following the 9th policy anniversary;
4. A single loan of $500 has been taken at the beginning of Policy Year 9, no withdrawals have been taken, and the Monthly Benefit payments are assumed to begin at the beginning of Policy year 10; and
5. No further loans or withdrawals can be taken during the benefit period (as stipulated in the contract).

Before Election is Made (at the end of Policy Year 9)

Face Amount ……	$	100,000.00	Minimum Lapse Protection Premium: ……	$	47.35
Policy Value: ……	$	5,171.23	Cumulative Premiums for Lapse Protection:	$	4,442.04
Surrender Charges: ……	$	458.00	Cumulative Premiums Paid to Date: ……	$	8,734.05
Lapse Protection Account Value……	$	6,480.15	Policy Debt: ……	$	522.87

Immediately After Election is Made (at the beginning of Policy Year 10)

Face Amount: ……..	$	95,000.00	Minimum Lapse Protection Premium: ……	$	0
Policy Value: ……	$	4,912.67	Cumulative Premiums for Lapse Protection:	$	4,219.94
Surrender Charges: ……	$	0	Cumulative Premiums Paid to Date: ……	$	8,297.35
Lapse Protection Account Value……	$	6,156.14	Policy Debt: ……	$	496.73

Policy Loan Repayment: ……	$26.14
Net Monthly Benefit: ……..	$4,973.86

12 Months after Election is Made (at the beginning of Policy Year 11)

Face Amount: ……..	$	40,000.00	Minimum Lapse Protection Premium:……	$	0
Policy Value: ……	$	2,138.77	Cumulative Premiums for Lapse Protection:	$	1,776.82
Surrender Charges: ……	$	0	Cumulative Premiums Paid to Date: ……	$	3,493.62
Lapse Protection Account Value……	$	2,781.01	Policy Debt: ……	$	219.61

Effect on Monthly Deduction

During a Benefit Period, all monthly deductions continue. If on any monthly anniversary such deduction would cause the policy to lapse, we will waive the monthly deduction or the monthly lapse protection deduction, if any, as required to maintain the policy. Any waiver of deductions is only effective during a Benefit Period.

Acknowledgement:
I acknowledge that I have received and read the Summary and Disclosure Statement for Chronic Illness Accelerated Death Benefit Rider.

_____ _____
Signature of Insured Date

_____ _____
Signature of Owner (if other than Insured) Date

PROTECTIVE LIFE INSURANCE COMPANY

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

RELIGIOUS FREEDOM PROTECTION AND CIVIL UNION ACT - ILLINOIS

Protective Life Insurance Company complies with the Illinois Religious Freedom Protection and Civil Union Act ("the Act").

The Act provides that parties to a civil union (as defined in the Act) are entitled to the same legal obligations, responsibilities, protections, and benefits that are afforded or recognized by the laws of the State of Illinois to spouses. For the purposes of interpreting this policy or contract under the Act, a party to a civil union will be included in any definition or use of the terms "spouse", "family", "immediate family", "dependent", "next of kin", "stepparent", "tenants by the entirety" and any other terms, whether or not gender-specific, that describe a spousal relationship.

Please note that the laws of the State of Illinois have no effect on the status of this policy or contract under the laws of the United States, which may affect the federal tax status of the owner and any beneficiary.

This notice is required by the State of Illinois.

LIFE INSURANCE BUYER'S GUIDE

Prepared by the National Association of Insurance Commissioners

The National Association of Insurance Commissioners is an association of state insurance regulatory officials. This association helps the various insurance departments to coordinate insurance laws for the benefit of consumers.

This guide does not endorse any company or policy

Reprinted by

PROTECTIVE LIFE INSURANCE COMPANY
Birmingham, AL 35202

Understand What Life Insurance Is
Life insurance pays a death benefit if you die while the policy is in effect, in exchange for premiums you pay before your death. You can use the death benefit to protect against financial hardships such as loss of your income, funeral expenses, medical or nursing care expenses, debt repayments, and child care costs after your death. You can get information from the NAIC InsureU Life Insurance website - www.insureuonline.org/insureu_type_life.htm

If You Need Life Insurance, Decide How Much Coverage to Buy
How much life insurance to buy depends on the financial needs that will continue after your death. Examples include supporting your family, paying for child(ren)'s education, and paying off a mortgage. Some questions you may want to ask about your own needs include:

- Does anyone depend on me financially?
- How much of the family income do I provide?
- How will my family pay my final expenses and repay debts after my death?
- Do I want to leave money to charity or family?
- If I have life insurance through my employer, is it enough to meet my financial obligations?

The answers to these questions can help you decide how much coverage you need. An Insurance agent, financial advisor, or insurance company representative can help you evaluate your insurance needs and give you information about available policies.

If You Already Have Life Insurance, Assess Your Current Life Insurance Policy
It's important to compare your current policy with any new policy you might buy. Keep in mind that you may be able to change your current policy to get benefits you want. Also, know that any changes in your health may impact your ability to get a new policy or the premium you'll pay. Don't cancel your current policy until you get the new one.

Also, while you may have free or low-cost life insurance through your employer, the death benefit usually is less than you need. And if you leave the employer, you may not be able to take this coverage with you.

Compare the Different Types of Insurance Policies
There are many types of life insurance policies. You should choose a policy with features that fit your individual needs. Some things to consider are:

- **Term Insurance vs. Cash Value Insurance.** Term insurance is intended to provide lower-cost coverage for a specific period of time ("a term"). If you want coverage for a longer period of time, such as for your lifetime, cash value insurance may be more cost effective. Most term policies don't build up cash values that you can use in the future.

- **Renewable Term vs. Non-renewable Term.** Most term life insurance coverage can be continued ("renewed") at the end of the term, even if your health has changed. If you renew a term policy, the new premiums are higher. Ask what the premiums will be before you renew the policy. Also ask if you'll lose the right to renew the policy at a certain age. A Non-renewable term policy can't be continued. You'll have to apply for a new policy if you still want coverage.

- **Whole Life vs. Universal Life.** Whole life and universal life insurance are two types of cash value insurance. A key difference between the two is how you pay for the coverage. You typically pay premiums for whole life insurance according to a set schedule. In a universal life policy, you can choose a flexible premium payment pattern as long as you pay enough to keep your policy in force.

- **Variable Life vs. Non-variable Life.** The investments you will choose (such as stock and bond funds) in a variable life policy directly impact your cash value. These policies have the greatest potential to build cash value but also the greatest risk of losing cash value. Non-variable life policies often have guaranteed minimums for some features (interest or cash value, for example) but not all. Non-variable life policies also have less potential to build cash value than variable policies.

Be Sure You Can Afford the Premium

Before you buy a life insurance policy, be sure you can pay the premiums. Can you afford the initial premium? If the premium increases later, will you still be able to afford it? The premiums for many life insurance policies are sensitive to changes in the company's investment earnings, claims costs, and other expenses. If those are worse than expected, you may have to pay a much higher premium. Ask what might be the highest premium you'd have to pay to keep your coverage.

Understand the Application Process

You can apply for life insurance through life insurance agents, the mail, and online. In addition to basic information, such as your name, address, employer, job title, and date of birth, you'll be asked for more personal information. Depending on the type of policy, the insurer may require you to see a doctor, answer health-related questions, or have a medical professional come to your home or office to assess your health. Usually a policy that doesn't require detailed health information will cost more and provide less coverage than one that does.

It's important to tell the truth on the application. The insurance company will check your answers so review the application before you sign. If the insurance company discovers false statements on your application after it issues your policy, it could reduce or cancel your coverage.

Choose a Beneficiary

A beneficiary is the person(s) or organization(s) you name to receive your life insurance policy's death benefit. You'll need to know the Social Security or tax identification number for all beneficiaries. Experts advise you not to name a minor child as a beneficiary. Insurance companies won't pay a minor. Instead, consider leaving the money to your estate or trust.

Evaluate the Future of Your Policy

Does your policy have a cash value? In some cash value policies, the values are low in the early years but build later on. In other policies the values build up gradually over the years. Most term policies have no cash value. Ask your insurance agent, financial advisor, or an insurance company representative for an illustration showing future values and benefits.

Read Your Policy Carefully
After you carefully read your policy, you should be able to answer the following important questions:

- Is your personal information correct?
- Do premiums or policy values vary from year to year?
- What part of the premium or policy value isn't guaranteed?
- How will the timing of money paid and received affect any interest the policy might earn?

Your insurance agent, financial advisor, or an insurance company representative can help you understand anything that isn't clear.

If you're not satisfied with your new policy, you can return it for a full refund within a certain period, usually 10 days after you receive it. The review period usually is stated on the first page of the policy.

Review Your Life Insurance Program Every Few Years
Review your policy with your insurance agent, financial advisor, or an insurance company representative every few years to keep up with changes in your policy and your needs.

- Have the premiums or benefits changed since your policy was issued?
- Do the death benefits still meet your needs?
- Do you need more or less coverage after life events, such as birth, adoption, marriage, job change, death, or divorce?

The insurance company can provide policy statements and illustrations to help with this review. As the policy owner, you can change beneficiaries at no cost. Be sure to review your beneficiaries every few years, especially after major life events that affect your life insurance needs.

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

PLEASE NOTE:

Under your state law, we are required to present you with the following **NOTIFICATION OF RIGHT TO NAME A SECONDARY ADDRESSEE** form, to inform you of the following:

You have the right to designate a secondary addressee to receive a notice concerning the potential lapse of your policy. The notice to the secondary addressee will be sent when the policy is in danger of lapsing.

****This form is not included in the application for life insurance document that will be covered during your telephone interview. Therefore, if you wish to name a secondary addressee, please call us at 1-800-366-9378, or fax us at 1-205-268-5807, or write us at P.O. Box 830619, Birmingham, Alabama 35283-0619.****

PROTECTIVE LIFE INSURANCE COMPANY

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

NOTIFICATION OF RIGHT TO NAME SECONDARY ADDRESSEE

Illinois policyholders have the right to designate a secondary addressee to receive notice of policy lapse or termination for nonpayment of premium. If you would like to make a designation, please complete the information below and return it to us at P.O. Box 830619, Birmingham, Alabama 35283-0619.

If you have any questions about your right to name a secondary addressee, 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

Secondary Addressee:

_____
Name

_____
Street Address or P.O. Box

_____
City, State, Zip Code