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

INDIVIDUAL LIFE INSURANCE - TOBACCO USE QUESTIONNAIRE

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

SECTION 1

Name	Policy Number(s)
Mailing Address – Street or P.O. Box	Daytime Telephone Number
City, State, Zip Code	Email Address

SECTION 2

(a) Please provide details of tobacco use or nicotine product use (i.e. cigarettes, cigars, pipes, chewing tobacco, nicotine patch, nicotine gum, etc.):

Type of tobacco or nicotine product used:	Frequency of use:	Date last used:

(b) Have you ever been treated by a member of the medical profession for any heart disorder, stroke, cancer, emphysema, chronic bronchitis, asthma, or any disease of the lungs? If Yes, give name and address of medical professional or facility seen, medications being taken and dates of visit. ☐ Yes ☐ No

I hereby represent that the statements and answers made in response to the above questions are complete and true to the best of my knowledge and belief. 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.

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 and State): _____ Date Signed: _____

Signature of Insured: _____

Signature of Owner (if other than insured): _____

Signature of Agent/Witness: _____

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INDIVIDUAL LIFE INSURANCE – CONTINUATION OF INFORMATION

Proposed Insured 1: _____
First Name | Middle Name | Last Name | Policy Number

Proposed Insured 2: _____
First Name | Middle Name | Last Name | Policy Number

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

_____	_____	_____	_____
Proposed Insured 1 (Sign Name in Full)	Date	Proposed Insured 2 (Sign Name in Full)	Date
_____	_____	_____	_____
Signature of Parent or Guardian	Date	Signature of Witness	Date
_____	_____		
Signature of Owner (Sign Name in Full) *(if other than Proposed Insured)*	Date		

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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 organization 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 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 is declined or if Protective Life is unable to offer coverage at an acceptable rate.
e. to the Life Insurance Representative(s) and its staff, affiliated companies and/or entities, insurance companies and their re-insurers representing me on my (our) application for life insurance.

SPECIAL REQUIREMENT FOR HIV/AIDS TESTING

If Protective Life 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 re-disclosure and no longer covered by certain federal rules governing privacy and confidentiality of health information. The information contained in these medical and financial records will be held in confidence and may be used only for the purpose of the procurement, or underwriting for the possible procurement or the evaluation of life, health, long term care, or other insurance products.
e. I (we) understand that my (our) personal information, including my (our) protected health information disclosed under this authorization will be incorporated into and made a part of any life and/or disability insurance policy(ies) issued by the Company and that the policy(ies) will be delivered to the policy owner.
f. *I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction. Any modifications to this authorization may preclude Protective Life'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**.)

THIS AUTHORIZATION <u>MUST</u> BE SIGNED WITHOUT MODIFICATION AND RETURNED WITH THE APPLICATION BEFORE PROCESSING.

SIGNATURES

Date of Authorization: X_____

_____

List Health Care Providers

X_____	_____	_____	_____
Proposed Insured 1 (Signature)	Print Name of Proposed Insured 1	Birthdate	Social Security Number
X_____	_____	_____	_____
Proposed Insured 2 (Signature)	Print Name of Proposed Insured 2	Birthdate	Social Security Number

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

PROTECTIVE LIFE INSURANCE COMPANY

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NOTICE AND CONSENT FORM FOR TESTING TO DETERMINE EXPOSURE TO THE CAUSATIVE AGENT OF AIDS

Dear Proposed Insured:
To evaluate eligibility for insurance coverage, it is requested that a sample of blood, oral and/or urine specimen be provided for testing to determine the probable causative agents of AIDS. Before an insurer can request a specimen and perform a test, the insurer must explain the testing protocols, as established by the Director of the District of Columbia Department of Health. The insurer is also required to obtain a written consent statement from the applicant for insurance confirming that the insurer has complied with its obligations.

The signing of this form indicates that the procedure used in implementing this test has been explained and has been shown to be in full compliance with the protocol currently adopted by the Director of the Department of Health. Additionally, by signing and dating this form, it is agreed that this test may be performed and that an underwriting decision may be based on the test results.

No insurer shall request or require you to take the testing protocol without first obtaining you or your legal guardian's signature on this consent form. You have the right to decide not to be tested and not to sign this form. Once the insurance company has asked you to sign this consent form, you or your legal guardian may wait 14 days before signing this informed consent.

In the event the test result is positive, the Department of Health recommends that you or your child are immediately put in contact with an HIV (infectious disease) provider. Please see form U-462 for further information.

DISCLOSURE OF TEST RESULTS:
All information regarding the performance of the test, including the test results, will be treated confidentially. The results of the test will be reported to the insurer identified on this form; the applicant or his or her legal guardian; a physician or health care provider if designated on this form by the applicants; a court of competent jurisdiction pursuant to a lawful court order; any person or entity involved solely in the underwriting process; and any other person or entity expressly named and given separate written authorization by the applicant. Results of the test shall not be otherwise disclosed.

MEANING OF POSITIVE TEST RESULTS:
Positive test results may adversely affect your application for insurance. This means that your application may be declined, an increased premium may be charged or other changes may be necessary.

SIGNATURE AND WRITTEN CONSENT:
I have read and I understand this Notice and Consent Form. I voluntarily consent to having an AIDS test performed and disclosed as described above. I understand that I have the right to request and receive a copy of this form. A certified photocopy of this form may serve and be deemed as valid as the original.

PHYSICIAN:	**and / or**	**HEALTH CARE PROVIDER:**
_____		_____
_____		_____
_____		_____

NOTICE OF RIGHT OF APPEAL:
We are required by law to provide you with the following information:

An applicant for insurance who tests positive under this testing protocol certified by the Director of the Department of Health may appeal to the Commissioner of the Department of Insurance, Securities and Banking to review the testing procedures and results, and may present additional medical evidence, including the result of similar tests for exposure to the probable causative agent of AIDS that the named applicant independently obtains. The Commissioner of the Department of Insurance, Securities and Banking can be reach at the following address:
810 First Street, NE, Suite 701, Washington, DC, 20002.

_____ _____
Date Signature of Proposed Insured or Parent/Guardian

Original - HOME OFFICE Copy - PROPOSED INSURED

PROTECTIVE LIFE INSURANCE COMPANY

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HIV TESTING PROTOCOL

HIV TEST FOR SCREENING AND DIAGNOSIS:

As HIV testing technology progresses and the District of Columbia Department of Health updates its recommendations, the Department of Insurance, Securities and Banking reserves its right to modify its minimum standard for testing protocols. Insurance issuers paying for the administration of the test must comply accordingly with the Department's minimum standards.

There are three types of HIV diagnostic tests: antibody tests, antigen/antibody tests, and nucleic acid (RNA) tests. Antibody tests detect antibodies, proteins that your body makes against HIV, not HIV itself. Antigen tests and RNA tests detect HIV directly.

The current testing protocol required in the District of Columbia is as follows:

Initial Test: Tests for HIV shall be conducted with an FDA-approved antigen/antibody combination (4th generation) immunoassay[1] that detects HIV-1 and HIV-2 antibodies and HIV-1 p24 antigen to screen for established infection with HIV-1 or HIV-2 and for acute HIV-1 infection. No further testing is required for specimens that are nonreactive on the initial immunoassay.

> ***Rationale:*** Initial testing with a 4th generation antigen/antibody combination immunoassay detects more acute HIV-1 infections than initial testing with a 3rd generation antibody immunoassay and identifies comparable numbers of established HIV-1 and HIV-2 infections, with comparable specificity.

Blood tests can detect HIV infection sooner after exposure than oral fluid tests because the level of antibody in blood is higher than it is in oral fluid. Likewise, antigen/antibody and RNA tests detect infection in blood before antibody tests. Some newer antigen/antibody lab tests can sometimes find HIV as soon as 3 weeks after exposure to the virus. No antigen/antibody or RNA tests are available for oral fluid.

Follow-up Testing: HIV tests are generally very accurate, but follow-up testing allows you and your health care provider to be sure the diagnosis is right. Specimens with a reactive antigen/antibody combination immunoassay result (or repeatedly reactive, if repeat testing is recommended by the manufacturer or required by regulatory authorities) should be tested with an FDA-approved antibody immunoassay that differentiates HIV-1 antibodies from HIV-2 antibodies. Reactive results on the initial antigen/antibody combination immunoassay and the HIV-1/HIV-2 antibody differentiation immunoassay should be interpreted as positive for HIV-1 antibodies, HIV-2 antibodies, or HIV-1 and HIV-2 antibodies, undifferentiated.

> ***Rationale:*** Use of the HIV-1/HIV-2 antibody differentiation assay after a reactive initial 4th generation HIV-1/HIV-2 antibody immunoassay detects HIV-1 antibodies earlier than the HIV-1 Western blot, reduces indeterminate results, and identifies HIV-2 infections. Turnaround time for test results is shorter and the cost is lower for the HIV-1/HIV-2 antibody differentiation assay compared with the HIV-1 Western blot. Available evidence is insufficient to recommend specific additional testing, without clinical follow-up, for specimens that are dually reactive for HIV-1 and HIV-2 antibodies on the differentiation immunoassay.

PROPORTION OF FALSE POSITIVE RESULTS EXPECTED:

According to the Centers for Disease Control and Prevention clinical data submitted by the manufacturers of Human Immunodeficiency Virus (HIV) antibody tests to the Food and Drug Administration (FDA) for licensure indicate that sensitivity and specificity of tests currently marketed in the United States are greater than 99%.

All blood, oral fluid and protocols licensed by the FDA follow the same test algorithm: specimens are tested singly by either a screening enzyme immunoassay or a 4th generation antigen/antibody combination assay, and if found reactive are retested in duplicate. If either duplicate is reactive, the specimen is considered repeatedly reactive and is submitted for further testing using either a FDA approved multi-spot test or an HIV-1/HIV-2 antibody differentiation immunoassay. Specimens found reactive by this second test are reported as positive for HIV antibodies. Although a positive result indicates infection with HIV, a diagnosis of Acquired Immunodeficiency Syndrome (AIDS) can only be made clinically if a person meets the case definition of AIDS established by the Centers for Disease Control and Prevention[1].

Data from multiple studies on 4th generation HIV tests demonstrated an overall sensitivity of 99.9-100%. Thus, the achievable false-positive rate of sequentially performed 4th generation tests can be less than 0.1% or less than 1/1,000 persons tested.

DISCLOSURE:
Reference material provided in this notice and consent form is for information purposes only. Applicants for insurance who have questions should seek guidance from a professional health provider.

HIV TESTING COUNSELING REFERRALS:
The DC Department of Health (DOH) HIV/AIDS, Hepatitis, STD, and TB Administration (HAHSTA) has prepared a comprehensive and easy-to-read directory of all DC HIV/AIDS services, most are funded by the District of Columbia Government. The directory contains information ranging from HIV testing locations to medical care, medications and support services, including nutrition services and housing. A special on-line version can be accessed below.

Directory of HIV/AIDS Services in the District of Columbia and Surrounding Areas
(http://haadirectory.doh.dc.gov/)

For a printable list of primary care sites in DC, compiled by the DOH Primary Care Bureau visit them at the link below.

Primary Care Bureau
(http://doh.dc.gov/page/primary-care-bureau)

The DC Primary Care Association (DCPCA) is a non-profit health equity and advocacy organization dedicated to improving the health of DC's vulnerable residents by ensuring access to high quality primary health care, regardless of an ability to pay. They work to ensure that all residents of Washington, DC have the ability and opportunity to lead healthier lives – through increased health care coverage, expanded access, improved quality, workforce development, and enhanced communication. Members of the DCPCA currently include 15 community health centers and community-based organizations located in the District of Columbia and the Maryland suburbs. Between them, member health centers own and operate nearly 60 health care delivery sites that serve approximately 200,000 residents, most of which offer HIV counseling and testing. A listing of health center locations can be found below.

DCPCA Find a Health Center
(http://www.dcpca.org/find-a-health-center)

[1] *Exception: As of April 2014, data are insufficient to recommend use of the FDA-approved single-use rapid HIV-1/ HIV-2 antigen/antibody combination immunoassay as the initial assay in the algorithm.*

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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, Attention: New Business, P.O. Box 830619, Birmingham, Alabama 35283-0619. Telephone: 800-366-9378

THIS NOTICE MUST BE GIVEN TO THE PROPOSED INSURED

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.