

PROTECTIVE LIFE INSURANCE COMPANY

P.O. Box 830771

Birmingham, AL 35283-0771

VARIABLE UNIVERSAL LIFE INSURANCE APPLICATION - RIDER WORKSHEET

Required if applying for additional benefits or riders.

New Business

Protective Policy Change from Policy: _____

Print Proposed/Primary Insured's Name

Proposed/Primary Insured's Social Security Number

*If applying for Child Rider, Income Provider Option Endorsement or Chronic Illness Accelerated Death Benefit Rider - ExtendCare please complete the rider specific supplemental application(s).

1. ADDITIONAL BENEFITS

- | | |
|---|--|
| <input type="checkbox"/> Accidental Death Benefit Rider \$ _____
<i>(Range \$10,000 - \$250,000)</i> | <input type="checkbox"/> Flexible Coverage Rider \$ _____ |
| <input type="checkbox"/> *Child Rider | <input type="checkbox"/> *Income Provider Option Endorsement |
| <input type="checkbox"/> *Chronic Illness Accelerated Death Benefit - ExtendCare Rider
Maximum Monthly Benefit Amount \$ _____
Elimination Period <i>(Number of Days)</i> _____ | <input type="checkbox"/> Lapse Protection Rider <i>(Preserver II and Premier III Only)</i> |
| <input type="checkbox"/> Waiver of Specified Premium <i>(Not available on Preserver II)</i>
Monthly Benefit Amount \$ _____ | <input type="checkbox"/> Protected Insurability Rider \$ _____ |

2. COVERED INSURED RIDER "CIR" *(Available on certain Universal Life Plans only)*

Name:	_____	_____	_____
Relationship to Primary Proposed Insured:	_____	_____	_____
Gender:	_____	_____	_____
Date of Birth:	_____	_____	_____
Birth State:	_____	_____	_____
Social Security Number:	_____	_____	_____
Amount:	_____	_____	_____
Beneficiary Name:	_____	_____	_____
Beneficiary Relationship to Primary Proposed Insured:	_____	_____	_____
Beneficiary Social Security No:	_____	_____	_____
Beneficiary Percentage:	_____	_____	_____

WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Signed at: _____ (City and State) _____ (Date).

Signature of Owner

Signature of CIR

Signature of Proposed/Primary Insured

Signature of CIR

Signature of Parent or Guardian

Witness to All Signatures