

**PROTECTIVE LIFE INSURANCE COMPANY**

**P.O. Box 830619**

**Birmingham, AL 35283-0619**

**STATEMENT OF HEALTH**

This has been completed as a condition to the Delivery or Change of:

\_\_\_\_\_  
Policy Number(s)

\_\_\_\_\_  
Proposed Insured (Printed)

Since the first application date, the proposed insured and any proposed insured family member has:

- **Not** submitted another application(s) for insurance to any other company.
- **Not** received notice that any application(s) for insurance has been declined, postponed or modified.
- Had **no** change in health or insurability as a life insurance risk because of any event or circumstance.
- **Not** consulted or been examined by a doctor or other medical professional.
- Remained in good health.

Any changes to the above statements should be given here:

\_\_\_\_\_  
\_\_\_\_\_

There are no changes to the above statements.

The proposed insured (and the applicant if other than the proposed insured) acknowledges:

- That all changes have been stated.
- The above statements are true and complete.
- The company can rescind the policy if a material fact is misrepresented on this form.
- Any insurance will not take effect until the company approves these statements, the policy is delivered to the applicant while alive, the first premium is paid and any amendments signed and returned. However, if the full first premium was paid along with the initial application for insurance and a Conditional Receipt/Temporary Life Receipt was signed, the terms of the Conditional Receipt/Temporary Life Receipt will apply.

**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 is a crime and may subject such person to criminal and civil penalties according to state law.**

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Proposed Insured

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Applicant (if other than Insured)

Copy To Be Returned To Company After Completion