Protective
Life Insurance Company

BROKERAGE LIFE INSURANCE APPLICATION PACKET

Includes:

- **Cover Page and Instructions**
- **Description of Information Practices**
  (Must be given to every Applicant)
- **Application**
- **Broker/Representative Report**
- **Part 1A-Supplemental Application (Non-Medical Declarations)**
- **Rider Worksheet**
- **Continuation of Information for Part I (Non-Medical) and Part II (Medical)**
- **Supplement to Life Insurance Application (Premium Financing)**
- **Temporary Life Insurance Receipt**
- **Pre-Authorized Withdrawal Agreement**
- **Replacement Form**
  (Must be provided to Proposed Insured if there is <u>any</u> existing insurance)
- **Assignment/Transfer of Ownership (Section 1035 Exchange)**
- **Authorization to Obtain and Disclose Information (HIPAA)**
  (Must be given to every Applicant)
- **HIV Consent**
- **Written Notice to California Seniors Aged 65 and Over**
- **Notice to Applicants Aged 65 and Older**
- **Confidential Financial Statement**

For Use in California Only
PLB-300-TLR (2/11)

Application Instructions

NOTE: Please remember that Protective Life can only accept or service an application from an applicant who speaks English or Spanish. Spanish applicants/applications must go through our TeleLife process.

1. Broker/Representative number (Agent number) must be included on the front page of the application in order to ensure commissions are paid correctly.

2. Complete each applicable question in the Application for Life Insurance. Please use a pen with black ink.

3. If using form **# PLB-301** and Proposed Insured is not being examined, must complete Part 1A – Supplemental Application – Non-Medical Declarations, form **# PL-102**.

4. Any additional benefits or riders must be noted on the Rider Worksheet, form **# PL-105R**. In addition, the following riders require these supplemental application forms, all of which can be found online.

    - If Proposed Insureds include children, complete Supplemental Application, form **# F-LAD-436**.
    - If applying for Income Provider Option, complete Supplemental Application, form **# P-U-437R**.

5. Complete and sign any additional forms (i.e. 1035 exchange, state replacements, etc.).

6. If payment is submitted with the application, complete and sign the Conditional Receipt and give to the applicant.

7. You may e-mail your applications to NBApps@protective.com and all requirements to NBRequirements@protective.com. You do not need to send the original application. However, we will need the original 1035 paperwork and assignment forms (if applicable). You may write the policy number, if known, or the insured's name and DOB on the transmittal send with the original forms for faster processing.

For Additional Information, Contact Protective Life at:

Home Office
Protective Life Insurance Company
ATTN: New Business
2801 Highway 280 South
Birmingham, Alabama 35223
Telephone: (800) 366-9378
Fax: (205) 268-5807

Regular Mail
Protective Life Insurance Company
ATTN: New Business
P.O. Box 830619
Birmingham, Alabama 35283-0619
Telephone: (800) 366-9378
Fax: (205) 268-5807

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

DESCRIPTION OF INFORMATION PRACTICES

(Including Medical Information Bureau Notice and Fair Credit Reporting Act Notice)

When we process your application for life insurance, we need the personal information you give us on your application. We may also need to obtain it from others. That's why we ask you to sign an authorization. With your authorization, we may get information from others. For example, we will get the results of any physical examination you take as a part of the application process. We may also get medical information about you from your doctors or from any hospital or clinic that has provided you services. We may also request a consumer reporting agency (a "CRA") to prepare an investigative consumer report. An investigative consumer report provides information about a person's character, general reputation, personal characteristics and mode of living, except as may be related directly or indirectly to his or her sexual orientation. To obtain the information, the CRA may interview neighbors, friends or other persons acquainted with the person who is the subject of the report. If we request such a report about you, you have the right to be interviewed and to know the nature and scope of the investigation. Upon request, you also have the right to get a copy of the report. To exercise any of these rights, please write to the address at the end of this notice.

Protecting personal and privileged information about our customers is important. We disclose information in only three situations:

First, we may disclose information if you have authorized us to disclose it. For example, with your authorization, we or our reinsurers may disclose information to other insurance companies to which you apply for life or health insurance, or to whom a claim for benefits may be submitted. We may disclose it to the Medical Information Bureau (the "MIB"). The MIB, formerly known as the Medical Information Bureau, is a not-for-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. When a person applies for life or health insurance with or submits a claim for benefits to an MIB member company, the company may request information from MIB. MIB provides the company making the request with any relevant information in its files. You may request MIB to disclose to you any information MIB may have about you. If you question the accuracy of information MIB has disclosed to you, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address and telephone number of MIB's information office are 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8374; 866-692-6901 (TTY 866-346-3642). Information for consumers about MIB may be obtained on its website at www.mib.com.

Second, we may disclose information if the law permits us to disclose it. For example, the law permits us to disclose information to others who provide services to help us process or administer our business. Medical examiners who assist us during underwriting and claims administrators who help us with our claims are the kinds of service providers to whom we may disclose information.

Third, sometimes we have a legal duty to disclose information. For example, we are required and committed to combating insurance fraud. We disclose information to law enforcement authorities investigating or prosecuting an insurance fraud scheme.

You have the right 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 and copy 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 for assistance, or call or write us at Protective Life Insurance Company, Attention: Vice President-Underwriting, P.O. Box 830619, Birmingham, Alabama 35283-0619. Telephone 800-567-8247

THIS NOTICE MUST BE GIVEN TO THE PROPOSED INSURED

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.

Broker/Representative Number *(Required)*

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SECTION I: INSUREDS — **LIFE INSURANCE APPLICATION, Part I**

Name(s) of Persons Applying for Coverage (Print in Full)	Relationship to Proposed Insured	Sex	Birth Date	Social Security Number	Birth State	Driver's License Number
Proposed Insured						
Spouse						
Children ***(Must complete Supplemental Application - Non Medical Declarations - as per Application Instructions.)***						

Residence: _____
Street Address Apt. No.

_____
City State Zip Code Telephone Number Number of Years

Send Premium Notices To *(If other than Residence)* : _____ (Name)

_____
Street Address City State Zip Code

Insured Email Address *(Optional)* : _____ Insured Cell Phone: _____

Owner Email Address *(Optional)* : _____ Owner Cell Phone: _____

Occupation	Number of Years	*(Required)* Annual Income	*(Required)* Net Worth	Employer Name and Address	Telephone Number
Proposed Insured's Occupation					
Spouse's Occupation					

SECTION II: PLAN OF INSURANCE

Face Amount $ _____(Insured) $_____(Spouse) $_____(Children)

Plan of Insurance *(Name of Product)* _____

Underwriting Class Quoted: _____ (*Protective will issue best available UW class.)*

If Universal Life: ☐ Level Face Amount ☐ Increasing Face Amount

If Term or Secure-T, Indicate Years: ☐ 10 Yrs ☐ 15 Yrs ☐ 20 Yrs ☐ 25 Yrs ☐ 30 Yrs

Section 1035: ☐ Yes ☐ No

1035 Loan Transfer: ☐ Yes ☐ No *(Not available on all plans.)*

CVAT: ☐ *(Unless CVAT box is checked, the Guideline Premium Test will apply.)*

Is Proposed Insured requesting Additional Benefits or Riders? ☐ Yes ☐ No

(If Yes, must complete Rider Worksheet as per Application Instructions.)

Premium Payment: ☐ Annual $_____ ☐ Semi-Annual $_____ ☐ Quarterly $_____ ☐ Monthly $_____
☐ Cash with Application $_____

SECTION III: BENEFICIARY DESIGNATIONS

If multiple beneficiaries are named, shares will be divided equally among the surviving beneficiaries, unless otherwise specified.

Primary Beneficiary	Relationship	%	Contingent Beneficiary	Relationship	%

SECTION IV: EXISTING COVERAGE/PENDING INSURANCE, REPLACEMENT AND OWNERSHIP OF POLICY

(Must be answered completely on all cases.)

Regarding all persons proposed for insurance, list all life insurance in force on each proposed insured's life.

Please be sure to list insurance policy information, whether owned by the insured or not. ***If "None" insert "None".***

Name of Insured	Company	Policy Number	Replace or Change ?	Amount	Purpose Bus/Per	Issue Date

a. Is the policy applied for to replace an existing insurance or annuity policy(ies) in this or any other company? ☐ Yes ☐ No
(If "Yes", give details above and complete any State required replacement forms and comparison statements.)

b. Is there any application for any other life or health insurance on the life of the proposed insured now pending or contemplated in this or any other company? ☐ Yes ☐ No

c. Has the proposed insured had a request for life or health insurance declined, postponed, rated, canceled, or restricted in any way? If "Yes", explain in Remarks Section. ☐ Yes ☐ No

d. Will you transfer ownership of the policy, or transfer interests in any trust owning the policy, in the next 3 years? ☐ Yes ☐ No

e. Is someone other than the Insured responsible for paying premiums? If "Yes", explain in Remarks Section. ☐ Yes ☐ No

f. Will anyone unrelated to the insured receive any of the policy death benefit? If "Yes", explain in Remarks Section. ☐ Yes ☐ No

g. Have you had a mortality analysis or life expectancy analysis performed? ☐ Yes ☐ No

h. Have you discussed transfer of the policy to be issued, or its death benefits, to a life settlement company, investor, offshore trust, investment trust, or entity associated with stranger owned or investment owned life insurance (commonly called SOLI or IOLI) or have you considered such a transfer? If "Yes", complete information below. ☐ Yes ☐ No

Name of Owner (If other than Proposed Insured) *Social Security Number or Taxpayer I.D. Number*

Address City *State* *Zip Code*

SECTION V: PURPOSE OF INSURANCE (TO BE ANSWERED BY PROPOSED OWNER)

a. Is the purpose of the insurance personal (Family or Estate Protection) or business (Key Man, Buy-Sell, etc)? ☐ Personal ☐ Business

If personal insurance, omit questions b - f below.

If business insurance, complete questions b - f below.

b. What percent of business does Proposed Insured own or control? _____ %

c. What is approximate net annual income of business? $ _____

d. What is approximate market value of the business? $ _____

e. What year was the business established? _____

f. If policy is a Key Man, Buy-Sell or other business owned policy, please complete information below:

Name and Title	% of Business Owned	Insurance Company	Amount Now Carried or Applied For
	%		$
	%		$
	%		$

SECTION VI: REMARKS AND SPECIAL REQUESTS

DECLARATIONS

I (We) represent that all statements and answers made in all parts of this application are full, complete and true. It is agreed that:

1. All such statements and answers shall be the basis of any insurance issued, and my (our) answers are material to the decision as to whether the risk is accepted by Protective Life.
2. No representative or medical examiner can make, alter or discharge any contract, accept risks, or waive Protective Life's rights or requirements.
3. Acceptance of a policy by the Owner shall constitute ratification of any changes made by the Company. 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.
4. 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(s) is (are) 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 Receipt and the Temporary Life Receipt is delivered to the Owner, the terms of the Temporary Life Receipt shall apply. No representative or medical examiner has any authority to waive or to alter these terms and conditions or to bind coverage under any other circumstances.
5. I have reviewed the attached Temporary Life Receipt and understand and agree that it provides a limited amount of life insurance for a limited period of time, and that such coverage is subject to the terms and conditions set forth in the Temporary Life Receipt.
6. The representative taking this application has made no statement or representation different from, contrary to or in addition to these Declarations and the terms and conditions of the attached Temporary Life Receipt.

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 _____ Date _____
(City and State)

(X) _____ (X) _____
Signature of Proposed Insured Signature of Spouse, If Proposed for Insurance

Signed At _____ Date _____
(City and State)

(X) _____ (X) _____
Signature of Owner, If Other than Proposed Insured Signature of Representative

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Life Insurance Company
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If Proposed Insured is not being examined, must complete Part 1A-Supplemental Application-Non-Medical Declarations, as per Application Instructions.

SECTION I: NON-MEDICAL HISTORY — **LIFE INSURANCE APPLICATION, Part II**

HAS PROPOSED INSURED: *(Must be answered for all Proposed Insureds.)*	Prop Ins Yes	Prop Ins No	Spouse Yes	Spouse No
1. Used tobacco or nicotine of any kind over the last 5 years? Type: _____ Frequency:_____ Date last used: _____	☐	☐	☐	☐
2. Consulted a physician or had treatment for the use or possession of: A. Alcohol?	☐	☐	☐	☐
B. Narcotics, stimulants, sedatives, hallucinogenic drugs?	☐	☐	☐	☐
3. In the past 5 years, been convicted of (i) two or more moving violations, (ii) driving under the influence of alcohol or other drugs, or (iii) had their driver's license suspended or revoked?	☐	☐	☐	☐
4. Have any proposed insureds ever been convicted of, or pled guilty or no contest to a felony, or do they have any such charge pending against them?	☐	☐	☐	☐
5. Flown as a pilot, student pilot or crew member, or intend to fly as such? (If "Yes", complete Aviation Questionnaire.)	☐	☐	☐	☐
6. Been a member of, or applied to be a member of, or received a notice of required service in, the armed forces, reserves or National Guard? *(If "Yes", please list: branch of service, rank, duties, mobilization category and current duty station in Section II below.)*	☐	☐	☐	☐
7. Engaged in any of the following activities in the past 2 years? If "Yes", complete the appropriate questionnaire. ☐ Racing ☐ Scuba Diving ☐ Hang Gliding ☐ Mountain Climbing ☐ Sky Diving ☐ Parachuting	☐	☐	☐	☐
8. Is Proposed Insured: a). A citizen of any country other than the United States or Canada? (If "Yes", provide country of citizenship, visa type and expiration date, and length of U.S. Residency.) _____	☐	☐	☐	☐
b). Have you traveled or resided outside of the United States in the past 2 years? (If "Yes", provide details.) _____	☐	☐	☐	☐
c). Intending to travel or reside outside the United States or Canada within the next 12 months? _____ To Where _____ When _____ Why _____ For How Long	☐	☐	☐	☐

SECTION II: DETAILS TO ANY "YES" ANSWERS TO QUESTIONS 1-8 *(Must be answered if applicable.)*

Name of Proposed Insured	Question Number	Date	Details or Reason	Name, Address, and Phone Number of Attending Doctor or Hospital

SIGNATURES

Signed at:_____City _____ State Proposed Insured _____ Date _____

Signed at:_____City _____ State Spouse (If Proposed Insured) _____ Date _____

Signed at:_____City _____ State Witness _____ Date _____

Protective Life Insurance Company

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

BROKER / REPRESENTATIVE REPORT

1. In what language were the questions on the application asked? ☐ English ☐ Spanish ☐ Other* _____
   * *Please remember that Protective Life cannot accept or service any application from an applicant who does not speak English or Spanish.*
2. Is the Proposed Insured a relative or does the Proposed Insured have a business relationship with you? ☐ Yes ☐ No
   If "Yes", provide details. _____
3. (a) Will this policy replace or change existing policy(ies)? ☐ Yes ☐ No
   (b) If replacement of existing insurance is involved, have you complied with all relevant state requirements, including any "Disclosure and Comparison Statements"? ☐ Yes ☐ No
   If "No", please explain. _____

   Answer questions (c) and (d) *only* if this is a replacement:

   (c) Did you use any pre-printed company approved sales materials? ☐ Yes ☐ No
   If "Yes", list name or form number here: _____

   (d) Did you use any Company approved, electronically generated, individualized sales materials (such as illustrations or concept materials)? If "Yes", you must provide a copy of these materials with the application. ☐ Yes ☐ No
4. Have you advised the proposed policyowner or do you know of any advice that has been given to the policyowner to transfer ownership of the policy to be issued, or its death benefits, to a life settlement company, investor, offshore trust, investment trust, or 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? ☐ Yes ☐ No
   If "Yes", please explain in Special Requests/Remarks below.
5. Has a mortality analysis or life expectancy analysis been performed on the Proposed Insured? ☐ Yes ☐ No
6. Has a medical examination been ordered? ☐ Yes ☐ No
   Name of Examiner: _____ Date of Exam: _____
7. Is Premium Financing involved in this case? ☐ Yes ☐ No
   If "Yes", please submit a cover letter describing the parameters.

I certify that: (1) both the Proposed Insured(s) and the Owner(s) read, speak and understand either the English or Spanish Language; and (2) each has explicitly told me that they understood each question and item contained in this application.

I certify that: (1) the answers given in this application are complete and true to the best of my knowledge and belief; (2) I know of nothing affecting the risk which is not set forth in my representative's report or this life insurance application; and (3) I carefully explained each question before recording each answer and before the application was signed.

I have verified the identity of the Owner by picture I.D. *(Does not apply to direct marketing situations.)* ☐ Yes ☐ No

Identification type: _____

Please include Driver's License Number if Owner is other than the Proposed Insured. _____

In Georgia, please include a copy of the Driver's License with application.

Broker/Representative's Signature	Broker/Representative's Commission Code No. Business Phone
Broker/Representative's Printed Name	Broker/Representative's E-Mail Address Date Place
Broker/Representative's Signature	Broker/Representative's Commission Code No. Business Phone
Broker/Representative's Printed Name	Broker/Representative's E-Mail Address Date Place
BGA/Broker Dealer Name	*For Underwriting and New Business Contact Purposes:*
BGA/Broker Dealer Contract Number	Fax Number E-Mail Address

Broker/Representative Special Requests / Remarks:

Protective Life Insurance Company

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

PART 1A - SUPPLEMENTAL APPLICATION - NON-MEDICAL DECLARATIONS

1. (a) _____ (Proposed Insured 1 (Print name)) _____ (Height) _____ (Weight) ☐ Gain ☐ Loss in past year? _____ lbs. Reason _____

   (b) _____ (Proposed Insured 2 (Print name)) _____ (Height) _____ (Weight) ☐ Gain ☐ Loss in past year? _____ lbs. Reason _____

	Prop Ins 1		Prop Ins 2		Prop Ins 3	
2. Within the past 10 years has any person proposed for insurance been treated or diagnosed by a physician as having: (**Circle** conditions to which "yes" answer applies and give details in number 5 below.)	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**
(a) Disorder of brain or spinal cord, paralysis, mental disorder, epilepsy, stroke, convulsions, chronic headaches.....	☐	☐	☐	☐	☐	☐
(b) Asthma, bronchitis, emphysema, tuberculosis or other disorder of the lungs or respiratory system.....	☐	☐	☐	☐	☐	☐
(c) High blood pressure, heart attack, heart murmur, chest pain or other disorder of the heart or blood vessels.....	☐	☐	☐	☐	☐	☐
(d) Any disorder of the esophagus, stomach, intestines, liver or pancreas.....	☐	☐	☐	☐	☐	☐
(e) Sugar or blood in the urine, chronic inflammation or other disorder of the kidneys.....	☐	☐	☐	☐	☐	☐
(f) Cancer, tumor or disorder of the prostate or reproductive organs.....	☐	☐	☐	☐	☐	☐
(g) Arthritis, osteoporosis or other disorder of the muscles, skin or bones including joints or spine.....	☐	☐	☐	☐	☐	☐
(h) Diabetes, recurrent infections, enlarged lymph glands, anemia, excess fatigue or other disorders of the glandular or blood systems.....	☐	☐	☐	☐	☐	☐
(i) State the specific date of last medical consultation.....	mmddyyyy		mmddyyyy		mmddyyyy	
(j) Name of Personal Physician _____ Address of Personal Physician _____						
3. Has any person proposed for insurance been diagnosed by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS) or "AIDS" related complex (ARC)?.....	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**
	☐	☐	☐	☐	☐	☐
4. Has any person proposed for insurance: **(Circle)** conditions to which "yes" answer applies and give details in number 5 below.)	Prop Ins 1		Prop Ins 2		Prop Ins 3	
	Yes	**No**	**Yes**	**No**	**Yes**	**No**
(a) Other than above, had examination, treatment or consultation with a physician during the past 5 years?.....	☐	☐	☐	☐	☐	☐
(b) Been on, or advised to be on any medication or prescribed diet?.....	☐	☐	☐	☐	☐	☐
(c) Sought or been advised to seek advice or treatment, or been arrested for the use of drugs or alcohol?.....	☐	☐	☐	☐	☐	☐
(d) Ever used narcotics, sedatives, depressants, stimulants or hallucinogens, other than under a doctor's prescription and direction?.....	☐	☐	☐	☐	☐	☐
(e) Ever used marijuana, cocaine, or any illegal drug or been arrested for the possession of drugs?.....	☐	☐	☐	☐	☐	☐
(f) Ever been or is currently a member of any alcohol or drug rehabilitation program?.....	☐	☐	☐	☐	☐	☐
(g) Ever attempted suicide?.....	☐	☐	☐	☐	☐	☐
(h) Had a parent, brother or sister who had and/or died from cancer, diabetes, stroke, heart or kidney disease, or who committed suicide? (Please show age of onset and/or age death occurred.).....	☐	☐	☐	☐	☐	☐

5. Person's Name	Question Number	Date of Diagnosis	Diagnosis - Medication Prescribed	Full Name and Complete Address of Attending Physician or Hospital

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.

Date _____ Proposed Insured 1 (Sign Name in Full) _____ Date _____

Witness _____ Proposed Insured 2 (Sign Name in Full) _____ Date _____

Signature of Parent or Guardian _____ Date _____

Rider Worksheet

Please print using black ink.

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☐ **New Business**
☐ **Protective Policy Change from Policy _____**

Print Proposed/Primary Insured's Name _____ **Proposed/Primary Insured's Social Security Number** _____

**** If applying for Chronic Illness Accelerated Death Benefit or Income Provider Option, please complete Supplemental Application as per Application Instructions.***

1. ADDITIONAL BENEFITS

☐ Accidental Death Benefit $ _____
(Range $10,000 - $150,000)
☐ * Chronic Illness Accelerated Death Benefit
Maximum Monthly Benefit Amount $ _____
Elimination Period *(Number of Days)* _____
☐ Death Benefit Plus Rider _____% *(Optional Interest Rate)*
☐ Disability Benefit *(Universal Life Only)*
Monthly Benefit Amount $ _____
☐ Enhanced Cash Surrender Value Rider
☐ Estate Protection Endorsement *(Survivorship Plans Only)*
☐ * Income Provider Option
☐ Protected Insurability Rider $ _____
☐ Return of Substandard Charges Option (ROSCO)
☐ Waiver of Premium (*Non-Universal Life*)

☐ Other _____

2. GUARANTEED INSURABILITY RIDER(S)

(Maximum of six)
(Universal Life Only - Maximum of $2.5 million including face amount)

☐ GIR - Variable Option(s) *List below*.

Amount	*Option Date*

☐ GIR - Survivor's Choice *List below*.

Amount	*Designated Life*	*Relationship*

3. ☐ COVERED INSURED RIDER (Available on certain Universal Life Plans only)

Name/Relationship to Primary Proposed Insured	Gender	Date of Birth	Height	Weight	Place of Birth
	Beneficiary			Relationship/Percentage	
Amount					
Name/Relationship to Primary Proposed Insured	Gender	Date of Birth	Height	Weight	Place of Birth
	Beneficiary			Relationship/Percentage	
Amount					

4. ☐ CHILDREN'S TERM RIDER _____ units (1 unit equals $1,000 death benefit - 20 units maximum)

Name	Relationship	Date of Birth	Gender	Place of Birth	Height	Weight

_____ _____ _____
Owner Signature *Date* *Witness to All Signatures*

_____ _____ _____
Proposed/Primary Insured Signature *Date* *Signed at: City State*

_____ _____
Signature of Parent or Guardian *Date*

Protective
Life Insurance Company

PROTECTIVE LIFE INSURANCE COMPANY
P. O. BOX 830619 / Birmingham, AL 35283-0619

Continuation of Information for Part I (Non-Medical) and Part II (Medical)

Proposed Insured: _____ Policy Number: _____
Last Name First Name M.I.

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.

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 _____this _____ day of _____, 20 _____
(City, State)

_____ _____
Signature of Proposed Insured Signature of Parent or Legal Guardian

_____ _____
Signature of Owner, If Other than Proposed Insured Signature of Witness

Protective
Life Insurance Company

Application Supplement - Part I

Supplement to Life Insurance Application

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): _____

(1) For any policy to be issued as a result of this application, will any portion of the initial or future premiums be borrowed, loaned or otherwise financed? ☐ Yes ☐ No

If yes, complete the "Statement of Owner Intent" (Application Supplement - Part II) and the "Premium Financing Disclosure and Acknowledgement" form.

(2) Is there any intention that any party other than the Owner(s) will obtain any right, title or interest in any policy issued on the life of the Proposed Insured(s) as a result of this application? ☐ Yes ☐ No

If yes, complete the "Statement of Owner Intent" (Application Supplement - Part II).

(3) Is a trust to be an Owner of any policy issued as a result of this application? ☐ Yes ☐ No

If yes, complete the "Trust Certification" (Application Supplement - Part III).

(4) If the application is for a non-variable permanent plan of insurance **AND** the issue age of any Proposed Insured is 65 or older **AND** the total coverage currently applied for across all Protective companies is $1,000,000 or more, complete the "Statement of Owner Intent" (Application Supplement - Part II).

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

		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 _____

Date _____

(X) _____
Witnessed by Agent

_____
Agent Name (Printed)

_____
Street Address

_____
City, State and Zip

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

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

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

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

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

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

		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.

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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

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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 _____

Date _____

(X) _____
Witnessed by Agent

_____
Agent Name (Printed)

_____
Street Address

_____
City, State and Zip

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

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

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

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

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

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

PRE-AUTHORIZED WITHDRAWAL AGREEMENT

FOR DRAFTING OF PREMIUM PAYMENTS

The person paying the premium on the life insurance policy listed below must sign this agreement.

I request and authorize Protective Life Insurance Company to draw against the account listed below to pay premiums once a policy has been issued. I understand that no coverage exists until a policy is issued or I receive a Conditional Receipt/Temporary Life Insurance Receipt.

Policy Number: _____ Name of Insured: _____

Name of Bank: _____

Street Address or P. O. Box: _____

City: _____ State: _____ Zip Code: _____

Type of Account: ☐ **Checking** ☐ **Savings**

Routing Number: _____ _____ _____ _____ _____ _____ _____ _____ _____

Account Number: _____

Premium Frequency: ☐ ***Monthly (*Only available by bank draft)** ☐ **Quarterly**

☐ **Semi-Annually** ☐ **Annually**

☐ **Draft the initial premium** - I understand that authorizing the drafting of the initial premium and providing the account information does not provide any life insurance coverage on myself or any applicant listed on the application for life insurance unless I have signed, dated and met the terms and conditions of the Protective Life Conditional Receipt Agreement/Temporary Life Insurance Receipt.

If the Company receives a Conditional/Temporary Receipt with this form your premium will be drafted immediately and you will be provided with conditional coverage subject to limited terms and conditions.

Variable life insurance premiums will not be deducted unless a policy is issued.

I request **future** drafts be made on the _____ day of the month. **(The draft date must be on or before the policy effective date.)** (1st-28th)

_____
Premium Payer - Depositor (Please Print)

_____ _____
Date **Signature**

PLEASE INCLUDE A VOIDED CHECK WITH APPLICATION. IF THIS IS TO DRAFT FROM A BROKERAGE ACCOUNT, A VOIDED CHECK IS NOT NECESSARY. DO NOT USE STAPLES.

PROTECTIVE LIFE INSURANCE COMPANY
P.O. Box 830619
Birmingham, Alabama 35283-0619
Telephone: (800) 366-9378

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	POLICY INFORMATION
Insurer _____	Insurer _____
Policy Generic Name _____	Policy Generic Name _____
Policy Number _____	Policy Number _____

POLICY INFORMATION	POLICY INFORMATION
Insurer _____	Insurer _____
Policy Generic Name _____	Policy Generic Name _____
Policy Number _____	Policy Number _____

Original – Home Office Copy – Applicant

PROTECTIVE LIFE INSURANCE COMPANY
P.O. Box 830619
Birmingham, Alabama 35283-0619
Telephone: (800) 366-9378

NOTICE REGARDING REPLACEMENT

REPLACING YOUR LIFE INSURANCE POLICY OR ANNUITY?

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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	POLICY INFORMATION
Insurer _____	Insurer _____
Policy Generic Name _____	Policy Generic Name _____
Policy Number _____	Policy Number _____

POLICY INFORMATION	POLICY INFORMATION
Insurer _____	Insurer _____
Policy Generic Name _____	Policy Generic Name _____
Policy Number _____	Policy Number _____

Original – Home Office Copy – Applicant

PROTECTIVE LIFE INSURANCE COMPANY
ASSIGNMENT/TRANSFER OF OWNERSHIP
SECTION 1035 EXCHANGE

INSURED: _____ **POLICY NUMBER(S):** _____

OWNER: _____ _____

INSURER: _____
(NAME OF EXISTING INSURANCE COMPANY)

_____ **$** _____
(STREET ADDRESS OF EXISTING INSURANCE COMPANY) (ESTIMATED VALUE)

_____ _____
(CITY/STATE/ZIP) (PHONE NO.)

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) Signature(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 Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington or Wisconsin, 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
AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

1. This authorization to obtain and disclose information complies with HIPAA regulations that exempt the minimum necessary rules as they apply 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) Medical Information Bureau, 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.
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 12 months from the Date of Authorization shown below or, in the event of a claim for benefits, for the duration of such claim.
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.)*
    ☐ If performed, I (we) would like copies of my (our) blood profile test results.

THIS AUTHORIZATION <u>MUST</u> BE SIGNED <u>WITHOUT MODIFICATION</u> AND RETURNED WITH THE APPLICATION BEFORE PROCESSING.

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

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 that exempt the minimum necessary rules as they apply 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) Medical Information Bureau, 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.
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 12 months from the Date of Authorization shown below or, in the event of a claim for benefits, for the duration of such claim.
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.)*
    ☐ If performed, I (we) would like copies of my (our) blood profile test results.

THIS AUTHORIZATION <u>MUST</u> BE SIGNED <u>WITHOUT MODIFICATION</u> AND RETURNED WITH THE APPLICATION BEFORE PROCESSING.

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

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.

Protective
Life Insurance Company

P.O. Box 830619 • Birmingham, Alabama 35283-0619

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

Protective Life Insurance Company
P.O. Box 830619
Birmingham, AL 35283-0619
1-800-366-9378

CONFIDENTIAL FINANCIAL STATEMENT

Name of Proposed Insured: _____

The following financial disclosures are made for the purposes of establishing insurability in connection with pending Life Insurance Application on my life. They are furnished as a true and accurate statement of my financial condition on _____, 20 _____.

ASSETS		LIABILITIES	
Cash in Banks	$	Mortgages (Home or Other)	$
Notes Receivable	$	Notes Payable to Banks	$
Cash Values Life Insurance	$	Notes Payable to Others	$
Real Estate	$	Accounts Payable	$
Business Interest	$	Taxes Payable	$
Stocks and Bonds	$	Mortgages or Liens on Real Estate	$
Personal Property *(auto, furniture, etc.)*	$	Other Liabilities *(describe)*	$
Cash Surrender Value - Life	$	TOTAL LIABILITIES	$
Other Assets *(describe)*	$	NET WORTH (This is your assets minus your liabilities)	$
TOTAL ASSETS	$		

Income	**Last Year**	**Prior Year**
Annual Salary		
Bonuses		
Dividends, Bonds, etc.		
Other Income (give details)		
TOTAL		

Additional Details: _____

There are no suits pending or judgments against me at this time **EXCEPT**:

_____

_____

Have you personally guaranteed a debt owed by another party? ☐ Yes ☐ No If "Yes" give details:

_____

_____ _____

Date Signature of Proposed Insured