Protective Preserver

Single Premium Variable Universal Life (VUL)

CALIFORNIA
APPLICATION PACKET

Includes:

- **Description of Information Practices**
  (Must be given to every Applicant)
- **Application with Funds Allocations**
- **Registered Representative Report**
- **Continuation of Information for Part I (Non-Medical) and Part II (Medical)**
- **Supplement to Life Insurance Application (Premium Financing)**
- **Long-Term Care - Third Party Designation**
- **Temporary Life Insurance Receipt**
- **Part 1A - Supplemental Application - Non-Medical Declarations**
- **Notice to Applicants Aged 65 or Older**
- **Written Notice to CA Seniors Aged 65 or Over (In Senior's Home)**
- **Authorization to Obtain and Disclose Information (HIPAA)**
- **HIV Consent**
- **Replacement of Life Insurance or Annuities**
- **Assignment/Transfer of Ownership Section 1035 Exchange**
- **Secondary Addressee**
- **W-9 Tax Form**

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

DESCRIPTION OF INFORMATION PRACTICES

(Including MIB, Inc. 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, Inc., (MIB), formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. 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. 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.

Single Premium Variable Universal Life Application to Protective Life Insurance Company

Please Make Check Payable To:
Protective Life Insurance Company
P.O. Box 830771, Birmingham, AL 35283-0771

1. PROPOSED INSURED
Driver's Lic. # ________________ ☐ Male ☐ Female

Name
Street Address
City *State* *Zip*
Phone Number *Tax I.D./Social Security No.*
Birthdate Mo/Day/Yr *Birthplace* *Marital Status*
E-mail Address

2. OWNER (If other than Proposed Insured)
☐ Male ☐ Female

Name
Street Address
City *State* *Zip*
Phone Number *Tax I.D./Social Security No.*
Birthdate Mo/Day/Yr *Birthplace* *Marital Status*
E-mail Address

3. PRIMARY BENEFICIARY *Name, Address, Relationship & Percentage*

CONTINGENT BENEFICIARY *(If any)*

4. POLICY INFORMATION
Premium Payment $ ______________
Initial Face Amount $ ______________
Cash with Application $ ______________
Proposed Insured: Have you used tobacco or nicotine of any kind over the last 12 months? ☐ **Yes** ☐ **No**
Long-Term Care Accelerated Death Benefit Rider? ☐ **Yes** ☐ **No**
Lapse Protection Rider? ☐ **Yes** ☐ **No**

5. TO AVOID DELAY IN PROCESSING - THIS QUESTION MUST BE ANSWERED:
Is there an intention that any party other than the owner will obtain any right, title or interest in any policy issued on the life of the proposed insured as a result of this application? ☐ **Yes** ☐ **No**
If "yes", please explain under "Remarks".

6. REGARDING ALL PERSONS PROPOSED FOR INSURANCE:
Please answer all questions. If Question #6a is answered "yes" do not accept cash or give a temporary life insurance agreement with this application. If any question below is answered "yes", give details under Question 7.

	Question	YES	NO
a.	Within the past 5 years have you been treated for cancer, diabetes, cardiovascular disease, stroke, central nervous system disorders, muscular disorders or respiratory disorders?	☐	☐
b.	During the past 5 years have you consulted a physician or visited a clinic or hospital as a patient?	☐	☐
c.	Will the policy applied for replace or change any life insurance or annuity in force?	☐	☐
d.	Do you have an application pending in another company? (If yes, give company and amount in "Remarks")	☐	☐
e.	Has any life or health insurance applied for ever been declined, postponed or offered other than applied for?	☐	☐
f.	Have you piloted or been a crew member aboard an aircraft within the past 2 years or have any intention of becoming a pilot?	☐	☐
g.	Have you ever participated in a sport or avocation such as racing, hang gliding, scuba, sky or skin diving?	☐	☐
h.	Have you used tobacco or nicotine of any kind over the last 12 months?	☐	☐
i.	Within the last 5 years have you had a DUI conviction, had your driver's license restricted or revoked, or been cited for more than two moving violations?	☐	☐
j.	Within the last 10 years, have you been convicted of a felony?	☐	☐
k.	Do you have any intention of traveling or residing outside the U.S. or Canada within the next two years?	☐	☐

7. DETAILS OF ALL "YES" ANSWERS

Question Number	Date of Occurrence	Details, Diagnosis, Treatment, Medication, Results	Duration	Names & Address of Doctors, Hospitals & Medical Facilities Consulted

8. REGARDING ALL PERSONS PROPOSED FOR INSURANCE, LIST ALL INSURANCE IN FORCE ON EACH PROPOSED INSURED'S LIFE. INCLUDE INSURANCE WHETHER OWNED BY THE INSURED OR NOT.

Person	Policy #	Company Name	Issue Date	Amount	Purpose (Bus/Pers)	Type (Life/ADB/CI)	REPLACEMENT YES	NO
							❑	❑
							❑	❑
							❑	❑

9. COMPLETE IF APPLYING FOR LONG-TERM CARE ACCELERATED DEATH BENEFIT RIDER:

Do you have another long-term care insurance policy or certificate in force (including health care service contract, health maintenance organization contract)? ☐ YES ☐ NO

Did you have another long-term care insurance policy or certificate in force during the last 12 months? ☐ YES ☐ NO

If so, with which company? ______________________________

If that policy or certificate lapsed, when did it lapse? ______________________________

Are you covered by Medicaid? ☐ YES ☐ NO

10. TELEPHONE TRANSFERS

Protective will not be responsible for any loss, liability, cost or expense for acting on telephone instructions.

☐ By checking this box, I authorize the Company to honor my telephone instructions to transfer account values among Sub-accounts, subject to the conditions of the prospectus.

☐ By checking this box, I authorize the Company to honor telephone instructions from the Registered Representative who signs this application to transfer account values among Sub-accounts, subject to the conditions of the prospectus.

REMARKS:

Home Office Endorsement:

Policy Number: ______________________________________

11. PREMIUM PAYMENT ALLOCATION:
Select the allocation for your premium payments. (If no allocation is specified, all proceeds will be allocated to the OppenheimerFunds Government Money Fund/VA.) **You may also select the sub-accounts for which your monthly charges (other than Mortality & Expense) will be deducted.** (If no designation, charges will be deducted as stated in the prospectus.)

Purchase Allocation	Monthly Deduction Allocation	**American Funds** / ***American Funds Insurance Series***
______%	______%	Asset Allocation *Class 2*
______%	______%	Blue Chip Income and Growth *Class 2*
______%	______%	Global Growth *Class 2*
______%	______%	Global Small Capitalization *Class 2*
______%	______%	Growth *Class 2*
______%	______%	International *Class 2*
______%	______%	New World *Class 2*
		ClearBridge Investments, LLC
		ClearBridge
______%	______%	Small Cap Growth *Class II*
______%	______%	Variable Mid Cap *Class II*
		Fidelity Management & Research Co.
		Fidelity Variable Insurance Products
______%	______%	Contrafund® *Service Class*
______%	______%	Index 500 *Service Class*
______%	______%	Investment Grade Bond *Service Class*
______%	______%	Mid Cap *Service Class*
		Franklin Templeton Investments
		Franklin Templeton Variable Insurance
______%	______%	Franklin Flex Cap Growth VIP *Class 2*
______%	______%	Franklin Income VIP *Class 2*
______%	______%	Franklin Mutual Shares VIP *Class 2*
______%	______%	Franklin Rising Dividends VIP *Class 2*
______%	______%	Franklin Small Cap Value VIP *Class 2*
______%	______%	Franklin Small Mid Cap Growth VIP *Class 2*
______%	______%	Franklin US Government Securities VIP *Class 2*
______%	______%	Templeton Developing Markets VIP *Class 2*
______%	______%	Templeton Foreign VIP *Class 2*
______%	______%	Templeton Global Bond VIP *Class 2*
______%	______%	Templeton Growth VIP *Class 2*
		Goldman Sachs Asset Management LP
		Goldman Sachs Variable Insurance Trust
______%	______%	Core Fixed Income *Service Class*
______%	______%	Growth Opportunities *Service Class*
______%	______%	Mid Cap Value *Service Class*
______%	______%	Strategic Growth *Service Class*
______%	______%	Strategic International Equity *Service Class*

Purchase Allocation	Monthly Deduction Allocation	**Invesco V.I.** / ***Invesco Variable Insurance Funds***
______%	______%	American Value *Class II*
______%	______%	Comstock *Class I*
______%	______%	Equity and Income *Class II*
______%	______%	Global Real Estate *Class II*
______%	______%	Government Securities *Class II*
______%	______%	Growth and Income *Class I*
______%	______%	International Growth *Class II*
______%	______%	Mid Cap Growth *Class II*
______%	______%	Small Cap Equity *Class II*
		Lord, Abbett & Co. LLC
		Lord Abbett Series Fund
______%	______%	Bond Debenture
______%	______%	Calibrated Dividend Growth
______%	______%	Classic Stock
______%	______%	Fundamental Equity
______%	______%	Growth Opportunities
______%	______%	Mid Cap Stock
		OppenheimerFunds, Inc.
		Oppenheimer Variable Account Funds
______%	______%	Capital Appreciation *VA Service Shares*
______%	______%	Global *VA Service Shares*
______%	______%	Global Strategic Income *VA Service Shares*
______%	______%	Government Money *VA Service Shares*
______%	______%	Main Street *VA Service Shares*
		PIMCO Funds
		PIMCO Variable Insurance Trust
______%	______%	All Asset *Advisor Class*
______%	______%	Long-Term US Government *Advisor Class*
______%	______%	Low Duration *Advisor Class*
______%	______%	Real Return *Advisor Class*
______%	______%	Short-Term *Advisor Class*
______%	______%	Total Return *Advisor Class*
		TheRoyceFunds
		Royce Capital Fund
______%	______%	Micro-Cap *Service Class*
______%	______%	Small-Cap *Service Class*
		Protective Life General Account
______%	______%	Fixed Account
______%	______%	DCA Fixed Account (For Dollar Cost Averaging as "Source Fund" only, 12 month maximum.)
		Other
______%	______%	________________________________

TOTAL ALLOCATIONS <u>MUST</u> EQUAL 100%

12. DOLLAR COST AVERAGING

Transfer the amount indicated below:

☐ Monthly ☐ Quarterly ________ Months *(Minimum 6 Months)* ________ Day *(1-28)*

From Source Fund	Amount *(Sub-account minimum $5,000)*
______________________	$ ______________________

To Destination Fund	*Amount (Minimum $100)*
______________________	$ ______________________
______________________	$ ______________________
______________________	$ ______________________
______________________	$ ______________________
______________________	$ ______________________
______________________	$ ______________________
______________________	$ ______________________

13. PORTFOLIO REBALANCING

Rebalancing to begin on:

______/______/________ (date) (Rebalancing due date can only be days 1-28)

Rebalancing should occcur: ☐ Quarterly ☐ Semi-Annually ☐ Annually

The variable contract value will be automatically rebalanced to the current premium payment allocations. Therefore, purchases made to specific funds will also be rebalanced.

DECLARATIONS: 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. It is agreed that:

(a) All such statements and answers shall be the basis of any insurance issued.

(b) No agent or medical examiner can make, alter or discharge any contract, accept risks, or waive the Company's rights or requirements.

(c) 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 is 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 attached Temporary Life Insurance Agreement and that Agreement is delivered to the Owner, the terms of the Temporary Life Insurance Agreement shall apply.

(d) Acceptance of a policy by the Owner shall constitute ratification of any changes made by the Company under "Home Office Endorsements." 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.

AUTHORIZATION: The Proposed Insured hereby authorizes any licensed physician, medical practitioner, hospital, clinic, or other medically related facility, insurance company, the Medical Information Bureau (MIB), consumer reporting agencies (CRA) or other organization, institution or person, that has any records or knowledge of my health, to give to Protective Life Insurance Company (Protective Life), its CRA or its reinsurer any such information. A photographic copy of this authorization shall be as valid as the original. Protective Life can give information to its affiliates, MIB, consumer reporting agencies, and its reinsurers. Protective Life can also give it to persons doing services for it, or to other insurers. This is true only if it is in connection with my application and claim. Protective Life can disclose non-sensitive information to the agent representing me on this application only when it is necessary to provide an explanation of the reasons for the Company's decision to require special underwriting requirements or whenever my application cannot be approved as applied. I also hereby authorize Protective Life to draw and test my blood and urine as may be necessary to underwrite my application for insurance coverage. The tests to be performed, may include, but are not limited to, tests for cholesterol and related blood lipids, diabetes, liver or kidney disorders, the presence of antibodies to the Human Immunodeficiency Virus (HIV) that has been associated with Acquired Immune Deficiency Syndrome (AIDS). If I have been tested, diagnosed, or treated for HIV (AIDS Virus), sexually transmitted diseases, psychiatric disorders, mental health or drug and/or alcohol use, Protective Life is specifically authorized to release all health care information relating to such diagnosis, testing, or treatment. Without a court order, state or federal law to the contrary, or a written authorization by us, these blood and urine test results will be held in the strictest confidence and made known only to Protective Life, its reinsurers, MIB. Protective Life can also give these tests results to other insurers. This is true only if it is in connection with my application. This authorization shall be valid for 30 months from the date shown below, or, in the event of a claim benefits, the duration of such claim. Upon request, I or my authorized representative will be given a copy of this authorization.

Do you want to be interviewed if an investigative consumer report will be made? ☐ **Yes** ☐ **No**

Do you believe that this policy will meet your insurance needs and financial objectives? ☐ **Yes** ☐ **No**

Did you receive the prospectus for the policy applied for and the prospectus for each of the funds? ☐ **Yes** ☐ **No**

Do you understand that the amount and duration of the death benefit and the amount of policy values may vary, depending on the investment experience of the variable accounts and that additional premium may be necessary to keep the policy in force if investment experience is poor? ☐ **Yes** ☐ **No**

Are you purchasing this insurance to replace or change any inforce life insurance, annuities, long-term care insurance or health insurance policies or will the premium for this policy be funded by a withdrawal from an existing life insurance policy or annuity? ☐ **Yes** ☐ **No**

If Yes, Company(ies) ____

If life insurance or annuities, estimated transfer amount $_____________

If we are unable to issue a life insurance policy, do you wish to apply for a deferred annuity? ☐ **Yes** ☐ **No**

IMPORTANT INFORMATION ABOUT IDENTIFICATION INFORMATION

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 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 ______________________________________ (X) ____

(City and State) *Proposed Insured (Sign Name in Full)*

Date ____ (X) ____

Applicant/Owner(s) (if other than Proposed Insured)

(X) ____ (X) ____

Witness to All Signatures *Signature of Parent or Guardian (if applicable)*

If the Owner is a Corporation, Partnership or Trust, a Corporate Officer, Partner or the Trustee must sign and state title. If Joint Owner(s), both Owner(s) must sign.

REGISTERED REPRESENTATIVE REPORT

Complete for all applications and send to Home Office

1. QUESTIONS FOR REGISTERED REPRESENTATIVE TO ANSWER:

a. Is this insurance being purchased to replace or change any inforce life insurance, annuities, long-term care insurance or health insurance policies or will the premium for this policy be funded by a withdrawal from an existing life insurance policy or annuity? *If Yes, please include all required replacement forms.* ☐ Yes ☐ No
If Yes, Company(ies) ________________________________

b. I have explained to the Applicant that the policy is not effective until a policy is delivered and the initial premium payment is paid and the health and other conditions of the Proposed Insured are determined to be the same as that described in the application on the date the policy is delivered. ☐ Yes ☐ No

c. Have you complied with all relevant state requirements, including any "disclosure and comparison statements"? ☐ Yes ☐ No

d. On the basis of the Applicant's circumstances (including annual income, net worth, marital status, dependent status and current life insurance program) and their purpose for acquiring this insurance, is the purchase of this insurance suitable? Estimate of net worth $____________________ ☐ Yes ☐ No

e. Did you give an illustration to the Applicant? ☐ Yes ☐ No
(If Yes, please attach copy of the illustration.)
Note: A signed illustration is required before the policy may be put in force.

f. Have you advised the proposed policyowner or do you know of any advice that has been given to the policyowner to transfer the ownership of the policy being applied for to a life settlement company or other entity associated with stranger owned or investment owned life insurance (commonly called SOLI or IOLI) or are you otherwise aware that the policyowner may be contemplating such a transfer? If yes, please explain in the "Remarks" section of this application. ☐Yes ☐ No

g. If Proposed Insured is applying for the Long-Term Care Accelerated Death Benefit Rider, answer the following:
What other health insurance policies have you sold to the Proposed Insured?

List the policies, which you sold to the Proposed Insured, that are still in force.

List the policies, which you sold to the Proposed Insured in the past 5 years, that are no longer in force.

2. PRINT REGISTERED REPRESENTATIVE INFORMATION

	Registered Representative #1	Registered Representative #2
Name		
Signature		
Percentage		
Street Address		
City / State / Zip		
Phone Number		
Broker / Dealer		
Agent Number		

3. PROCESSING INSTRUCTIONS

a. Each Proposed Insured must be given the Description of Information Practices.
b. If cash is submitted with the application, complete and sign the Temporary Life Insurance Agreement and give to the Applicant.
c. Complete and sign any additional forms (i.e. 1035 exchange or state replacement forms, if applicable).
d. Advise the Proposed Insured that they will be contacted by a Company Representative to collect medical information and/or arrange a time for a paramedical exam, if applicable.
e. Contact your Broker Dealer to determine where to send the completed paperwork. There may be special processing procedures.

Regular Mail
Protective Life Insurance Company
[P.O. Box 830771
Birmingham, Alabama 35283-0771
FAX (205) 268-7079]

Overnight Mail
Protective Life Insurance Company
[2801 Highway 280 South
Birmingham, Alabama 35223
Telephone (205) 268-1000 (operator)]

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

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) ____________ Date ____________
(if other than Proposed Insured)

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:	**Yes**	**No**
(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? 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? If Yes, complete the "Premium Financing Disclosure" (Disclosure and Acknowledgement)	☐	☐
(3) Will a trust, including family trust, own this policy? 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? 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 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 ______________________ (State), this __________ day of ______________________ (Month), __________ (Year).

Signature(s) of Proposed Insured(s): X ______________________________ SIGN HERE

X ______________________________ SIGN HERE

Signature(s) of Owner(s)/Trustee(s): X ______________________________ SIGN HERE
(provide officer's title if policy is owned by a corporation)

X ______________________________ SIGN HERE

Signature of Witness: X ______________________________ SIGN HERE

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.

Signed at: ______________________________ (City and State)   ______________________ Date

X ______________________________ SIGN HERE
Producer Signature   ______________________ Producer Name (Print)

Protective Life
Insurance Company
2801 Highway 280 South
Birmingham, AL 35223

Long-Term Care – Third Party Designation

Do you wish to designate a second person to receive notice of lapse or termination of your long-term care rider? ☐ **YES** ☐ **NO**

(If YES, please print the name and address of the second addressee below:)

____
Name

____
Street Address

____
City State Zip Code

I understand that in connection with my application for insurance with Protective Life Insurance Company I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long-term care rider. I also understand and agree that if I chose not to designate a third person to receive notice of lapse or termination, I will have waived my right to have a third party person notified. I understand that if I do designate a third person, that I will have the right to change that person no less than once every two years.

____
Signed at (City, State)

____
Date

____
Signature of Registered Representative

____
Signature of Proposed Insured

____
Signature of Proposed Owner
(If other than Proposed Insured)

____
Registered Representative Number
(for Protective Life)

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

NOTIFICATION OF RIGHT TO NAME A SECONDARY ADDRESSEE

Under California law, 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.

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.

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

TEMPORARY LIFE INSURANCE RECEIPT

THIS RECEIPT PROVIDES A LIMITED AMOUNT OF LIFE INSURANCE COVERAGE, FOR A LIMITED PERIOD OF TIME, SUBJECT TO THE TERMS OF THIS RECEIPT.

Premium payment in the amount of $_______________ is made for Life Insurance on each person proposed for insurance. **ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO THE INSURANCE COMPANY – DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.**

QUALIFYING SCREENING QUESTIONS

	Question	Yes	No
1	Has any person proposed for insurance in this application:		
	a. within the past 90 days been admitted to a hospital or other medical facility, been advised to be admitted, or had surgery performed or recommended?	☐	☐
	b. within the past 2 years, been treated for heart trouble, stroke, or cancer, or had such treatment recommended by a physician or other practitioner?	☐	☐
2	Is any person proposed for insurance in this application under 15 days of age or over the age of 80 years (nearest birthday)?	☐	☐

If any of the above questions, including any subpart thereof, is answered YES or LEFT BLANK, no representative of Protective Life Insurance Company is authorized to accept a premium and NO COVERAGE will take effect under this Receipt. No one is authorized to accept a premium on Proposed Insureds under 15 days of age or over age 80 and NO COVERAGE will take effect under this Receipt.

TERMS AND CONDITIONS

AMOUNT OF COVERAGE — $1,000,000 OVERALL MAXIMUM FOR ALL POLICIES, APPLICATIONS, AND RECEIPTS

If a premium has been accepted by Protective Life Insurance Company for an application for Life Insurance and any person proposed for Insurance in such application dies while this temporary life receipt is in effect, Protective Life will pay, subject to the the conditions and limitations contained herein, to the beneficiary designated in such application a death benefit equal to the lesser of:

a. the amount of life insurance 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 insured's death under any other Protective Life policy, application, temporary receipt or the like, or (ii) $50,000.

In no event shall Protective Life's liability under this Receipt exceed $1,000,000. Any money received will be refunded.

DATE COVERAGE BEGINS

Temporary Life Insurance under this Receipt will begin on the date this Receipt is executed and the application has been completed.

DATE COVERAGE TERMINATES

Temporary Life Insurance under this Receipt will terminate automatically on the earlier of:

a. the date that Protective Life mails notice of termination of coverage and refund of the advance premium payment to the Applicant at the address designated in this application, or

b. the date that Protective Life approves for issue the policy applied for at the rate class and for the amount indicated in this application. In no event shall coverage be provided under this Receipt if the policy applied for has been issued.

LIMITATIONS

This receipt does not provide benefits for disability. If Temporary Life Insurance is terminated in accordance with (a) above, Protective Life's liability under this Receipt is limited to a refund of the premium payment made. If any person proposed for insurance dies by suicide, Protective Life's liability under this Receipt is limited to a refund of the payment made. There is no coverage under this Receipt if the check submitted as payment is not honored by the bank on first presentation. No one is authorized to waive or modify any of the provisions of this Receipt. COVERAGE UNDER THIS RECEIPT SHALL BE VOID IF THERE IS FRAUD OR A MATERIAL MISREPRESENTATION IN THE APPLICATION FOR LIFE INSURANCE OR IN ANY ANSWER TO THE QUALIFYING SCREENING QUESTIONS OF THIS RECEIPT.

I (WE) HAVE RECEIVED A COPY OF AND HAVE READ THIS TEMPORARY LIFE INSURANCE RECEIPT AND DECLARE THAT THE ANSWERS ARE TRUE TO THE BEST OF MY (OUR) KNOWLEDGE AND BELIEF. I (WE) UNDERSTAND AND AGREE TO ALL ITS TERMS.

Signed At ____________________________

(X) ____________________________
Proposed Insured 1 (Sign Name in Full)

Date ____________________________

(X) ____________________________
Proposed Insured 2 (Sign Name in Full)

(X) ____________________________
Witnessed by Agent

____________________________ (X)
Signature of Parent or Guardian, if Minor

____
Agent Name (Printed)

(X) ____________________________
*Applicant/Owner, if Other than Proposed Insured

____
Street Address

*If owner is Corporation, Partnership or Trust, a Corporate Officer, Partner or the Trustee must sign and state title.

____
City, State and Zip

NOTICE TO APPLICANT:

You should retain the copy of this Receipt. The original will be retained by Protective Life. If you do not hear from us regarding the insurance applied for within 100 days from the date of this Receipt, notify us at Protective Life Insurance Company, P.O. Box 830619, Birmingham, Alabama 35283-0619, Attention: Vice President, Underwriting Services.

ORIGINAL – HOME OFFICE **COPY – APPLICANT**

TEMPORARY LIFE INSURANCE RECEIPT

THIS RECEIPT PROVIDES A LIMITED AMOUNT OF LIFE INSURANCE COVERAGE, FOR A LIMITED PERIOD OF TIME, SUBJECT TO THE TERMS OF THIS RECEIPT.

Premium payment in the amount of $_______________ is made for Life Insurance on each person proposed for insurance. **ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO THE INSURANCE COMPANY – DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.**

QUALIFYING SCREENING QUESTIONS

	Question	Yes	No
1	Has any person proposed for insurance in this application:		
	a. within the past 90 days been admitted to a hospital or other medical facility, been advised to be admitted, or had surgery performed or recommended?	☐	☐
	b. within the past 2 years, been treated for heart trouble, stroke, or cancer, or had such treatment recommended by a physician or other practitioner?	☐	☐
2	Is any person proposed for insurance in this application under 15 days of age or over the age of 80 years (nearest birthday)?	☐	☐

If any of the above questions, including any subpart thereof, is answered YES or LEFT BLANK, no representative of Protective Life Insurance Company is authorized to accept a premium and NO COVERAGE will take effect under this Receipt. No one is authorized to accept a premium on Proposed Insureds under 15 days of age or over age 80 and NO COVERAGE will take effect under this Receipt.

TERMS AND CONDITIONS

AMOUNT OF COVERAGE — $1,000,000 OVERALL MAXIMUM FOR ALL POLICIES, APPLICATIONS, AND RECEIPTS

If a premium has been accepted by Protective Life Insurance Company for an application for Life Insurance and any person proposed for Insurance in such application dies while this temporary life receipt is in effect, Protective Life will pay, subject to the the conditions and limitations contained herein, to the beneficiary designated in such application a death benefit equal to the lesser of:

a. the amount of life insurance 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 insured's death under any other Protective Life policy, application, temporary receipt or the like, or (ii) $50,000.

In no event shall Protective Life's liability under this Receipt exceed $1,000,000. Any money received will be refunded.

DATE COVERAGE BEGINS

Temporary Life Insurance under this Receipt will begin on the date this Receipt is executed and the application has been completed.

DATE COVERAGE TERMINATES

Temporary Life Insurance under this Receipt will terminate automatically on the earlier of:

a. the date that Protective Life mails notice of termination of coverage and refund of the advance premium payment to the Applicant at the address designated in this application, or
b. the date that Protective Life approves for issue the policy applied for at the rate class and for the amount indicated in this application. In no event shall coverage be provided under this Receipt if the policy applied for has been issued.

LIMITATIONS

This receipt does not provide benefits for disability. If Temporary Life Insurance is terminated in accordance with (a) above, Protective Life's liability under this Receipt is limited to a refund of the premium payment made. If any person proposed for insurance dies by suicide, Protective Life's liability under this Receipt is limited to a refund of the payment made. There is no coverage under this Receipt if the check submitted as payment is not honored by the bank on first presentation. No one is authorized to waive or modify any of the provisions of this Receipt. COVERAGE UNDER THIS RECEIPT SHALL BE VOID IF THERE IS FRAUD OR A MATERIAL MISREPRESENTATION IN THE APPLICATION FOR LIFE INSURANCE OR IN ANY ANSWER TO THE QUALIFYING SCREENING QUESTIONS OF THIS RECEIPT.

I (WE) HAVE RECEIVED A COPY OF AND HAVE READ THIS TEMPORARY LIFE INSURANCE RECEIPT AND DECLARE THAT THE ANSWERS ARE TRUE TO THE BEST OF MY (OUR) KNOWLEDGE AND BELIEF. I (WE) UNDERSTAND AND AGREE TO ALL ITS TERMS.

Signed At ____________________________ (X) ____________________________
Proposed Insured 1 (Sign Name in Full)

Date ____________________________ (X) ____________________________
Proposed Insured 2 (Sign Name in Full)

(X) ____________________________
Witnessed by Agent

____________________________ (X)
Signature of Parent or Guardian, if Minor

____
Agent Name (Printed)

(X) ____________________________
*Applicant/Owner, if Other than Proposed Insured

____
Street Address

*If owner is Corporation, Partnership or Trust, a Corporate Officer, Partner or the Trustee must sign and state title.

____
City, State and Zip

NOTICE TO APPLICANT:

You should retain the copy of this Receipt. The original will be retained by Protective Life. If you do not hear from us regarding the insurance applied for within 100 days from the date of this Receipt, notify us at Protective Life Insurance Company, P.O. Box 830619, Birmingham, Alabama 35283-0619, Attention: Vice President, Underwriting Services.

ORIGINAL – HOME OFFICE **COPY – APPLICANT**

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

INDIVIDUAL LIFE INSURANCE – PART 1A SUPPLEMENTAL APPLICATION – MEDICAL DECLARATIONS

SECTION 1

Proposed Insured 1		
Name (First, Middle, Last)		
Height	*Weight*	☐ *Gain* ☐ *Loss* *Pounds in past year?*
Reason for Weight Gain or Loss		
Currently pregnant ☐ *Yes* ☐ *No* *If "Yes," anticipated delivery date*		

Proposed Insured 2		
Name (First, Middle, Last)		
Height	*Weight*	☐ *Gain* ☐ *Loss* *Pounds in past year?*
Reason for Weight Gain or Loss		
Currently pregnant ☐ *Yes* ☐ *No* *If "Yes," anticipated delivery date*		

Please use the Continuation of Information form if additional space is needed for details listed below.

SECTION 2

Has any person proposed for insurance ever been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for a disease or disorder such as : (**Circle** conditions to which "Yes" answer applies and give details below)	**Proposed Insured 1** Yes No	**Proposed Insured 2** Yes No
(a) Any disorder or disease of the **brain or nervous system** (such as paralysis, epilepsy, stroke, convulsions, chronic headache)........	☐ ☐	☐ ☐
(b) Any disorder or disease of the **heart, blood vessels, or circulatory system** (such as high blood pressure, heart attack, heart murmur, chest pain)........	☐ ☐	☐ ☐
(c) Any disorder or disease of the **respiratory system** (such as Asthma, bronchitis, emphysema, tuberculosis).........	☐ ☐	☐ ☐
(d) Any disorder or disease of the **stomach, liver, intestines, rectum, pancreas, or abdominal organs**................	☐ ☐	☐ ☐
(e) Any disorder or disease of the **genitourinary organs** (such as kidneys, urinary tract, blood or sugar in the urine, chronic inflammation)........	☐ ☐	☐ ☐
(f) Any disorder or disease of the **skeletal system** (such as arthritis, osteoporosis, joints, bones, spine, muscles)......	☐ ☐	☐ ☐
(g) Any disorder or disease of **eyes, ears, nose or throat**........	☐ ☐	☐ ☐
(h) Any disorder or disease of the **blood, skin, thyroid, lymph or other glands** (such as anemia, diabetes)............	☐ ☐	☐ ☐
(i) Any **psychiatric or mental health** disorders or diseases (such as attempted suicide, Bipolar, Obsessive-compulsive)........	☐ ☐	☐ ☐
(j) Any **gynecological** disorders or diseases (such as irregular Pap Smear, Toxic Shock Syndrome)......................	☐ ☐	☐ ☐
(k) Any **cancer, tumor, cyst or nodule**........	☐ ☐	☐ ☐
(l) Any **sexually transmitted** disorders or diseases........	☐ ☐	☐ ☐
(m) Any disorders or diseases of the **immune system** *except those related to the Human Immunodeficiency Virus (AIDS Virus)*........	☐ ☐	☐ ☐

Please provide details for any/all "Yes" responses.

	Question Number	Date of Diagnosis	Diagnosis, Medication or Treatment Prescribed	Medical Professional or Facility
Proposed Insured 1				
Proposed Insured 2				

SECTION 3

Has any person proposed for insurance ever been diagnosed or treated by a member of the medical profession for specified symptoms such as: (**Circle** conditions to which "Yes" answer applies and give details below)	**Proposed Insured 1** Yes No	**Proposed Insured 2** Yes No
(a) 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…………………………………..	☐ ☐	☐ ☐
(b) Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS)………..……………	☐ ☐	☐ ☐

Please provide details for any/all "Yes" responses.

	Question Number	Date of Diagnosis	Diagnosis, Medication or Treatment Prescribed	Medical Professional or Facility
Proposed Insured 1				
Proposed Insured 2				

SECTION 4

Has any person proposed for insurance ever (**Circle** conditions to which "Yes" answer applies and give details below)	**Proposed Insured 1** Yes No	**Proposed Insured 2** Yes No
(a) Used narcotics, barbiturates, amphetamines, hallucinogens, marijuana, heroin, cocaine, or other habit forming drugs, except as prescribed by a physician…………………………………………………………………………………	☐ ☐	☐ ☐
(b) Received medical treatment or counseling for, or been advised by a physician to discontinue, the use of alcohol or prescribed or non-prescribed drugs…………………………………………………………………………………………….	☐ ☐	☐ ☐
(c) Been a member of any self-help group such as Alcoholics Anonymous or Narcotics Anonymous……………………..	☐ ☐	☐ ☐

Please provide details for any/all "Yes" responses.

	Question Number	Date of Diagnosis	Diagnosis, Medication or Treatment Prescribed	Medical Professional or Facility
Proposed Insured 1				
Proposed Insured 2				

SECTION 5

The following questions in Section 5 do not include answers related to the Human Immunodeficiency Virus (AIDS virus) or for minor viruses, injuries, common colds that prevented normal activities for a period of less than five (5) days. Within the past five (5) years, has any person proposed for insurance (**Circle** items or conditions to which "Yes" answer applies and give details below)	**Proposed Insured 1** Yes No	**Proposed Insured 2** Yes No
(a) Been treated, examined or advised by a member of the medical profession for any condition other than stated above……..	☐ ☐	☐ ☐
(b) Been advised by a member of the medical profession to get specified medical care which has not been completed, such as any hospitalization, surgery or diagnostic test………………………………………………………………………..	☐ ☐	☐ ☐
(c) Been an inpatient or outpatient in a hospital, clinic, medical facility, or any similar entity…………………………………	☐ ☐	☐ ☐
(d) Had any diagnostic tests such as: an electrocardiogram (EKG), MRI, CT-Scan or X-ray…………………………………	☐ ☐	☐ ☐
(e) Been on, or advised to be on any prescribed, non-prescribed (over the counter) medication or prescribed diet………	☐ ☐	☐ ☐
(f) Been unable to work, attend school or perform normal activities of life age and gender or been confined at home…...	☐ ☐	☐ ☐
(g) Has made a claim for or received benefits, compensation or pension for any injury, sickness, disability or impaired condition…….	☐ ☐	☐ ☐

Please provide details for any/all "Yes" responses.

	Question Number	Date of Diagnosis	Diagnosis, Medication or Treatment Prescribed	Medical Professional or Facility
Proposed Insured 1				
Proposed Insured 2				

SECTION 6

For the following Family Medical History question, please provide in section number 8 below for each parent or sibling: diagnosis, age of diagnosis, date last treated, age – if still alive and if not alive, age, date, and cause of death.	Proposed Insured 1 Yes No	Proposed Insured 2 Yes No
Has any person proposed for insurance had a parent or sibling diagnosed or treated by a member of the medical profession for certain conditions, such as heart or vascular disease, cancer, diabetes, high blood pressure, kidney disease, attempted suicide or mental illness…………	☐ ☐	☐ ☐

Please provide details for any/all "Yes" responses.

	Family Member	Age of Diagnosis	Diagnosis	Date Last Treated	Age – if still alive and if not alive, age, date, and cause of death.
Proposed Insured 1					
Proposed Insured 2					

SECTION 7

Name, Address and Phone Number of Personal Physician or Medical Facility that is consulted for routine health care or periodic check-ups.	
Proposed Insured 1	Name:
	Address:
	Phone Number:
	Date and Reason of last consult:
	Name:
	Address:
	Phone Number:
	Date and Reason of last consult:
Proposed Insured 2	Name:
	Address:
	Phone Number:
	Date and Reason of last consult:
	Name:
	Address:
	Phone Number:
	Date and Reason of last consult:

Please use the Continuation of Information form if additional space is needed for details listed above.

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 ______

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

NOTICE TO APPLICANTS AGED 65 OR OLDER

The sale or liquidation of any stock, bond, IRA, certificate of deposit, mutual fund, annuity or other asset to fund the purchase of this life insurance product may have tax consequences, early withdrawal penalties, or others costs or penalties as a result of the sale or liquidation. You may wish to consult your independent legal or financial advisor prior to selling or liquidating any assets and prior to the purchase of any life or annuity products being solicited, offered for sale or sold.

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

Written Notice to California Seniors Aged 65 or Over

This notice must be delivered by the Insurance Representative to the Senior no less than 24 hours prior to the initial meeting in the Senior's home. If the Senior has an existing insurance relationship with the Insurance Representative and requests a meeting with the Senior in the Senior's home the same day, a notice shall be delivered to the Senior prior to the meeting.

Please insert the appropriate information below. If a Protective Life application is taken, one signed and completed copy of this form should be returned to the Protective Life Home Office with the application packet and one signed and completed copy of this form should be maintained by the Senior.

(1) During this visit or a follow-up visit, you will be given a sales presentation on the following (indicate all that apply):

( ) Life Insurance

( ) Other Insurance products (specify):______________________________

(2) You have the right to have other persons present at the meeting, including family members, financial advisors or attorneys.

(3) You have the right to end the meeting at any time.

(4) You have the right to contact the Department of Insurance for information, or to file a complaint. (800) 927-HELP (4357)

(5) The following individuals will be coming to your home: (list all attendees, and insurance license information, if applicable):

Signature of Insurance Representative: ____________________ Date: ________

Protective Life Agent Number: ____

Signature of Senior (Proposed Insured 1): _____________________________

Signature of Senior (Proposed Insured 2): _____________________________

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

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

1. This authorization to obtain and disclose information complies with HIPAA regulations as they relate to life insurance. I (we) authorize Protective Life Insurance Company (Protective Life) and its reinsurers to obtain directly through designated third parties and use any information about or relating to me (us) that may affect my (our) insurability. Protective Life and its reinsurers may obtain and use health and medical information to include all dates of service, including but not limited to information about chart notes, EKG's, drug use, alcohol use, nicotine use, physical and mental diseases and illness, and psychiatric disorders. Protective Life and its reinsurers may also obtain and use non-health and non-medical information, including but not limited to financial information, credit reports, consumer reports, driving record, criminal record, and information about avocations and aviation activity. All of this information may be used to evaluate an application for insurance, a claim for insurance benefits, or both. Information relating to communicable diseases and other risk factors relating to me or to my spouse or life partner may be used to evaluate an application for insurance on either me or my spouse or life partner. The Protective Life sales agent or regional sales office representing me on my (our) application for insurance may obtain the information described in this paragraph directly from any of the persons or organizations listed in paragraph 2 in order to expedite the delivery of the information to Protective Life.

2. I (we) authorize the following persons and organizations to release and disclose the information described in paragraph 1 to Protective Life, directly through designated third parties or its agents acting on its behalf; (i) my (our) doctor(s); (ii) medical practitioners; (iii) pharmacists and Pharmacy Benefit Managers; (iv) 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; (v) insurers; (vi) reinsurers; (vii) MIB, Inc. (**MIB**); (viii) my (our) current and previous employers; and (ix) 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 paragraph 1 to a **CRA**.

3. I (we) authorize Protective Life to draw and test my (our) blood, and/or oral fluids, and urine as may be necessary to obtain information to be used to underwrite my (our) application for insurance. These tests may include, but are not limited to, tests for cholesterol and related blood lipids, diabetes, liver or kidney disorders, immune disorders (other than HIV/AIDS; reference number 7 below), and 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.

4. I (we) authorize Protective Life to release and disclose the information described in paragraphs 1 and 3 to its affiliates, its reinsurers, persons or organizations providing services relating to insurance underwriting for Protective Life, **MIB**, and as otherwise required by law. I (we) authorize Protective Life to release and disclose the information described in paragraphs 1 and 3 to other duly licensed life insurers if I (we) have applied or apply to the other insurers for insurance. I (we) authorize Protective Life Insurance Company, or its reinsurers, to make a brief report of my personal health information to **MIB**.

5. I (we) authorize Protective Life to release and disclose the information described in paragraphs 1 and 3 to the Agent and their Representative 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.

6. I (we) authorize Protective Life to release and disclose the information described in paragraphs 1 and 3 to the sales agent representing me on my (our) application for insurance if it is necessary to provide an explanation of the reasons for Protective Life's decision to impose special underwriting requirements, whenever my application cannot be approved as submitted, or in connection with a claim for benefits.

7. **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 me (us) to authorize that testing separately. I (we) hereby authorize Protective Life to obtain and use the results of any HIV tests that I (we) separately authorize, and if permitted by law, to disclose the results of those tests to its reinsurers and **MIB**.

8. This authorization shall be valid for 24 months from the Date of Authorization shown below or, in the event of a claim for benefits, for the duration of such claim.

Home Office - ORIGINAL Applicant - COPY

9. During the evaluation of my (our) insurance application, I (we) understand that I (we) have the right to revoke the authorizations in paragraphs 1 through 7 by writing to Protective Life at P.O. Box 830619 • Birmingham, AL 35283-0619. If this authorization is revoked, this would result in the file being closed and no coverage provided.

10. I understand I do not have to sign this authorization in order to obtain **health care benefits (treatment, payment or enrollment).**

11. I (we) understand that information about me (us) may be disclosed under this authorization to persons or organizations that are not subject to the Health Insurance Portability and Accountability Act **(HIPAA)** and that the information would then no longer be protected by **HIPAA** and any related regulations.

12. *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.*

13. ☐ I (we) have been given a copy of this authorization form and Protective Life's Description of Information Practices.

    ☐ I (we) would like to be interviewed if an investigative consumer report will be made. *(Please check if you wish to be interviewed.)*

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

Proposed Insured 1 (Signature)	Date of Birth	**Date of Authorization:** ______________ When applicable, print name(s) of minor(s) below:
Print Name (Proposed Insured 1)	Social Security #	
Proposed Insured 2 (Signature)	Date of Birth	
Print Name (Proposed Insured 2)	Social Security #	**Health Care Provider**
Parent or Legal Guardian (Signature)		Physician Name
		Physician Name

Home Office - ORIGINAL Applicant - COPY

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

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

1. This authorization to obtain and disclose information complies with HIPAA regulations as they relate to life insurance. I (we) authorize Protective Life Insurance Company (Protective Life) and its reinsurers to obtain directly through designated third parties and use any information about or relating to me (us) that may affect my (our) insurability. Protective Life and its reinsurers may obtain and use health and medical information to include all dates of service, including but not limited to information about chart notes, EKG's, drug use, alcohol use, nicotine use, physical and mental diseases and illness, and psychiatric disorders. Protective Life and its reinsurers may also obtain and use non-health and non-medical information, including but not limited to financial information, credit reports, consumer reports, driving record, criminal record, and information about avocations and aviation activity. All of this information may be used to evaluate an application for insurance, a claim for insurance benefits, or both. Information relating to communicable diseases and other risk factors relating to me or to my spouse or life partner may be used to evaluate an application for insurance on either me or my spouse or life partner. The Protective Life sales agent or regional sales office representing me on my (our) application for insurance may obtain the information described in this paragraph directly from any of the persons or organizations listed in paragraph 2 in order to expedite the delivery of the information to Protective Life.

2. I (we) authorize the following persons and organizations to release and disclose the information described in paragraph 1 to Protective Life, directly through designated third parties or its agents acting on its behalf; (i) my (our) doctor(s); (ii) medical practitioners; (iii) pharmacists and Pharmacy Benefit Managers; (iv) 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; (v) insurers; (vi) reinsurers; (vii) MIB, Inc. (**MIB**); (viii) my (our) current and previous employers; and (ix) 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 paragraph 1 to a **CRA**.

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4. I (we) authorize Protective Life to release and disclose the information described in paragraphs 1 and 3 to its affiliates, its reinsurers, persons or organizations providing services relating to insurance underwriting for Protective Life, **MIB**, and as otherwise required by law. I (we) authorize Protective Life to release and disclose the information described in paragraphs 1 and 3 to other duly licensed life insurers if I (we) have applied or apply to the other insurers for insurance. I (we) authorize Protective Life Insurance Company, or its reinsurers, to make a brief report of my personal health information to **MIB**.

5. I (we) authorize Protective Life to release and disclose the information described in paragraphs 1 and 3 to the Agent and their Representative 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.

6. I (we) authorize Protective Life to release and disclose the information described in paragraphs 1 and 3 to the sales agent representing me on my (our) application for insurance if it is necessary to provide an explanation of the reasons for Protective Life's decision to impose special underwriting requirements, whenever my application cannot be approved as submitted, or in connection with a claim for benefits.

7. **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 me (us) to authorize that testing separately. I (we) hereby authorize Protective Life to obtain and use the results of any HIV tests that I (we) separately authorize, and if permitted by law, to disclose the results of those tests to its reinsurers and **MIB**.

8. This authorization shall be valid for 24 months from the Date of Authorization shown below or, in the event of a claim for benefits, for the duration of such claim.

Home Office - ORIGINAL Applicant - COPY

9. During the evaluation of my (our) insurance application, I (we) understand that I (we) have the right to revoke the authorizations in paragraphs 1 through 7 by writing to Protective Life at P.O. Box 830619 • Birmingham, AL 35283-0619. If this authorization is revoked, this would result in the file being closed and no coverage provided.

10. I understand I do not have to sign this authorization in order to obtain **health care benefits (treatment, payment or enrollment).**

11. I (we) understand that information about me (us) may be disclosed under this authorization to persons or organizations that are not subject to the Health Insurance Portability and Accountability Act **(HIPAA)** and that the information would then no longer be protected by **HIPAA** and any related regulations.

12. *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.*

13. ❐ I (we) have been given a copy of this authorization form and Protective Life's Description of Information Practices.

    ❐ I (we) would like to be interviewed if an investigative consumer report will be made. *(Please check if you wish to be interviewed.)*

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

Proposed Insured 1 (Signature)	Date of Birth	**Date of Authorization:** ____________ When applicable, print name(s) of minor(s) below:
Print Name (Proposed Insured 1)	Social Security #	
Proposed Insured 2 (Signature)	Date of Birth	
Print Name (Proposed Insured 2)	Social Security #	**Health Care Provider**
Parent or Legal Guardian (Signature)		Physician Name
		Physician Name

Home Office - ORIGINAL Applicant - COPY

P.O. Box 830771 • Birmingham, Alabama 35283-0771

NOTICE AND CONSENT FOR AIDS-RELATED TESTING

To evaluate your insurability, the Insurer named above, Protective Life Insurance Company, has requested that you provide a sample of your blood, urine, or saliva for testing and analysis to determine the presence of human immunodeficiency virus (HIV) antibodies. By signing and dating this form you agree that this test may be done and that underwriting decisions will be based on the test result. A series of three tests will be performed by a licensed laboratory through a medically accepted procedure.

Pre-Testing Considerations

Many public health organizations have recommended that before taking an AIDS-related test a person seek counseling to become informed concerning the implications of such a test. You may wish to consider counseling, at your expense, prior to being tested.

Meaning of Positive Test Result

The test is not a test for AIDS. It is a test for antibodies to the HIV virus, the causative agent for AIDS, and shows whether you have been exposed to the virus. A positive test result does not mean that you have AIDS but that you are at significantly increased risk of developing problems with your immune system. The test for HIV antibodies is very sensitive. Errors are rare, but they do occur. Your private physician, a public health clinic, or an AIDS information organization in your city might provide you with further information on the medical implications of a positive test.

Positive HIV antibody test results will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged, or that other policy changes may be necessary.

Confidentiality of Test Results

All test results are required to be treated confidentially. They will be reported by the laboratory to the Insurer. The test results may be disclosed as required by law or may be disclosed to employees of the Insurer who have the responsibility to make underwriting decisions on behalf of the Insurer or to outside legal counsel who needs such information to effectively represent the Insurer in regard to your application. The results may be disclosed to a reinsurer, if the reinsurer is involved in the underwriting process. The test may be released to an insurance medical information exchange under procedures that are designed to assure confidentiality, including the use of general codes that also cover results of tests for other diseases or conditions not related to AIDS, or for the preparation of statistical reports that do not disclose the identity of any particular person.

Notification of Test Result

If your test results are negative, no routine notification will be sent to you. If your test results are reported by the laboratory to the Insurer as being positive, you are entitled to that information if you so desire. Because a trained person should deliver that information so that you can understand clearly what the test result means, you are asked to list your private physician so that the Insurer can have him or her tell you the test result and explain its meaning.

Name of physician for reporting a possible positive test result: ______________________________

Address: ____

If you do not wish to know the results of the test, initial here: ________ In the event the test is positive and you are denied coverage because of that fact and you request the reason for the denial, the insurer may require you to name a physician at that time in order to receive the information.

If you want to know the results of the test but do not at present have a private physician, Initial here: ________________
The result will be sent to you at the address provided by registered mail with delivery restricted to you only.

Consent

I have read and I understand this Notice and consent for AIDS-Related Testing. I voluntarily consent to the withdrawal of blood, urine, or saliva from me, the testing of that blood, urine, or saliva, and the disclosure of the test results as described above. I have read the information on this form about what a test result means and understand that I should contact a local AIDS service group or my private physician for further information and counseling if the test result is positive.

I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

____
Signature of Proposed Insured or Parent/Guardian

Date Signed: ______________________________

____
Name of Proposed Insured

____
Address

PROTECTIVE LIFE INSURANCE COMPANY
P.O. Box 830619
Birmingham, Alabama 35283-0619
Telephone: (205) 879-9230

NOTICE REGARDING REPLACEMENT

REPLACING YOUR LIFE INSURANCE POLICY 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 company or agent 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 your policy.

You are urged not to take action to terminate, assign or alter your existing policy until your new policy has been issued and you have examined it and found it acceptable.

____________________ __________ ____________________

Applicant's Signature Date Agent's Signature

* *

POLICY INFORMATION SHEET FOR EXISTING INSURANCE

Name of Applicant ____________________ D.O.B. ____________

Address ____

Proposed Insured if other than Applicant __________________________

Application Number of Proposed Insurance __________________________

The following policy(ies) may be replaced as a result of this transaction:

POLICY INFORMATION

Insurer ____________________

Policy Generic Name ____________

Policy Number ________________

POLICY INFORMATION

Insurer ____________________

Policy Generic Name ____________

Policy Number ________________

POLICY INFORMATION

Insurer ____________________

Policy Generic Name ____________

Policy Number ________________

POLICY INFORMATION

Insurer ____________________

Policy Generic Name ____________

Policy Number ________________

PROTECTIVE LIFE INSURANCE COMPANY
P.O. Box 830619
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We are required by law to notify your existing company that you may be replacing your policy.

You are urged not to take action to terminate, assign or alter your existing policy until your new policy has been issued and you have examined it and found it acceptable.

______________________________ ____________ ______________________________

Applicant's Signature Date Agent's Signature

* *

POLICY INFORMATION SHEET FOR EXISTING INSURANCE

Name of Applicant ______________________________ D.O.B. ____________________

Address ____

Proposed Insured if other than Applicant ________________________________

Application Number of Proposed Insurance _______________________________

The following policy(ies) may be replaced as a result of this transaction:

POLICY INFORMATION

Insurer ______________________________

Policy Generic Name ____________________

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Insurer ______________________________

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Policy Number _________________________

POLICY INFORMATION

Insurer ______________________________

Policy Generic Name ____________________

Policy Number _________________________

POLICY INFORMATION

Insurer ______________________________

Policy Generic Name ____________________

Policy Number _________________________

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

ASSIGNMENT/TRANSFER OF OWNERSHIP SECTION 1035 EXCHANGE

INSURED: ______________________________

OWNER: ______________________________

INSURER:
(Provide Name of Existing Insurance Company with Street Address, City, State and Zip Code) ______________________________

POLICY NUMBER(S): ______________________________

ESTIMATED VALUE: $______________________________

PHONE NUMBER(S): ______________________________

For value received, I hereby assign and transfer to Protective Life Insurance Company ("Protective Life") all right, title, and interest to the above listed policy(ies) in an exchange intended to qualify under Section 1035 of the Internal Revenue Code. However, this assignment and all other terms and agreements set forth below are conditioned upon Protective Life's underwriting and approving a new life insurance policy on the life of the Insured(s) named above. This conditional assignment will not become effective unless and until Protective Life approves a new life insurance policy.

I understand that if Protective Life approves a new life insurance policy on the life of the Insured(s) named above, then Protective Life will surrender the assigned policy(ies) and it/they will no longer be in force or effect as of the date of surrender. I further understand that, if Protective Life approves the new life insurance policy, Protective Life will collect whatever cash surrender values are available from the existing insurance company on the assigned policy(ies) and apply such amount received as premium on the new life insurance policy. I understand that the cash surrender value of the policy on the actual date of surrender is likely to be different from the cash surrender value of the policy today. This is especially true if the policy to be surrendered is a variable policy, since the cash surrender value of a variable policy fluctuates with the market. I agree that Protective Life assumes no responsibility if the full scheduled cash surrender values of the assigned policy(ies) are not received.

I certify that the above listed policy(ies) is/are currently in force and not subject to any prior assignments, any legal or equitable claims, or liens. I further certify that there is no proceeding in bankruptcy pending against me.

I hereby designate Protective Life as beneficiary of the above listed policy(ies) to the extent of the cash surrender value thereof at the date of death of the Insured(s) named above. All other beneficiary designations under the above listed policy(ies) will remain in effect. **I FURTHER UNDERSTAND THAT THE POLICY(IES) TO BE ISSUED BY PROTECTIVE LIFE WILL HAVE THE SAME DESIGNATED INSURED(S) AND OWNER(S) AS THE ABOVE LISTED POLICY(IES).**

I certify that if the above listed policy(ies) is/are not attached to this conditional assignment that it/they has/have been lost or destroyed. I hereby waive all rights and benefits under such policy(ies) and agree to return it/them to you if it/they comes/come into my possession.

I understand and agree that I will be responsible for keeping the above listed policy(ies) in force by paying any premiums as they become due until such time as Protective Life notifies me in writing that I have been issued a new life insurance policy.

I understand that under Section 1035, reporting may be required for federal income tax purposes. The replaced company is required to report all exchanges of insurance contracts on Form 1099-R, including tax-free exchanges under Section 1035 in situations in which a policyholder has an outstanding policy loan at the time of exchange. If there is an outstanding policy loan at the time of the exchange, the transaction may not be characterized as tax-free. In fact, any gain will be taxed to the extent of the outstanding policy loan. Accordingly, I understand that it is advisable when filing my individual federal income tax return that I enclose a copy of the reporting form (Form 1099-R) with an explanation that the policy was exchanged pursuant to Section 1035 or otherwise and that Protective Life has no responsibility for the validity of this Assignment.

Check One: ☐ I have enclosed the policy(ies). ☐ I certify that the policy(ies) has/have been lost or destroyed. After due search and inquiry, to the best of my knowledge, it/they is/are not in the possession or control of any other person.

Insured(s) Signatures(s)	Witness	Date
*Spouse Signature *(For Community Property States Only)*	Witness	Date
Owner Signature	Witness	Date
Owner Signature	Witness	Date
Collateral Assignee/Irrevocable Beneficiary Signature, if any	Witness	Date

(If the Owner resides in the Community Property states of AZ, CA, ID, LA, NM, NV, TX, WA or WI we recommend that the Owner's spouse also sign this form. Signatures must be witnessed by a disinterested party of legal age.)*

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

ASSIGNMENT/TRANSFER OF OWNERSHIP SECTION 1035 EXCHANGE

INSURED: ____________________

OWNER: ____________________

INSURER:
(Provide Name of Existing Insurance Company with Street Address, City, State and Zip Code) ____________________

POLICY NUMBER(S): ____________________

ESTIMATED VALUE: $____________________

PHONE NUMBER(S): ____________________

For value received, I hereby assign and transfer to Protective Life Insurance Company ("Protective Life") all right, title, and interest to the above listed policy(ies) in an exchange intended to qualify under Section 1035 of the Internal Revenue Code. However, this assignment and all other terms and agreements set forth below are conditioned upon Protective Life's underwriting and approving a new life insurance policy on the life of the Insured(s) named above. This conditional assignment will not become effective unless and until Protective Life approves a new life insurance policy.

I understand that if Protective Life approves a new life insurance policy on the life of the Insured(s) named above, then Protective Life will surrender the assigned policy(ies) and it/they will no longer be in force or effect as of the date of surrender. I further understand that, if Protective Life approves the new life insurance policy, Protective Life will collect whatever cash surrender values are available from the existing insurance company on the assigned policy(ies) and apply such amount received as premium on the new life insurance policy. I understand that the cash surrender value of the policy on the actual date of surrender is likely to be different from the cash surrender value of the policy today. This is especially true if the policy to be surrendered is a variable policy, since the cash surrender value of a variable policy fluctuates with the market. I agree that Protective Life assumes no responsibility if the full scheduled cash surrender values of the assigned policy(ies) are not received.

I certify that the above listed policy(ies) is/are currently in force and not subject to any prior assignments, any legal or equitable claims, or liens. I further certify that there is no proceeding in bankruptcy pending against me.

I hereby designate Protective Life as beneficiary of the above listed policy(ies) to the extent of the cash surrender value thereof at the date of death of the Insured(s) named above. All other beneficiary designations under the above listed policy(ies) will remain in effect. **I FURTHER UNDERSTAND THAT THE POLICY(IES) TO BE ISSUED BY PROTECTIVE LIFE WILL HAVE THE SAME DESIGNATED INSURED(S) AND OWNER(S) AS THE ABOVE LISTED POLICY(IES).**

I certify that if the above listed policy(ies) is/are not attached to this conditional assignment that it/they has/have been lost or destroyed. I hereby waive all rights and benefits under such policy(ies) and agree to return it/them to you if it/they comes/come into my possession.

I understand and agree that I will be responsible for keeping the above listed policy(ies) in force by paying any premiums as they become due until such time as Protective Life notifies me in writing that I have been issued a new life insurance policy.

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Check One: ☐ I have enclosed the policy(ies). ☐ I certify that the policy(ies) has/have been lost or destroyed. After due search and inquiry, to the best of my knowledge, it/they is/are not in the possession or control of any other person.

Insured(s) Signatures(s)	Witness	Date
*Spouse Signature *(For Community Property States Only)*	Witness	Date
Owner Signature	Witness	Date
Owner Signature	Witness	Date
Collateral Assignee/Irrevocable Beneficiary Signature, if any	Witness	Date

(If the Owner resides in the Community Property states of AZ, CA, ID, LA, NM, NV, TX, WA or WI we recommend that the Owner's spouse also sign this form. Signatures must be witnessed by a disinterested party of legal age.)*

Taxpayer Identification Number and Certification

Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

Business name/disregarded entity name, if different from above

Check appropriate box for federal tax classification; check only **one** of the following seven boxes:

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ▶ _______

Note. For a single-member LLC that is disregarded, do not check LLC; check the appropriate box in the line above for the tax classification of the single-member owner.

☐ Other ▶

Exemptions (codes apply only to certain entitles, not individuals):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _______________

(Applies to accounts maintained outside the U.S.)

Address (number, street, and apt, or suite no.)

Requester's name and address (optional)

City, State, and ZIP code

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on the "Name" line to avoid backup withholding. For individuals, this is your social security (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3 of the W-9 instructions at website listed below. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3 of W-9 instructions at website listed below.

Note. If the account is in more than one name, see the chart on page 4 of W-9 instructions for guidelines on whose number to enter.

Social security number

			-			-				

Employer identification number

		-							

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or) I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. citizen or other U.S. person , and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN.

Sign Here Signature of U.S. person ▶ Date ▶

IMPORTANT – if any part of the payment made to you could be subject to backup withholding and we do not receive this completed form, we will do backup withholding of 28% on those amounts.

IRS W-9 form instructions can be used for clarification in completing this form. See www.irs.gov/pub/irs-pdf/fw9.pdf