

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 MUST BE SIGNED WITHOUT MODIFICATION AND RETURNED WITH THE APPLICATION BEFORE PROCESSING.

SIGNATURES

Date of Authorization: X _____

List Health Care Providers

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

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

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

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INFORMED CONSENT FOR THE HUMAN IMMUNODEFICIENCY VIRUS (HIV) ANTIBODY TEST

If you want to be tested to see if you have been infected with HIV, the virus that causes AIDS, please read the following and ask for an oral explanation of anything that you do not understand.

Purpose of Test: This test shows if you have antibodies to the Human Immunodeficiency Virus (HIV) that causes AIDS; if there are antibodies, you have been infected with HIV and can pass the virus on to others. This test can not determine if you have AIDS.

Blood Drawing: This HIV antibody test is a blood and/or a urine test. A sample of blood and/or urine will be collected from you and then analyzed by a laboratory to determine if it contains HIV antibodies.

Limitations: As with many laboratory tests, there is a possibility of inaccurate results. For instance, a false negative result could occur if you have recently been exposed to the virus but have not yet developed antibodies.

Potential Uses of Test: If your HIV antibody test results are known, it may help your doctor determine the medical care you need. It may also help you make personal decisions, such as whether to have children and how best to avoid the risk behaviors that transmit the virus. Your results are reported to the Montana Department of Health and Environmental Sciences (DHES), but only positives or negatives; no name is attached. If testing for insurance, refer to insurance company testing section.

Counseling: At a minimum, counseling in the form of written materials developed by the DHES must be given to you before you consent to have the HIV antibody test performed and additional written materials from DHES must be provided to you after you receive the test results from your health care provider or designee.

Voluntary and Anonymous Testing: Taking an HIV antibody test is voluntary; you do not have to take the test. If you prefer, anonymous testing in which your name is not known to those performing the test, is available at several locations established by the DHES in Montana. These locations can be obtained from the DHES, your local health department or calling 1-800-233-6668. (Refer to insurance section.)

Withdrawal of Consent: You may withdraw your consent from the HIV test at any time until the blood and/or urine lab specimen is collected.

Confidentiality: Your test result is a confidential medical record and is protected by Montana law, which states that medical information can be released only with your consent, or under conditions specified by the Uniform Health Care Act (Title 50, Chapter 16, Part 5, MCA) or by the Government Health Care Act (Title 50, Chapter 16, Part 6, MCA). When authorizing a health care provider to release information you may specify which part of your medical records you want released and to whom. Signing a medical information release consent form does not waive your legal rights.

Local Health Department and Insurance Company Testing: If the test is being performed as part of an application for insurance, results will be reported to the health care provider designated by you, if it is positive. A negative test may be obtained from your insurance company. (If there is no health care provider designated, a positive test, result may be reported to the local health department for post-test counseling.) A positive test result may have an effect on your ability to obtain insurance. Ask your insurance representative about who receives and has access to your HIV antibody test results.

Unconscious or Otherwise Mentally Incapacitated: If the patient is 1) unconscious or otherwise mentally incapacitated, 2) there is no legal guardian, 3) there are medical indications of an HIV-related condition, 4) the test is advisable in order to determine the proper course of treatment then the patient's next of kin (parent, adult child, grandparent, adult sibling, or legal spouse); or the patient's significant other (individual living in a current spousal relationship with another individual but who is not legally a spouse of that individual) may receive pretest counseling and provide written informed consent. If circumstances in 1-4 above exist and the patient is in a hospital, then the person designated in the patient's medical records may receive pretest counseling and provide written informed consent on behalf of the patient. If circumstances in 1-4 above exist and the patient is in a hospital, and none of the persons listed above are available; the health care faculty may within a reasonable time order a HIV test.

STATEMENT OF CONSENT: By signing below, I certify that:

- (1) I have read and understand the above explanation of the HIV antibody test, including an explanation of the nature of the test, what the test results mean, counseling requirements, the test is voluntary and test results are confidential;
- (2) I have received and read written pre-test counseling materials drafted by the DHES;
- (3) I understand that anonymous testing, if I desire it, is available at one of the counseling/testing sites established by the DHES or elsewhere;
- (4) I agree to have a sample of my blood or urine tested for the presence of the HIV antibody, and authorize

Name of Health Care Provider: _____

Address: _____

to receive and inform me of the results of the test. Post-test counseling is to be given, at minimum in the form of written materials developed by the DHES.

- (5) I understand that when tested for insurance purposes that a positive test result will be given to the designated health care provider (listed above). If desired, I can seek results of a negative test from the insurance company.
- (6) I authorize Protective Life Insurance Company or its reinsurers to make a brief report of any personal health information to the MIB.

Date

Signature of person to be tested or that subject's representative (as defined under section "Unconscious or Otherwise Mentally Incapacitated"). Initials or other identifier if testing anonymously.

Print Name of Signatory

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HIV ANTIBODY TEST

Materials provided by the Department of Health and Environmental Sciences - STATE OF MONTANA

BEFORE YOU TAKE THE HIV ANTIBODY TEST

THE HIV VIRUS

Human immunodeficiency virus (HIV) is the virus that causes Acquired Immune Deficiency Syndrome (AIDS). The virus injures your immune (infection-fighting) system. If your immune system becomes so weakened by the virus that you can't fight off other diseases on your own, you have developed AIDS.

THE HIV ANTIBODY TEST

When you have an HIV infection, your body produces antibodies. The HIV antibody test is a test for those antibodies. This test is voluntary. You do not have to take the test.

A **POSITIVE TEST** means that you are infected with HIV. You can pass the virus to other people through certain behaviors. A positive test doesn't mean you have AIDS.

A **NEGATIVE TEST** means that you probably don't have HIV infection. However, because it takes time for the body to make antibodies some people may have a negative test and still be infected with the virus. If the test is done between the time the virus enters your body and the time antibodies are made, the test will be negative. You would still be able to transmit the virus to others.

Even if you have a negative test, you can still get the virus.

HOW HIV IS SPREAD

HIV is not spread by common everyday contact, but by certain risky activities. These risky activities are called RISK BEHAVIORS. These behaviors involve passing semen, vaginal secretions, and/or blood from an infected person to someone else. You can get the virus when an infected person's semen, vaginal secretions, or blood enters your body. Open sores make it easier for the virus to enter someone's body. Having sexually transmitted diseases like herpes or syphilis could cause open sores. These sexually transmitted diseases are treatable. See your doctor or nearest health department.

A woman who is carrying HIV may transmit the virus to her unborn child. She may also transmit the virus through her milk to a nursing infant.

THESE ARE RISK BEHAVIORS:

Sexual Contacts

- penis in or around vagina
- penis in or around rectum
- tongue or mouth in or around rectum
- tongue or mouth in or around vagina
- tongue or mouth on or around penis

Sharing Needles or Syringes

Perinatal

- infected mother to unborn child

NOTE: Since blood and blood products used in transfusions have been tested for HIV antibodies since 1985, the risk of getting HIV infection through a blood transfusion is extremely low. There is no risk in donating blood.

HOW YOU CAN PROTECT YOURSELF

The virus is in the semen, vaginal secretions and/or blood of an infected person. You can protect yourself by shielding yourself from these body fluids.

RISK REDUCING BEHAVIORS

(Safest listed first)

- Don't have sex (abstinence)
- Have only one sex partner (monogamy); both must be HIV free
- Use latex condoms (rubbers)
- Don't share needles or syringes
- Use clean needles or syringes

The sex act is risky. Latex condoms reduce the risk. Natural fiber condoms do not reduce the risk. Latex condoms must be used throughout the sexual activity and you must use them in the right way. Don't be afraid to ask your pre-test counselor for demonstrations. The spermicide nonoxynol-9 is also recommended, but only when used with a condom. Do not use oil-based lubricants with a condom.

If you are a person who engages in risk behaviors, do not donate blood. Avoid pregnancy until you are certain you and your partner are HIV free.

REASONS TO TAKE THE TEST

The test will tell you if you have the virus. It will allow your doctor to begin treatment sooner. New drugs can help maintain your health if you have the virus. Risk reducing behaviors can prevent the spread of HIV.

CONCERNS ABOUT TAKING THE TEST

Finding out you have an HIV infection is frightening. You may develop AIDS. You may transmit the virus to someone else. Having the virus can affect your entire life. It is important to consider who is available to talk to you about your test. This is not information to share casually.

Free and anonymous testing is available at Counseling and Testing Sites. A list of Counseling and Testing Sites is available by calling the Montana AIDS HOTLINE at 1-800-233-6668, or your nearest health department.

CONFIDENTIALITY (PRIVACY)

The professionals performing and recording this test value the necessity of keeping your test results confidential. You may be concerned about the possibility of friends, employers, neighbors or your insurance company finding out your test result. Discuss confidentiality policies with your pre-test counselor to find out under what circumstances others might have access to the result.

PARTNER NOTIFICATION

If your test is positive, sex and needle-sharing partner(s) need to be notified and given the opportunity to receive counseling and testing. This is a very sensitive task. Public health personnel can either tell your partner(s) or help you in how to tell your partner(s). By law, public health personnel cannot tell your partner(s) the time or place of possible infection or your identity.

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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.