

# 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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## HIV TESTING INFORMATION STATEMENT & CONSENT FORM - VERMONT

Vermont law requires that this entire statement be read aloud to you. It contains important information about HIV testing and your rights under Vermont law. A copy of it will be given to you to keep and review.

The insurance company you are applying to for coverage may want to take a sample from you to be tested by a laboratory for indication of HIV infection. This information may be used as part of its decision whether to sell you insurance coverage. The insurance company may request a sample of your blood in order to conduct the test. The insurance company will pay for this test.

HIV stands for human immunodeficiency virus. HIV is the virus that causes AIDS (acquired immunodeficiency syndrome). Different laboratory tests can be used to identify HIV infection, the most common being a combination HIV antibody/antigen test. Presence of HIV antibodies or antigens in the sample means that a person has been infected with the HIV virus. While a positive HIV antibody/antigen test result does not mean that you have AIDS, it does mean that you are at a seriously increased risk of developing AIDS and more testing is needed to assess your health. A negative test result means that no HIV antibodies or antigens were found. Because of varying incubation periods (also known as the window period), absence of HIV antibodies or antigens does not guarantee that you have not been infected with the virus. In addition, the absence of HIV antibodies or antigens does not mean that you are immune to the virus. If your HIV antibody/antigen test is indeterminate, a nucleic acid test (NAT) may be ordered to provide more information. More information about the HIV testing process specific to the insurance company you are applying to can be requested of their medical staff.

If after listening to this statement you do not wish to be tested, do not sign the informed consent form and the application process will be suspended. Before deciding whether to consent to this testing you may, at your own choice and expense, consult with a personal physician or counselor or the Vermont Department of Health regarding HIV and HIV testing. Anonymous HIV testing is also available, the results of which would not be connected to any personally identifying information. To find an anonymous HIV testing site contact the Vermont Department of Health using the contact information at the end of this letter. Any delay in your application resulting from pursuing the options described above will not affect the status of your application or policy.

If after listening to this statement you decide to proceed, you may choose to receive the test results directly or to designate in writing (on the informed consent form) any other person whom you want to receive the results.

All test results will be treated confidentially. The laboratory that conducts the test will report the results to the insurance company, which may in turn report results to its affiliates, reinsurers, medical personnel and insurance support organizations that are involved in the decision by the insurer to sell you insurance. Test results will not be shared with your insurance agent or broker. You have the right to sue a person for damages arising from the unauthorized negligent or knowing disclosure of HIV-related test results.

If your test result is positive or indeterminate, the insurance company may report a nonspecific test code to the medical information bureau (MIB, LLC). The MIB, LLC is a central computerized facility that keeps on file the health information of the applicants for life and health insurance for use by insurance companies. In addition, positive test results must be reported to the Vermont Department of Health.

You have rights that include the following:

1. If your HIV status is determined to be negative, coverage shall not be denied based on HIV status.
2. Your HIV test will only be considered as positive if testing results meet the most current Centers for Disease Control and Prevention recommended laboratory HIV testing algorithm or more reliable confirmatory test or test protocol that has been approved by the United States Food and Drug Administration.
3. If the HIV-1/2 antibody differentiation test result is indeterminate, the insurer may delay action on the application, but no change in preexisting coverage, benefits, or rates under any separate policy or policies held by the individual shall be based upon such indeterminacy.
4. If the HIV-1 NAT test is invalid, the full testing algorithm shall be repeated.
5. No application for coverage shall be denied based on an indeterminate or invalid result. Any underwriting decision granting a substandard classification or exclusion based on the individual's prior HIV-related test results shall be reversed, and the company performing any previous HIV-related testing that had forwarded to a medical information bureau reports based upon the individual's prior HIV-related test results shall request the medical information bureau to remove any abnormal codes listed due to such prior test results.

6. If you are denied insurance, or offered insurance on any other than a standard basis, because of the positive results of an HIV-related test, you may request a retest once within the three-year period following the date of the most recent test; and in any event, upon updates to the Centers for Disease Control and Prevention recommended laboratory HIV testing algorithm for serum or plasma specimens. If such retest is negative, a new application for coverage shall not be denied by the insurer based upon the results of the initial test. Any underwriting decision granting a substandard classification or exclusion based on the individual's prior HIV-related test results shall be reversed, and the company performing a retest which had forwarded to a medical information bureau reports based upon the individual's prior HIV-related test results shall request the medical information bureau to remove any abnormal codes listed due to such prior test results.
  
7. Any individual who sustains damage as a result of the unauthorized negligent or knowing disclosure of that individual's individually-identifiable HIV-related test result information in violation of subdivision (H) of this subdivision (20) may bring an action for appropriate relief in Superior Court against any person making such a disclosure. The Court may award costs and reasonable attorney's fees to the individual who prevails in an action brought under this subdivision.

Information about HIV and how to access anonymous HIV testing sites in Vermont is available at the Vermont Department of Health website: [www.healthvermont.gov/disease-control/hiv](http://www.healthvermont.gov/disease-control/hiv) or by calling (800) 882-2437. Additional information about HIV is available at the Centers for Disease Control and Prevention's website [www.cdc.gov/hiv](http://www.cdc.gov/hiv) or by calling (800) 232-4636.

HIV is a treatable infection. In the event you test positive for HIV, it is very important that you seek medical care. You can obtain helpful information from the Vermont AIDS Hotline at (800) 882-2437.

If you choose, you will now be asked to sign a written informed consent form permitting the insurance company to have you tested for HIV.

**Informed Consent**

*To be signed before medical professional or company agent obtains sample.*

This statement has been read aloud to me and I understand this ***HIV TESTING INFORMATION STATEMENT & CONSENT FORM***. I voluntarily consent to the collection of blood samples for the purpose of testing to determine if HIV antibodies or antigens are present and the disclosure of the test results as described above.

Name of Proposed Insured	Signature of Proposed Insured	Date
Birth Date	State of Residence	
Name of Medical Professional or Company Agent Collecting Sample	Signature of Medical Professional or Company Agent Collecting Sample	

***Notification of Test Results***

*To be completed at time of application or when a Medical Professional or company agent obtains sample.*

**You may choose to receive the test results directly or to designate below another person to whom the results should be sent:**

**PLEASE SEND MY TEST RESULTS TO:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

VT-Bulletin 138-Form 1 (Rev. 09/2019)

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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](http://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](http://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.