LIFE INSURANCE APPLICATION PACKET

Includes:

- **Application**
- **HIPAA Disclosure**
  (must be given to every Applicant)
- **Conditional Receipt**
- **Supplemental Life Application**
  (must be completed if Riders are purchased)
- **Description of Information Practices**
  (must be given to every Applicant)

Application Instructions

1. Complete **each** question in the Application for Life Insurance (ILD-1038). Please use a pen with black ink. If additional benefits and/or riders are selected, follow the same procedures for the Supplemental Life Application.

2. Provide complete names, addresses, SSN/Tax IDs and birthdates for all applicants, owners, beneficiaries and doctors. Complete the signature area on the back of the application.

3. Each applicant must be given the Description of Information Practices and HIPAA Disclosure Form.

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

5. Complete and sign any additional forms (i.e. 1035 exchange, state replacements,etc.). See Protective Life and Annuity Administrative Forms Packet.

6. Fax App - To expedite the underwriting process you can FAX the application to (205) 268-4516. The entire application must be faxed.

7. **CONTACT YOUR HOME OFFICE** to determine where to send the completed paperwork. There may be special processing procedures. Unless otherwise advised by your home office, make checks payable to Protective Life and Annuity Insurance Company. If you are sending the business directly to Protective, please use the following address:

Protective Life and Annuity Insurance Company
Institutional Distribution Group
P.O. Box 830735
Birmingham, AL 35283
1-800-265-1545

8. 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.

For Additional Information, Contact
Protective Life and Annuity Insurance Company
at (800) 265-1545

Life Insurance Application to
Protective Life and Annuity Insurance Company

Protective Life and Annuity Insurance Co.
Institutional Distribution Group
P.O. Box 830735, Birmingham, AL 35283

1. Proposed Insured 1

Name | *Birth Date* | *State of Birth* | *Sex* | *Social Security No.*

Occupation | *Marital Status* | *Driver's Lic. No. & State* | *Home Phone No.* | *Work Phone No.*

Home Address (Street Address - City, State, Zip)

Employer's Name | *Employer's Address* | *Years Employed*

2. Proposed Insured 2 – Relationship to Proposed Insured 1: _____

Name | *Birth Date* | *State of Birth* | *Sex* | *Social Security No.*

Occupation | *Marital Status* | *Driver's Lic. No. & State* | *Home Phone No.* | *Work Phone No.*

Home Address (Street Address - City, State, Zip)

Employer's Name | *Employer's Address* | *Years Employed*

3. ☐ **Owner if other than a Proposed Insured** (Owner must sign Page 2)
☐ Payor (if other than Owner – furnish information in Remarks on Page 2)

Name | *Relationship* | *Soc. Sec. No. or Tax I.D. No.*

Birthdate | *Address (Street Address - City, State, Zip)*

Home Phone No. | *Work Phone No.*

All notices and reports will be sent to the Owner unless otherwise specified in Remarks

4. PRIMARY BENEFICIARY *Name, Address, Social Security No., Birthdate, Relationship, Percentage*

CONTINGENT BENEFICIARY *(If any)*

5. PLAN INFORMATION
Initial Premium $_____ Initial Face Amount $_____
Planned Periodic Premium $_____
Plan Type _____
☐ Level Death Benefit ☐ Increasing Death Benefit
Premium Mode:
☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ PAC
Cash With Application $_____
Issue best available Underwriting Class? ☒ Yes

6. REGARDING ALL PERSONS PROPOSED FOR INSURANCE:
Please answer all questions. If any Question (#7a-m) is answered "yes", give details under Question 8.

	Prop. Ins. 1		Prop. Ins. 2	
	Yes	**No**	**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, hypertension or cholesterol?	☐	☐	☐	☐
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 Section 9)	☐	☐	☐	☐
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? If yes, complete the aviation questionnaire	☐	☐	☐	☐
g. Have you ever participated in a sport or avocation such as racing, hang gliding, scuba, sky or skin diving? If yes, complete the hazardous sport or racing questionnaire.	☐	☐	☐	☐
h. Have you smoked a cigarette or used tobacco in any form? If "yes", include type of tobacco and date last used in Section 8 below	☐	☐	☐	☐
i. Have you ever had a DUI conviction, had your driver's license suspended or revoked, or been convicted of more than two moving violations? If "yes", indicate date of incident(s) and driver's license number in Section 8.	☐	☐	☐	☐
j. Within the last 10 years, have you been convicted of a felony?	☐	☐	☐	☐
k. Are you a permanent resident of the United States, Puerto Rico or Canada?	☐	☐	☐	☐
l. Do you have any intention of traveling or residing outside the U.S. or Canada within the next two years?	☐	☐	☐	☐
m. Had a parent or sibling who died of cancer, diabetes, heart disease or stroke prior to age 60?	☐	☐	☐	☐

7. DETAILS OF ALL "YES" ANSWERS (Please attach an additional sheet of paper if necessary)

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

8. LIFE INSURANCE IN FORCE (Including Business Insurance): (If none, insert "none")

Person	Company	Year Issued	Life Amount	Accidental Death Amount	To Be Replaced?

9. PROCESSING PROCEDURES

Depending on the amount of insurance, Protective Life and Annuity will contact you to collect answers to pertinent medical information or a paramedical organization will handle these requirements by a medical exam and/or tests. Protective Life and Annuity may call you regarding an investigative consumer report.

The most convenient place to call: ☐ Home ☐ Business

Best Days: ☐ Mon. ☐ Tue. ☐ Wed. ☐ Thur. ☐ Fri.

Best Time: ☐ Morning ☐ Afternoon ☐ Evening

10. In order to speed processing, please provide name, address and phone number of Proposed Insured's personal physician:

11. REMARKS

12. HOME OFFICE ENDORSEMENTS

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 and shall be attached to and made a part of the policy.

(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 Agreement(s) and the Agreement(s) are delivered to the Owner, the terms of the Agreement(s) shall apply.

(d) Acceptance of a policy by the Owner shall constitute ratification of any changes made by the Company under "Home Office Endorsements." 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 acknowledges receipt of the Description of Information Practices. The Proposed Insured hereby authorizes any licensed physician, medical practitioner, hospital, clinic, or other medically related facility, insurance company, the MIB, consumer reporting agencies (CRA) or other organization, institution or person, that has any records or knowledge of me or my health, to give to Protective Life and Annuity Insurance Co., its CRA or its reinsurer any such information. A photographic copy of this authorization shall be as valid as the original. Protective Life and Annuity can give information to MIB, consumer reporting agencies, reinsurers and other insurers. I also hereby authorize Protective Life and Annuity Insurance Company to draw and test my blood and urine as may be necessary to underwrite my application for insurance coverage. These tests to be performed, may include, but are not limited to, tests for cholesterol and related blood lipids, diabetes, liver or kidney disorders, immune disorders, the presence of antibodies to the Human Immunodeficiency Virus (HIV) (if permitted by law). This is the virus that has been associated with Acquired Immune Deficiency Syndrome (AIDS). This authorization shall be valid 24 months from the date shown below or in the event of a claim of benefits, the duration of such claim.

Does this policy meet your insurance needs and financial objectives? ☐ Yes ☐ No

X _____ X _____

***Proposed Insured 1** (Signature)* ***Proposed Insured 2** (Signature)*

X _____

***Owner**, if other than Proposed Insured 1 or Proposed Insured 2.*

Owner Signed At _____ (*City*), _____ (*State*) . **Date** _____ (*Mo./Day/Yr.*)

X _____

Parent Guardian (Signature)

Agent: Will this policy replace or change any existing insurance policy(s) or annuity? ☐ Yes ☐ No

X _____

Agent Signature *Agent Name (print)* *Broker Number* *Broker Dealer or Financial Institution (Print)* *Phone Number*

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

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

This Authorization to Obtain and Disclose Information complies with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") as related to Life Insurance.

USE OF MEDICAL, NON-HEALTH AND NON-MEDICAL INFORMATION

I (we) authorize Protective Life and Annuity Insurance Company (Protective Life and Annuity) and its reinsurers to obtain, directly or through designated third parties, and to use any information about or relating to me (us) that may affect my (our) insurability. Protective Life and Annuity and its reinsurers, Life Insurance Representative(s) or regional sales office representing me on my (our) application for insurance may:

a. obtain and use health and medical information from all dates of service, including but not limited to information about chart notes, EKG's, nicotine use, physical and mental diseases and illness, and psychiatric disorders (excluding psychotherapy notes);
b. obtain and use non-health and non-medical information, including but not limited to financial information, credit reports, consumer reports, driving record, criminal record, character, general reputation, personal characteristics or behavioral and lifestyle factors and information about avocations and aviation activity;
c. use all of this information to evaluate an application for insurance, a claim for insurance benefits, or both;
d. use any information relating to communicable diseases and other risk factors relating to me or to my spouse or life partner to evaluate an application for insurance on either me or my spouse or life partner.

RELEASE AND DISCLOSE INFORMATION FROM THIRD PARTIES

I (we) authorize the following persons and organizations to release and disclose the information described in the ***USE OF MEDICAL, NON-HEALTH AND NON-MEDICAL INFORMATION*** section to Protective Life and Annuity, directly through the following designated third parties or its representative(s) acting on its behalf:

a. my (our) doctor(s); medical practitioners; pharmacists and Pharmacy Benefit Managers;
b. medical and related facilities, including hospitals, clinics, facilities run by the Veteran's Administration, Kaiser Permanente, The Cleveland Clinic Foundation including all satellite facilities and The Mayo Clinic;
c. insurers; reinsurers;
d. my (our) current and previous employers;
e. MIB, Inc. **(MIB**); and commercial consumer reporting agencies **(CRA).**

All of these persons and organizations other than **MIB** may release the information described above to a **CRA** acting for Protective Life and Annuity. **MIB** may not release the information described in the ***USE OF MEDICAL, NON-HEALTH AND NON-MEDICAL INFORMATION*** section to a **CRA**.

TESTING OF BLOOD, ORAL FLUIDS AND URINE

I (we) authorize Protective Life and Annuity to draw and test my (our) blood, and/or oral fluids, and urine as necessary to underwrite my (our) application for insurance. These tests may include, but are not limited to:

a. tests for cholesterol and related blood lipids, diabetes, liver or kidney disorders, immune disorders (other than HIV/AIDS).
b. tests for the presence of drugs, nicotine, or their metabolites.

This authorization does not include genetic testing. Unless otherwise required by law or regulation, Protective Life and Annuity may, but is not obligated to, release any of these test results directly to me or to my spouse or life partner.

RELEASE OF MEDICAL, NON-HEALTH, NON-MEDICAL AND TESTING INFORMATION

I (we) authorize Protective Life to release and disclose the information described in the ***USE OF MEDICAL, NON-HEALTH AND NON-MEDICAL INFORMATION*** section and the ***TESTING OF BLOOD, ORAL FLUIDS AND URINE*** section:

a. to its affiliates, its reinsurers, persons or organization providing services relating to insurance underwriting for Protective Life and Annuity, **MIB** and as otherwise required by law.
b. to release and disclose the information to other duly licensed life insurers if I (we) have applied or apply to the other insurers for insurance.
c. to its reinsurers, to make a brief report of my personal health information to **MIB**.
d. to the Life Insurance Representative(s) representing me to duly licensed specific life insurers for the purpose of applying for life insurance if my (our) application with Protective Life and Annuity is declined or if Protective Life and Annuity is unable to offer coverage at an acceptable rate.
e. to the Life Insurance Representative(s) and its staff, affiliated companies and/or entities, insurance companies and their re-insurers representing me on my (our) application for insurance if it is necessary to provide an explanation of the reasons for Protective Life and Annuity's decision to impose special underwriting requirements, whenever my application cannot be approved as submitted, or in connection with a claim for benefits.

SPECIAL REQUIREMENT FOR HIV/AIDS TESTING

If Protective Life and Annuity 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 and Annuity may require a separate authorization. I (we) hereby authorize Protective Life and Annuity:

a. to obtain and use the results of any HIV tests that I (we) separately authorize.
b. (if permitted by law) to disclose the results of any tests to its reinsurers and **MIB**.

GENERAL INFORMATION

a. This authorization shall be valid for 24 months from the Date of Authorization shown below.
b. During the evaluation of my (our) insurance application, I (we) understand that I (we) have the right to revoke the authorizations in the previous sections (above) by writing to Protective Life and Annuity at P.O. Box 830619 • Birmingham, Alabama 35283-0619. If this authorization is revoked, this would result in the file being closed and no coverage provided.
c. I understand I do not have to sign this authorization in order to obtain **health care benefits (treatment, payment or enrollment).**
d. I (we) understand that any information about me (us) that is disclosed pursuant to this authorization may be subject to re-disclosure and no longer covered by certain federal rules governing privacy and confidentiality of health information. The information contained in these medical and financial records will be held in confidence and may be used only for the purpose of the procurement, or underwriting for the possible procurement or the evaluation of life, health, long term care, or other insurance products.
e. I (we) understand that my (our) personal information, including my (our) protected health information disclosed under this authorization will be incorporated into and made a part of any life and/or disability insurance policy(ies) issued by the Company and that the policy(ies) will be delivered to the policy owner.
f. *I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction. Any modifications to this authorization may preclude Protective Life and Annuity's ability to process this application.*

AUTHORIZATIONS AND INVESTIGATIVE CONSUMER REPORT

☐ I (we) have been given a copy of this **Authorization to Obtain and Disclose Information** along with the **Description of Information Practices**.

☐ I (we) authorize the preparation of an investigative consumer report and would like to be interviewed if an investigative consumer report will be made. (Please refer to the **Description of Information Practices** for additional information regarding the interview for an **Investigative Consumer Report**.)

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

SIGNATURES

Date of Authorization: X_____

_____
List Health Care Providers

X_____	_____	_____	_____
Proposed Insured 1 (Signature)	Print Name of Proposed Insured 1	Birthdate	Social Security Number
X_____	_____	_____	_____
Proposed Insured 2 (Signature)	Print Name of Proposed Insured 2	Birthdate	Social Security Number

_____	X_____	_____
If Minor, Print Name	Parent or Legal Guardian (Signature)	Print Name of Parent or Legal Guardian

Home Office – ORIGINAL Applicant - COPY

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

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a. obtain and use health and medical information from all dates of service, including but not limited to information about chart notes, EKG's, nicotine use, physical and mental diseases and illness, and psychiatric disorders (excluding psychotherapy notes);
b. obtain and use non-health and non-medical information, including but not limited to financial information, credit reports, consumer reports, driving record, criminal record, character, general reputation, personal characteristics or behavioral and lifestyle factors and information about avocations and aviation activity;
c. use all of this information to evaluate an application for insurance, a claim for insurance benefits, or both;
d. use any information relating to communicable diseases and other risk factors relating to me or to my spouse or life partner to evaluate an application for insurance on either me or my spouse or life partner.

RELEASE AND DISCLOSE INFORMATION FROM THIRD PARTIES

I (we) authorize the following persons and organizations to release and disclose the information described in the ***USE OF MEDICAL, NON-HEALTH AND NON-MEDICAL INFORMATION*** section to Protective Life and Annuity, directly through the following designated third parties or its representative(s) acting on its behalf:

a. my (our) doctor(s); medical practitioners; pharmacists and Pharmacy Benefit Managers;
b. medical and related facilities, including hospitals, clinics, facilities run by the Veteran's Administration, Kaiser Permanente, The Cleveland Clinic Foundation including all satellite facilities and The Mayo Clinic;
c. insurers; reinsurers;
d. my (our) current and previous employers;
e. MIB, Inc. **(MIB**); and commercial consumer reporting agencies **(CRA).**

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a. to its affiliates, its reinsurers, persons or organization providing services relating to insurance underwriting for Protective Life and Annuity, **MIB** and as otherwise required by law.
b. to release and disclose the information to other duly licensed life insurers if I (we) have applied or apply to the other insurers for insurance.
c. to its reinsurers, to make a brief report of my personal health information to **MIB**.
d. to the Life Insurance Representative(s) representing me to duly licensed specific life insurers for the purpose of applying for life insurance if my (our) application with Protective Life and Annuity is declined or if Protective Life and Annuity is unable to offer coverage at an acceptable rate.
e. to the Life Insurance Representative(s) and its staff, affiliated companies and/or entities, insurance companies and their re-insurers representing me on my (our) application for insurance if it is necessary to provide an explanation of the reasons for Protective Life and Annuity's decision to impose special underwriting requirements, whenever my application cannot be approved as submitted, or in connection with a claim for benefits.

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a. to obtain and use the results of any HIV tests that I (we) separately authorize.
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GENERAL INFORMATION

a. This authorization shall be valid for 24 months from the Date of Authorization shown below.
b. During the evaluation of my (our) insurance application, I (we) understand that I (we) have the right to revoke the authorizations in the previous sections (above) by writing to Protective Life and Annuity at P.O. Box 830619 • Birmingham, Alabama 35283-0619. If this authorization is revoked, this would result in the file being closed and no coverage provided.
c. I understand I do not have to sign this authorization in order to obtain **health care benefits (treatment, payment or enrollment).**
d. I (we) understand that any information about me (us) that is disclosed pursuant to this authorization may be subject to re-disclosure and no longer covered by certain federal rules governing privacy and confidentiality of health information. The information contained in these medical and financial records will be held in confidence and may be used only for the purpose of the procurement, or underwriting for the possible procurement or the evaluation of life, health, long term care, or other insurance products.
e. I (we) understand that my (our) personal information, including my (our) protected health information disclosed under this authorization will be incorporated into and made a part of any life and/or disability insurance policy(ies) issued by the Company and that the policy(ies) will be delivered to the policy owner.
f. *I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction. Any modifications to this authorization may preclude Protective Life and Annuity's ability to process this application.*

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☐ I (we) authorize the preparation of an investigative consumer report and would like to be interviewed if an investigative consumer report will be made. (Please refer to the **Description of Information Practices** for additional information regarding the interview for an **Investigative Consumer Report**.)

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

SIGNATURES

Date of Authorization: X_____

_____
List Health Care Providers

X_____	_____	_____	_____
Proposed Insured 1 (Signature)	Print Name of Proposed Insured 1	Birthdate	Social Security Number
X_____	_____	_____	_____
Proposed Insured 2 (Signature)	Print Name of Proposed Insured 2	Birthdate	Social Security Number

_____	X_____	_____
If Minor, Print Name	Parent or Legal Guardian (Signature)	Print Name of Parent or Legal Guardian

Home Office – ORIGINAL Applicant - COPY

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

CONDITIONAL RECEIPT AGREEMENT

☐ Term Life Insurance ☐ Universal Life Insurance

This agreement provides only a limited amount of insurance, for a limited period of time, and then only if all the terms and conditions of this agreement are met. No Agent of Protective Life and Annuity Insurance Company (the Company) can alter or waive any of the provisions of this Agreement. No life insurance is provided under the terms of this document in the event of the death of the proposed insured(s) by suicide. In the event of suicide, while sane or insane, the Company's sole liability will be the return of any money received.

Received: ☐ Check in the amount of $_____, ☐ Pre-Authorized Funds Withdrawal, ☐ Other _____

as conditional payment of the first premium for an insurance policy on the life of Proposed Insured(s)_____

_____.

An application for life insurance on each person proposed for insurance is being made today to the Company. This conditional payment is received under and is subject to the exact conditions set out below, all of which are a part of this Agreement.

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO PROTECTIVE LIFE AND ANNUITY INSURANCE COMPANY.

DO NOT MAKE CHECKS PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK. CASH, MONEY ORDERS AND CASHIER'S CHECKS WILL NOT BE ACCEPTED.

NOTE: Premium may not be collected **(1)** where the face amount applied for plus any in force life insurance and accidental death benefits (including those applied for) on Proposed Insured(s) with the Company and its affiliates exceeds **$1,000,000**; OR **(2)** on Proposed Insured(s) under 15 days of age or over age 80; OR **(3)** for cases in which the Proposed Insured(s) intends to leave the United States within the next 60 days. Any premium received under **(1)**, **(2)** or **(3)** of this note will be refunded.

CONDITIONS UNDER WHICH INSURANCE MAY BECOME EFFECTIVE PRIOR TO POLICY DELIVERY

Unless each and every condition below has been fulfilled exactly, no insurance will become effective prior to policy delivery to the Owner:

(A) on the Effective Date the Proposed Insured(s) is (are) insurable exactly as applied for under the Company's published underwriting rules for the plan, amount and premium rate class applied for;

(B) the amount paid with the application and shown above is equal to the first full modal premium for the plan, amount and premium rate class applied for; and

(C) the Proposed Insured(s) has/have completed all examinations and/or tests requested by the Company. No more than two examinations will be requested.

EFFECTIVE DATE OF COVERAGE

Insurance issued based on the application will take effect on the latest of:

(A) the date of the application;

(B) the date requested in the application; or

(C) the date of the last of any medical examinations or tests required under the rules and practices of the Company.

AMOUNT OF COVERAGE - $1,000,000 MAXIMUM (per Proposed Insured)

The total amount of insurance on Proposed Insured(s) which may become effective prior to delivery of the policy to the Owner **shall not exceed $1,000,000** with the Company and its affiliates. This amount includes other life insurance and accidental death benefits on such Proposed Insured(s) currently in force and applied for with the Company and its affiliates.

TERMINATION AND REFUND OF PREMIUM

There shall be no insurance coverage under this Agreement and this Agreement shall be void if:

(A) premium payment is

(1) by check, and it is not honored by the drawee bank upon presentation;

(2) by Pre-Authorized Funds Withdrawal (PAW), and the deduction is not honored by the drawee bank;

(3) by Payroll Deduction Authorization (PDA) and the Employer does not make payroll deductions as authorized by the Employee; or

(B) if the application to which this Agreement was attached is not approved as applied for by the Company within ninety days from its date, the Company's only liability in such event(s) will be to return any money received.

NOTICE TO APPLICANT: You should retain a copy of this Agreement. The Original will be retained by Protective Life and Annuity.

_____	_____	_____	_____
Agent Signature	Date	Owner Signature	Date

ALL MONIES WILL BE DRAFTED/DEPOSITED IMMEDIATELY UPON RECEIPT OF THIS FORM.

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

CONDITIONAL RECEIPT AGREEMENT

☐ Term Life Insurance ☐ Universal Life Insurance

This agreement provides only a limited amount of insurance, for a limited period of time, and then only if all the terms and conditions of this agreement are met. No Agent of Protective Life and Annuity Insurance Company (the Company) can alter or waive any of the provisions of this Agreement. No life insurance is provided under the terms of this document in the event of the death of the proposed insured(s) by suicide. In the event of suicide, while sane or insane, the Company's sole liability will be the return of any money received.

Received: ☐ Check in the amount of $_____, ☐ Pre-Authorized Funds Withdrawal, ☐ Other _____

as conditional payment of the first premium for an insurance policy on the life of Proposed Insured(s)_____

_____.

An application for life insurance on each person proposed for insurance is being made today to the Company. This conditional payment is received under and is subject to the exact conditions set out below, all of which are a part of this Agreement.

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DO NOT MAKE CHECKS PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK. CASH, MONEY ORDERS AND CASHIER'S CHECKS WILL NOT BE ACCEPTED.

NOTE: Premium may not be collected **(1)** where the face amount applied for plus any in force life insurance and accidental death benefits (including those applied for) on Proposed Insured(s) with the Company and its affiliates exceeds **$1,000,000**; OR **(2)** on Proposed Insured(s) under 15 days of age or over age 80; OR **(3)** for cases in which the Proposed Insured(s) intends to leave the United States within the next 60 days. Any premium received under **(1)**, **(2)** or **(3)** of this note will be refunded.

CONDITIONS UNDER WHICH INSURANCE MAY BECOME EFFECTIVE PRIOR TO POLICY DELIVERY

Unless each and every condition below has been fulfilled exactly, no insurance will become effective prior to policy delivery to the Owner:

(A) on the Effective Date the Proposed Insured(s) is (are) insurable exactly as applied for under the Company's published underwriting rules for the plan, amount and premium rate class applied for;

(B) the amount paid with the application and shown above is equal to the first full modal premium for the plan, amount and premium rate class applied for; and

(C) the Proposed Insured(s) has/have completed all examinations and/or tests requested by the Company. No more than two examinations will be requested.

EFFECTIVE DATE OF COVERAGE

Insurance issued based on the application will take effect on the latest of:

(A) the date of the application;

(B) the date requested in the application; or

(C) the date of the last of any medical examinations or tests required under the rules and practices of the Company.

AMOUNT OF COVERAGE - $1,000,000 MAXIMUM (per Proposed Insured)

The total amount of insurance on Proposed Insured(s) which may become effective prior to delivery of the policy to the Owner **shall not exceed $1,000,000** with the Company and its affiliates. This amount includes other life insurance and accidental death benefits on such Proposed Insured(s) currently in force and applied for with the Company and its affiliates.

TERMINATION AND REFUND OF PREMIUM

There shall be no insurance coverage under this Agreement and this Agreement shall be void if:

(A) premium payment is

(1) by check, and it is not honored by the drawee bank upon presentation;

(2) by Pre-Authorized Funds Withdrawal (PAW), and the deduction is not honored by the drawee bank;

(3) by Payroll Deduction Authorization (PDA) and the Employer does not make payroll deductions as authorized by the Employee; or

(B) if the application to which this Agreement was attached is not approved as applied for by the Company within ninety days from its date, the Company's only liability in such event(s) will be to return any money received.

NOTICE TO APPLICANT: You should retain a copy of this Agreement. The Original will be retained by Protective Life and Annuity.

_____	_____	_____	_____
Agent Signature	Date	Owner Signature	Date

ALL MONIES WILL BE DRAFTED/DEPOSITED IMMEDIATELY UPON RECEIPT OF THIS FORM.

Supplemental Life Application

Please print using black ink.

Protective Life and Annuity Insurance Company
Institutional Distribution Group
P.O. Box 830735
Birmingham, AL 35283

Questions 7a. - 7m. on the application must be answered for all persons applying for insurance on this Supplemental Life Application.

1. ADDITIONAL BENEFITS

☐ Accidental Death Benefit $_____

☐ Waiver of Premium

2. ☐ **CHILDREN'S RIDER** _____ units

Dependent Children	Date of Birth	Birthplace	Height	Weight

3. LIFE INSURANCE IN FORCE (for insured - *including business*)

Person	Company	Year Issued	Life Amount	Accidental Death Benefit	Replacement?

Protective Life and Annuity 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 and Annuity may receive from doctors and hospitals who have attended you.

Information regarding your insurability will be treated as confidential. Protective Life and Annuity, 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 and Annuity, 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 and Annuity, 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 and Annuity 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

Protective Life and Annuity Insurance Company
Home Office: 2801 Highway 280 South, Birmingham, AL 35223
P.O. Box 2606, Birmingham, AL 35202-2606
Administrative Office: P.O. Box 830735, Birmingham, AL 35283
Telephone: 1-800-265-1545

HIV RELATED INFORMATION - NEW YORK

Who Can Receive HIV Related Information?

Under New York State Public Health Law, HIV related information is confidential and may only be given:

a. To you (or a person authorized by law who consented to the test for you);

b. To anyone whom you have specifically authorized to receive such information by signing a written release;

c. To a health care facility (such as a hospital, blood bank, or clinical laboratory) or a health care provider (such as a physician, nurse, or mental health counselor) providing care to you or your child, and anyone working for such a facility or provider who reasonably needs the information to supervise, monitor or administer a health service;

d. To a person who your doctor believes is at significant risk for HIV infection, if you do not notify that person after being counseled to do so;

e. To a committee or organization responsible for reviewing or monitoring a health facility;

f. To a federal, state, country, or local health officer when state or federal law requires disclosure;

g. To a government agency, when the agency needs the information to supervise, monitor or administer a health or social service;

h. To an authorized foster care or adoption agency;

i. To insurance companies and other third party payors such as Medicaid, if necessary for the payment of services to you;

j. To any person to whom a court orders disclosure under limited circumstances set forth by law. Except in an emergency situation, advance notice and an opportunity to oppose the release of such information would be given to you;

k. To the Division of Parole, the Division of Probation, the Commission of Correction, or a medical director of a local correctional facility, as permitted by HIV confidentiality regulations of such organization;

l. By a physician to the person who consents for your health care (parent, guardian, etc.) if disclosure is necessary to provide timely care for you, and you have been counseled regarding the need for disclosure. A physician may not disclose such information if it is against your best interest to do so.

You can ask your doctor if HIV related information about you has been released to anyone listed above.

Protective Life and Annuity Insurance Company
Home Office: 2801 Highway 280 South, Birmingham, AL 35223
P.O. Box 2606, Birmingham, AL 35202-2606
Administrative Office: P.O. Box 830735, Birmingham, AL 35283
Telephone: 1-800-265-1545

NOTICE AND CONSENT FOR BLOOD TESTING WHICH MAY INCLUDE AIDS VIRUS (HIV) ANTIBODY/ANTIGEN TESTING AND AUTHORIZATION OF RELEASE OF HIV TEST INFORMATION

EXAMINER: _____

ADDRESS: _____

To determine your insurability, the Insurer named above has requested that you provide a sample of your blood for testing and analysis. All tests will be performed by a licensed laboratory.

1. What tests may be performed?
   Tests which may be performed include: determinations of blood cholesterol and related lipids (fats) and screening for liver or kidney disorders, diabetes, immune disorders, and the presence of HIV antibodies/antigens.

2. What is the HIV Antibody Test?
   The HIV antibody test is a blood test. The test shows if you have antibodies to the virus that causes AIDS. A sample of your blood will be taken from your arm with a needle. If the first test shows that you have antibodies, a different test will then be done on the same blood sample to make sure the first test was right. The HIV antigen test directly identifies AIDS viral particles.

   A positive test result means that you have been exposed to the virus and are infected. It does not mean that you have AIDS or that you will become sick with AIDS in the future; *but it is an indication that you may develop AIDS and may wish to consider further independent testing.*

   A negative test result means that you are probably not infected with the virus. It takes the body time to produce HIV antibodies. If you have been exposed to HIV recently, you need to be retested in several months to make sure you are not infected. Your doctor or counselor will explain this to you.

3. What are the benefits of taking the test?
   If you test negative:
   - You can learn how to protect yourself from getting infected with the virus in the future. Ask your doctor or counselor how.

   If you test positive:
   - You can learn how to avoid giving the virus to others.
   - Knowing that you are infected is important for your health. Your doctor can care for you better.
   - If you are a woman or man who is thinking of having a child, you can learn about the risks of passing the virus to your baby.
   - If you are a woman who is already pregnant, your doctor can provide information on the full range of options and services available to you.

4. Voluntary Testing
   Taking an HIV antibody test is voluntary. You do not have to take the test.
   If you do not wish anyone to know your test results or even that you have been tested, you can go to an anonymous test site. This is a place where you can receive counseling and the HIV test without giving your name or address. You can find the nearest anonymous test site by calling the AIDS Hotline at 1-800-541-2437.

5. Confidentiality of Test Results

If you take the HIV antibody test, your test results are confidential. Under New York State Law, confidential HIV related information can only be given to people you allow to have it by signing this consent and release form, or to those persons included on the back of this form.

By signing this release form, you agree that the test results will be reported by the laboratory to the insurer. When necessary for business reasons in connection with insurance you have or have applied for with the insurer, the insurer may disclose test results to others involved solely in the underwriting process such as its affiliates, reinsurers, employees or contractors. If the insurer is a member of the MIB, Inc., and if the test results for HIV antibodies/antigens are other than normal, the insurer will report to the MIB, Inc., a generic code which signifies only a non-specific blood and/or urine test abnormality. If your HIV test is normal, no report will be made about it to the MIB, Inc. Other test results may be reported to the MIB, Inc., in a more specific manner. The organizations described in this paragraph may maintain the test results in a file or data bank. There will be no other disclosure of test results or even that the tests have been done except as may be required or permitted by law or as authorized by you.

If your HIV test results are normal, no routine notification will be sent to you. If the HIV test results are other than normal, the insurer will contact you. The insurer may also contact you if there are other abnormal test results which, in the insurer's opinion, are significant. The insurer will ask you for the name of a physician, other health care provider, or other designee to whom you may authorize disclosure and with whom you may wish to discuss the results. *If you elect to receive the HIV test results directly, you may call the State Health Department's toll-free number for further information about AIDS, the meaning of HIV test results and the availability and location of HIV counseling services. You should consult your physician about the meaning of and need for counseling, where appropriate, as to the HIV test results.*

6. Risks Involved with Disclosure and Sources of Help

If you test positive, you should be careful about telling others what your test showed. Some HIV positive people have been discriminated against by employers, landlords and others. If you experience discrimination because of release of HIV related information, you may contact the New York State Division of Human Rights at (212) 870-8624 or the New York City Commission of Human Rights at (212) 566-5493. These agencies are responsible for protecting your rights.

7. For More Information

If you have further questions about informed consent for HIV antibody testing, you may contact the New York State Department of Health at (518) 486-1595.

Name and address of facility/provider obtaining release:

Name: _____

Address: _____

Name of person whose HIV related information will be released: _____

Name and address of person signing this form (if other than above):

Name: _____

Address: _____

Relationship to person whose HIV information will be released: _____

Name and address of person who will be given HIV related information:

Name: _____

Address: _____

Reason for release of HIV related information: _____

Time during which release is authorized: From: _____ To: _____

My questions about this form have been answered. I know that I do not have to allow release of HIV related information, and that I can change my mind at any time.

_____ _____

Date Signature

My questions about the HIV test have been answered. I agree to take the HIV antibody test.

_____

Date

_____ _____

Signature of person who will be tested Signature of person authorized to consent for person to be tested

_____ _____

Name of person who will be tested *(Please print)* Name of person authorized to consent *(Please print)*

I have explained the means by which the HIV antibody test is done, the meaning of the results and the possible consequences of disclosure of the test results to the individual above, and have answered any questions she/he had about the test.

_____ _____

Name Title

_____

Facility/Provider Name

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

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 attached to and made 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

Protective Life and Annuity 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 and are full, complete and true 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.

Signed in _____, this _____ day of _____, _____.
(State) (Month) (Year)

_____ _____
Signature of Proposed Insured 1 Address, Date of Birth, Telephone Number, Social Security Number

_____ _____
Signature of Proposed Insured 2 Address, Date of Birth, Telephone Number, Social Security Number

_____ _____
Signature of Owner/Trustee & Title if Corporation 1 Address, Date of Birth, Telephone Number, Social Security Number

_____ _____
Signature of Owner/Trustee & Title if Corporation 2 Address, Date of Birth, Telephone Number, Social Security Number

_____
Signature of Witness

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 _____ _____
Producer Signature Producer Name (Print)