PROTECTIVE LIFE INSURANCE COMPANY

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

INDIVIDUAL LIFE INSURANCE APPLICATION PACKET - INSTRUCTIONS

The forms listed on page 1 are required on all cases submitted.
All forms must be dated on or before the application signed date.

FORM NUMBER	FORM NAME	INSTRUCTIONS
PL-DIP	Description of Information Practices	This notice MUST be given to the Proposed Insured on all cases submitted.
ICC12-400	Individual Life Insurance Application	Protective Life can only accept or service an application from an applicant who speaks English or Spanish. Spanish speaking applicants must go through our TeleLife process. Complete each question in the Application for Insurance. If completing by hand, please use a pen with black ink. If applying for any riders see instructions for Rider Worksheet on Page 2.
ICC14-PL701	Supplement to Life Insurance Application (STOLI)	Must complete on all cases being submitted.
ICC18-HIPAA2	Authorization to Obtain and Disclose Information (HIPAA)	Must complete on all cases being submitted. Leave a copy of this form with the applicant. **Signature and date is required.**
PLX-408	Broker/Representative Report	The correct Broker/Representative PLICO Contract Number must be included in order to ensure commissions are paid correctly. Include Split Share Percentage.
ICC13-406A	Continuation of Information	Use this form if additional space is needed for information.
U-595	Notice and Consent Form for AIDS (HIV) Testing	Must complete on all cases submitted. Leave a copy of this form with the applicant.
PLX-588	Life Insurance Illustration Certification & Acknowledgement	Only required for illustrated UL products when an illustration is not obtained. Illustrations are required prior to issue.

NOT FOR USE WITH VARIABLE UNIVERSAL LIFE PRODUCTS

The forms listed on page 2 may be required if circumstances apply. Forms are available on MyProtective.com.

FORM NUMBER	FORM NAME	INSTRUCTIONS
ICC20-403R	Rider Worksheet	If applying for any additional benefits or riders, the Rider Worksheet must be completed. In addition, the following riders require these supplemental application forms, which can be found online at MyProtective.com forms site. Leave a copy of each form with the applicant. If applying for the Children's Term Rider, complete form number ICC17-404R. If apply for the Chronic Illness Accelerated Death Benefit Rider, provide the applicant with the L652-DSC Disclosure form. The medical examiner will need to complete the Supplemental Underwriting Application form number ICC13-P226. If applying for the Pre-determined Death Benefit Payout Endorsement (IPO), complete form number ICC18-437R.
PL-104	Pre-Authorized Withdrawal Agreement	Use in cases where the applicant elects to have premium payments drafted from a bank account.
PL-CR	Conditional Receipt Agreement	If payment is submitted with the application, must complete and sign the Conditional Receipt Agreement. Leave a copy of this form with the applicant.
A-1128-MI and A-1128b-MI	Replacement Form	Must complete and sign regarding existing coverage. Leave a copy of this form with the applicant.
F-LAD-277	Assignment/Transfer of Ownership (Section 1035 Exchange)	Must complete on 1035 Exchange/Transfer cases. Leave a copy of this form with the owner. **Send the Original to the Home Office.**
ICC20-405R	Confidential Financial Statement	To be signed by the Proposed Insured if Face Amount is $5,000,001 or greater (for Proposed Insured(s) age 0-70) and $3,000,001 or greater (for Proposed Insured(s) age 71 and older) or at the discretion of underwriting.
ICC12-402	Part 1A Supplemental Application (Medical Declarations)	If the Proposed Insured is NOT being examined, this form must be completed.

E-mail Address: NBApps@protective.com
If e-mailing the application, you do not need to send the original application. However, we will need the original 1035 paperwork and assignment forms (if applicable).

Mailing Addresses:

Home Office – 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

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

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DESCRIPTION OF INFORMATION PRACTICES

(Including MIB, Inc. Notice and Fair Credit Reporting Act Notice)

DISCLOSURE OF INFORMATION

In considering your application for insurance, information from various sources must be considered. These include the results of your physical examination, if required, and any reports Protective Life may receive from doctors and hospitals who have attended you.

Information regarding your insurability will be treated as confidential. Protective Life, or its reinsurers, may, however, make a brief report of any personal health information thereon to the MIB, Inc., (MIB), formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901. If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

Protective Life, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

INVESTIGATIVE CONSUMER REPORT

Furthermore, as part of our procedures for processing your insurance application, an investigative consumer report may be prepared by one or more of the commercial agencies offering this service whereby information is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted. This inquiry includes information as to your insurance risk score, character, general reputation, personal characteristics or behavioral and lifestyle factors, except as may be related directly or indirectly to your sexual orientation. You have the right to be personally interviewed if we order an investigative consumer report. You also have the right to receive a copy of the report by making a written request to Protective Life, within a reasonable period of time, to receive additional detailed information about the nature and scope of this investigation.

YOU CAN REVIEW AND CORRECT YOUR INFORMATION

As a general practice, we will not disclose personal or privileged information about you to anyone else without your consent, unless a legitimate business need exists or disclosure is required or permitted by law. You are entitled, upon request, to receive a more detailed statement of our information practices. You also have the right to access the personal information about you that we have in our records. You may see a copy of the information, or we will send it to you, whichever you prefer. You also have the right to request correction of personal information we may have about you which you think is wrong. To exercise these rights, please write to us at the address appearing at the end of this notice.

Ask our agent/producer for assistance or call or write us at Protective Life Insurance Company, Attention: New Business, P.O. Box 830619, Birmingham, Alabama 35283-0619. Telephone: 800-366-9378

THIS NOTICE MUST BE GIVEN TO THE PROPOSED INSURED

AGENT/PRODUCER COMPENSATION DISCLOSURE

Agents/Producers receive compensation from an insurer or third party, which may differ depending upon the product or insurer. Additional compensation may be received by the Agent/Producer based on other factors including premium volume placed with the company and loss or claim experience.

PL-DIP 03/2016

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

SECTION I: INSUREDS **INDIVIDUAL LIFE INSURANCE APPLICATION**

1. Proposed Insured 1

Name (First, Middle, Last)			
Gender	*Birthdate*	*Birth State*	*Marital Status*
Driver's License Number and State		*Social Security Number*	
Home Phone	*Work Phone*	*Cell Phone*	
Address (Street, City, State, Zip Code and Number of Years)			
Email Address			

Proposed Insured 2

Name (First, Middle, Last)			
Gender	*Birthdate*	*Birth State*	*Marital Status*
Driver's License Number and State		*Social Security Number*	
Home Phone	*Work Phone*	*Cell Phone*	
Address (Street, City, State, Zip Code and Number of Years)			
Relationship to Prop Ins 1	*Email Address*		

2. Employment Information

Proposed Insured 1

Employer's Name	
Employer's Address	
Annual Income	*Net Worth*
Occupation	*Number of Years*

Proposed Insured 2

Employer's Name	
Employer's Address	
Annual Income	*Net Worth*
Occupation	*Number of Years*

3. Owner *(If other than Proposed Insured, must complete information below. If Trust, include Name and Date of Trust.)*

Name	*Date of Trust*	*Birthdate*	*Relationship to Prop Ins*
Phone Number	*SSN/Taxpayer ID No.*	*Email Address*	
Street Address, City, State, Zip Code			

4. Send Premium Notices To *(If other than Owner)*

Name/Relationship	*Street, Address, City, State, Zip Code*

SECTION II: PLAN OF INSURANCE

Plan of Insurance: (Name of Product)	*Face Amount:* *(Proposed Insured 1)* $	*(Proposed Insured 2)* $	
If Term or Alternative to Term: (Indicate Years) ☐ 10 ☐ 15 ☐ 20 ☐ 25 ☐ 30 ☐ 35 ☐ 40	*Underwriting Class Quoted:* *(Protective will issue best underwriting class.)*		
If Universal Life: ☐ *Level Face Amount* ☐ *Increasing Face Amount*	*Section 1035:* ☐ *Yes* ☐ *No*	*1035 Loan Transfer:* ☐ *Yes* ☐ *No*	*CVAT:* ☐ *(If not checked, the Guideline Premium Test will apply, subject to product availability.)*

Is Proposed Insured Requesting Additional Benefits, Riders, or Child Coverage? ☐ *Yes* ☐ *No* *(If Yes, must complete the Rider Worksheet.)*	*Premium Payment:*	☐ *Annual* $	☐ *Quarterly* $	☐ *Semi-Annual* $
		☐ *Monthly (Pre-Authorized Withdrawal Only)* $		☐ *Cash with Application* $

SECTION III: BENEFICIARY DESIGNATIONS

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

	Name(s)	*Address, Telephone # & Date of Birth*	*Social Security #*	*Relationship*	*Percentage*
1.	*Primary Beneficiary Name(s)*				
2.	*Contingent Beneficiary Name(s)*				

SECTION IV: EXISTING COVERAGE/PENDING INSURANCE AND REPLACEMENT

(Must be answered completely on all cases.)

1. Is the policy applied for to replace an existing insurance or annuity policy(ies) with this or any other company? ……………..……. ☐ Yes ☐ No
(If Yes, complete any State required replacement forms and comparison statements.)

2. 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 any proposed insured or not. **If None, insert None.**

Name of Insured	*Company*	*Policy Number*	
Replace or Change?	*Amount*	*Purpose: Business/Personal*	*Issue Date*
Name of Insured	*Company*	*Policy Number*	
Replace or Change?	*Amount*	*Purpose: Business/Personal*	*Issue Date*
Name of Insured	*Company*	*Policy Number*	
Replace or Change?	*Amount*	*Purpose: Business/Personal*	*Issue Date*

3. Is there any application for any other life or health insurance on the life of any proposed insured now pending or being considered with this or any other company? *(If Yes, complete information below.)* …………………………………………………... ☐ Yes ☐ No

Company Name	*Amount of Coverage*	*Total Amount to be Placed*	*Purpose of Coverage*

4. Has any proposed insured had a request for life or health insurance declined, postponed, rated, canceled, or restricted in any way? *If Yes, please explain.* …………………………………………………………………………………………………….. ☐ Yes ☐ No

5. In the next 3 years, will the ownership of the policy or interest in any trust owning the policy be transferred? *If Yes, please explain.* ……………………………………………………………………………………………….…. ☐ Yes ☐ No

6. Is someone other than any Proposed Insured responsible for paying premiums? *If Yes, please explain.* ……………………….. ☐ Yes ☐ No

7. Will anyone unrelated to any Proposed Insured receive any of the policy death benefit? *If Yes, please explain.* ……………….... ☐ Yes ☐ No

8. Has a mortality analysis or life expectancy analysis been performed on any Proposed Insured? ……………………………….... ☐ Yes ☐ No

9. Has any Proposed Insured 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, please explain.* …………………………..…….. ☐ Yes ☐ No

Remarks and Explanations to any Yes answers in Section IV.

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

Question	Answer
1. What is the purpose of the insurance? (Personal – Family/Estate Protection, Asset Transfer or Business – Key Man, Buy-Sell, etc.) **If Business insurance, complete questions 2 – 6 below.**	☐ *Personal* ☐ *Business*
2. What percent of business does any Proposed Insured own or control?	%
3. What is approximate net annual income of business?	$
4. What is approximate market value of the business?	$
5. What year was the business established?	

6. Please complete the information below:

Name / Business Partner		*Title*
% of Business Owned	*Insurance Company*	*Amount Now Carried or Applied For*
Name / Business Partner		*Title*
% of Business Owned	*Insurance Company*	*Amount Now Carried or Applied For*
Name / Business Partner		*Title*
% of Business Owned	*Insurance Company*	*Amount Now Carried or Applied For*

SECTION VI: PERSONAL HISTORY

Provide details to any Yes answers under Section VII, Page 4.

HAS PROPOSED INSURED: (*Must be answered for all Proposed Insureds.*)	Proposed Insured 1 Yes	Proposed Insured 1 No	Proposed Insured 2 Yes	Proposed Insured 2 No
1. Used tobacco or nicotine of any kind over the last 5 years?	☐	☐	☐	☐
2. Consulted a physician or had treatment for the use or possession of:				
A. Alcohol? (*If Yes, complete the Alcohol Usage Questionnaire.*)	☐	☐	☐	☐
B. Narcotics, stimulants, sedatives, hallucinogenic drugs? (*If Yes, complete the Drug Use Questionnaire.*)	☐	☐	☐	☐
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 the Aviation Questionnaire.)*	☐	☐	☐	☐
6. Been a member of, or applied to be a member, or received a notice of required service in the armed forces, reserves or National Guard? (*If Yes, provide details below.*)	☐	☐	☐	☐
7. Engaged in any of the following activities in the past 2 years? (*If Yes, complete the appropriate questionnaire.*)	☐	☐	☐	☐
8. Is Proposed Insured: (*If Yes to **any** questions below, complete the Foreign Travel Questionnaire.*)				
a. A citizen of any country other than the United States or Canada? (*If Yes, provide details below.*)	☐	☐	☐	☐
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?	☐	☐	☐	☐

Question 1 details:

Type	*Frequency*	*Date Last Used*

Question 6 details:

Branch of Service	*Rank*	*Duties*	*Mobilization Category*	*Current Duty Station*

Question 7 activities: ☐ Racing ☐ Scuba Diving ☐ Hang Gliding ☐ Mountain Climbing ☐ Sky Diving ☐ Parachuting

Question 8a details:

Country of Citizenship	*Visa Type*	*Expiration Date*	*Length of U.S. Residency*

Question 8b details:

Travel Details

Question 8c details:

To Where	*Why*
When	*For How Long*

SECTION VII: SPECIAL REMARKS AND DETAILS TO ANY YES ANSWERS

(Must be answered if applicable.)

For each Yes answer, provide Section Number, Question Number, Name of the Proposed Insured, Date, Details or Reason. ***Include Any Attending Physician, Hospital or Medical Facility Name, Address and Phone Number.***

DECLARATIONS

I (We) have read or have had read to me (us) the completed Application before signing below. I (We) represent that all statements and answers made in all parts of this application are full, complete and true, to the best of my (our) knowledge and belief. 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 Conditional Receipt Agreement and the Conditional Receipt Agreement is delivered to the Owner, the terms of the Conditional Receipt Agreement 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 Conditional Receipt Agreement 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 Conditional Receipt Agreement.
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 Conditional Receipt Agreement.

IMPORTANT INFORMATION ABOUT IDENTIFICATION VERIFICATION

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 ______________________________ (City and State) Date ______________________________

(X) ______________________________ Signature of Proposed Insured 1

(X) ______________________________ Signature of Proposed Insured 2

Signed At ______________________________ (City and State) Date ______________________________

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

(X) ______________________________ Signature of Representative

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

SUPPLEMENT TO LIFE INSURANCE APPLICATION — **APPLICATION SUPPLEMENT – PART I**

The statements and answers to the questions listed below shall become a part of the attached application; shall be subject to the terms of the attached application; and shall become a part of any policy based on this application.

Print Name of Proposed Insured(s): ______________________________

For any policy to be issued as a result of this application:	**Yes**	**No**
(1) Will anyone other than the Insured, his or her family, or employer/business partner pay any portion of the initial or future premiums or obtain any right, title or interest in this policy? If Yes, complete the "Statement of Owner Intent" (Application Supplement – Part II)	☐	☐
(2) Will any portion of the initial or future premiums be borrowed, loaned or otherwise financed? If Yes, complete the "Premium Financing Disclosure" (Disclosure and Acknowledgement)	☐	☐
(3) Will a trust, including family trust, own this policy? If Yes, complete the "Trust Certification" (Application Supplement – Part III)	☐	☐
(4) Is the Proposed Insured age 65 or older AND total coverage applied for across all Protective companies $1,000,000 or more? If Yes, complete the "Statement of Owner Intent" (Application Supplement – Part II)	☐	☐

SIGNATURES

I (We) have read or have had read to me (us) the completed Supplement before signing below. All statements and answers in the Supplement are correctly recorded 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 and is subject to the applicable Fraud Statement as provided in the Application for Life Insurance.

Signed in ______________________ (State), this ________ day of ______________________ (Month), ____________ (Year).

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

X ______________________________

Signature(s) of Owner(s)/Trustee(s): X ______________________________

(provide officer's title if policy is owned by a corporation) X ______________________________

Signature of Witness: X ______________________________

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)

ICC14-PL701   10/2014

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PROTECTIVE LIFE 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 Insurance Company (Protective Life) 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 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, drug use, alcohol use, 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, 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. **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 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, see ***SPECIAL REQUIREMENT FOR HIV/AIDS TESTING*** section).
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 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, **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 is declined or if Protective Life 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 life insurance.

Home Office – ORIGINAL Applicant - COPY

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 a separate authorization. I (we) hereby authorize Protective Life:

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, or for the time limit, if any, permitted by applicable law in the state where the policy is delivered or issued for delivery, whichever period is shorter, or, in the event of a claim for benefits, for the duration of such claim.
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 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'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) 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 MUST 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 INSURANCE COMPANY

P.O. Box 830619
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AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

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

I (we) authorize Protective Life Insurance Company (Protective Life) 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 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, drug use, alcohol use, 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, 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. **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 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, see ***SPECIAL REQUIREMENT FOR HIV/AIDS TESTING*** section).
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 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, **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 is declined or if Protective Life 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 life insurance.

Home Office – ORIGINAL Applicant - COPY

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 a separate authorization. I (we) hereby authorize Protective Life:

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, or for the time limit, if any, permitted by applicable law in the state where the policy is delivered or issued for delivery, whichever period is shorter, or, in the event of a claim for benefits, for the duration of such claim.
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 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'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) 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 MUST 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 INSURANCE COMPANY

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

BROKER / REPRESENTATIVE REPORT

		Yes	No
1.	In what language were the questions on the application asked? *Please remember that Protective Life cannot accept or service any application from an applicant who does not speak English or Spanish. ☐ English ☐ Spanish ☐ Other* **List Other Language* : ______		
2.	Is the Proposed Insured a relative or does the Proposed Insured have a business relationship with you? *If Yes, Details:* ______	☐	☐
3.	(a) Will this policy replace or change existing policy(ies)?	☐	☐
	(b) If replacement of existing insurance is involved, have you complied with all relevant state requirements, including any Disclosure and Comparison Statements? *If No, Explain:* ______	☐	☐
	Answer questions (c) and (d) *only* if this is a replacement: (c) Did you use any pre-printed company approved sales materials? *If Yes, List Name or Form Number:* ______	☐	☐
	(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.)*	☐	☐
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? *If Yes, please explain in Special Requests/Remarks below.*	☐	☐
5.	Has a mortality analysis or life expectancy analysis been performed on the Proposed Insured?	☐	☐
6.	Has a medical examination been ordered? *If Yes, Name of Examiner:* ______ *Date of Exam:* ______	☐	☐
7.	Is Premium Financing involved in this case? (If Yes, please submit a cover letter describing the parameters.)	☐	☐
	I have verified the identity of the Owner by picture I.D. (*Authorized Representative if Business or Trustee if Trust)* *Identification Type:* ______ *Driver's License Number:* ______ Please include Driver's License Number if Owner is an individual and is other than the Proposed Insured. NOTE: Does not apply to direct marketing situations	☐	☐

I certify that:

a) **both the Proposed Insured(s) and the Owner(s) read, speak and understand either the English or Spanish language; and**
b) **each has explicitly told me that they understood each question and item contained in this application; and**
c) **the answers given in this application are complete and true to the best of my knowledge and belief; and**
d) **I know of nothing affecting the risk which is not set forth in my representative's report or this life insurance application; and**
e) **I carefully explained each question before recording each answer and before the application was signed.**

Signature of Broker/Representative ______ *Date* ______ *PLICO Contract Number* ______ *Share %* ______ *Business Phone Number* ______

Print Name of Above Signature ______ *Email Address* ______ *Signed at (City and State)* ______

Signature of Additional Broker/Representative ______ *Date* ______ *PLICO Contract Number* ______ *Share %* ______ *Business Phone Number* ______

Print Name of Above Additional Signature ______ *Email Address* ______ *Signed at (City and State)* ______

BGA/Broker Dealer Name ______ *PLICO Contract Number* ______

New Business Key Contact ______ *Email Address* ______ *Phone Number* ______

Broker/Representative Special Requests/Remarks:

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PROTECTIVE LIFE INSURANCE COMPANY

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

INDIVIDUAL LIFE INSURANCE – CONTINUATION OF INFORMATION

Proposed Insured 1: ____

First Name | Middle Name | Last Name | Policy Number

Proposed Insured 2: ____

First Name | Middle Name | Last Name | Policy Number

I have read or have had read to me the completed Supplemental Application before signing below. The above statements and answers are true and complete to the best of my knowledge and belief. I agree that such statements and answers shall be part of the application and shall be considered the basis of any insurance issued.

Proposed Insured 1 (Sign Name in Full) | Date | Proposed Insured 2 (Sign Name in Full) | Date

Signature of Parent or Guardian | Date | Signature of Witness | Date

Signature of Owner (Sign Name in Full) | Date
(if other than Proposed Insured)

ICC13-406A 3/2013

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

HUMAN IMMUNODEFICIENCY VIRUS (HIV) ANTIBODY TEST

IMPORTANT HEALTH INFORMATION BOOKLET
with Consent Form

Q: What is an HIV Test?

A: Human Immunodeficiency Virus (HIV) is the virus that causes Acquired Immunodeficiency Syndrome (AIDS).

Laboratory tests tell whether you have been infected with HIV. A test is not considered positive unless a different, backup test is done and also reads positive. These tests are conducted on a single sample of your blood or on an oral sample from your mouth or on a urine sample. Test results may, on rare occasions, be inconclusive, and this possibility should be discussed with your health professional.

Q: Will the HIV test tell me if I have AIDS?

A: No. A positive test means you have become infected with the virus. While some people infected with the virus have gone on to develop AIDS, others have not yet developed AIDS. Healthy lifestyle and behavior changes, improved diet, and, most importantly, early medical treatment may help you delay, or avoid, the development of AIDS.

Q: How long after exposure does it take to tell if I am infected?

A: Most people will test positive within three months after exposure. The average time is less than one month. However, a few people have taken up to six months or even one year to test positive.

Q: How does a person become infected with HIV?

A: The virus is most commonly spread through sexual contact (vaginal, anal, or oral sex) and by sharing needles or works to shoot injectable drugs. An infected mother may infect her baby during pregnancy, at the time of birth, or while breast feeding. Very rarely, contact with blood through open cuts or wounds, or splashes to the eyes, may also spread the virus. **You cannot get infected with the virus by donating or giving blood, or through casual contact.**

Q: Do I have to have this test?

A: Generally, getting tested is your decision. In Michigan, testing is required if you are a potential organ, semen, tissue, or blood donor; a military recruit; an immigrant; or if you have been charged and bound over, or convicted of certain crimes in a court of law. In addition, some health care facilities may have an admission requirement that you consent to be tested if a health care worker is accidentally exposed to your blood during your stay in their facility.

An insurance company has the right to request that you take an HIV test if you apply for new health or life insurance. If you refuse or if you test positive, as with any other potentially serious health condition, you will probably be turned down for this new insurance.

Q: Who should consider having the HIV test?

A: The Michigan Department of Community Health recommends that HIV testing be considered by anyone who meets any of the following:

- People who have had a sexually transmitted disease (venereal disease).
- People who have shared needles or who have a history of drug abuse.
- Men who have had sex with other men.
- Men or women who have had unprotected sex with anyone whose HIV status is unknown. (Unprotected sex means there has been an exchange of semen or vaginal secretions between the partners.)
- People who have had more than one sex partner.
- People who have had sex with prostitutes (male or female).
- People who received blood products or blood transfusions between 1978 and 1985.
- People who exchange sex for drugs or money.
- People who are infected with tuberculosis.
- People who have had exposure to the blood of someone who may be infected.
- People who have had sex with any person from the above list, particularly with injecting drug users.
- Women who are pregnant or who are considering pregnancy.
- Women who are diagnosed with invasive cervical cancer.

Q: Where can I have the test done without my name being used?

A: All local health departments and other testing centers designated by the Michigan Department of Community Health will provide the option to you to be tested with your name (confidential testing) or without your name (anonymous testing). Any person giving you this test is required by law to keep your test results confidential, with a few exceptions specified by law. If you request testing without your name, these facilities have trained counselors who will counsel you on an anonymous basis.

If anonymous testing is done and you have a positive test, you need to know that health care and treatment are not provided on an anonymous basis.

Q: Who will know the results of my tests?

A: Any person giving you this test is required by law to keep your test results confidential. Even the courts must follow specific rules before they can require disclosure through a court order. A subpoena is not sufficient to require disclosure; you will be asked to sign a separate release form. If this information needs to be released beyond the requirements of the law, you will be asked to sign a separate release form.

In Michigan, positive test results are reportable to the state and local health departments. The health department will maintain your confidentiality and use this information to understand the extent of infection in Michigan's communities. This information may also be used by your health provider or local health department as needed to properly diagnose and care for you and protect your health, to assist you in notifying your sexual or needle sharing partners, and to prevent spread of the virus. The test results, if positive, will also be given to a potential spouse if you are planning to get married. If you are a health care worker, you should be aware of state guidelines regarding infected health care workers.

If you are tested in a physician's private practice office, or in the office of a physician affiliated with or under contract with a Health Maintenance Organization, you may request that your name, address, and phone number not be included in the HIV-positive report to your local health department. It is against the law in Michigan for local health departments to keep lists of names of infected people.

Michigan law now requires that, if you are infected, your physician or the local health officer must warn (notify) all of your known sexual or needle-sharing partners of the fact that they have been exposed. In doing this, they are required to keep your identity confidential.

Q: Are there any risks involved in having the test done?

A: There are three ways you can be tested for HIV. They are by drawing a sample of blood, taking an oral sample from your mouth, or testing your urine. There are virtually no medical risks in drawing a small sample of blood. Only sterile needles and syringes are used for this purpose. Once the needle or syringe is used, it is safely thrown away, or properly sterilized. If an oral sample from the mouth is used for the test, a specially-treated pad is placed between the lower cheek and gum and held for two minutes. This causes no risk or pain. The urine test requires only a urine sample.

Before you are tested, you should carefully think about to whom you would tell the results, and what emotional support systems are available to you. The Michigan Civil Rights Commission has ruled that AIDS, HIV infection, and the suspicion of AIDS or HIV infection are considered handicapping conditions. Therefore, people are not to be discriminated against, and have all the rights of a handicapped person as defined under the Michigan Persons with Disabilities Civil Rights Act, P.A. 220 of 1976 (formerly, Michigan Handicappers' Civil Rights Act). Federal laws make similar rulings through the federal Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990. The Americans with Disabilities Act of 1990 strictly forbids discrimination against persons with HIV or AIDS.

Q: What will happen to the consent form after I sign it?

A: If you decide to be tested, you will be asked to sign a consent form. If you test anonymously, you can sign using a number or a fake name. Procedures for filing the consent form will vary from facility to facility. Please ask your health professional if you would like to know what their confidentiality procedure is.

Q: Can I change my mind after I sign the consent form?

A: Yes, you can change your mind at any time before the laboratory performs the test. If you change your mind, you will have to provide a written request to the person or organization providing you with this information booklet.

Q: How will this test help me?

A: If you are tested, you most likely will be required to appear in person to get your test results. Whether your results are positive or negative, your overall health may be helped from discussions with your health professional.

If you test negative, the test indicates either that you are not infected, or possibly, that you were infected very recently (within the past 3-6 months). You can learn through counseling how to protect yourself from infection in the future. If you have recently practiced risky behavior, you may want to be retested.

If you test positive, the test indicates that you have been infected with HIV. You can still take action to benefit your health and **reduce the chance of infecting others**. This includes maintaining a good state of physical and mental health. By doing so, you may delay the development of AIDS. It is suggested that you:

- Seek medical treatment immediately. Many drugs are now available for treatment of persons infected with HIV even if symptoms are not present. Early treatment is usually beneficial to many people with HIV.
- Receive all recommended vaccines. Discuss with your physician which vaccines are recommended and which should be avoided.
- Maintain good nutrition, exercise and get adequate rest.
- Receive emotional support and work on managing stress.
- Eliminate recreational drugs, or at least reduce alcohol and smoking.
- Stop injecting drugs. If you continue to inject, stop sharing equipment, and use a new syringe and needle each time. At the very least, you should learn to clean your needles or works with full-strength bleach and water.
- Don't have vaginal, anal, oral or other sexual contact that exposes others to your semen, vaginal secretions or blood. Avoid exposing others and getting sexually-transmitted diseases (through abstinence or by always using latex or polyurethane condoms or barriers).

- Inform all known sexual or needle-sharing partners, including any new partners, about your infection.
- Do not donate blood or organs (change designation on driver's license).
- Seek counseling regarding becoming pregnant or fathering a child.
- If you are pregnant and planning to continue that pregnancy, discuss with your physician treatments that may protect your baby.

Q: Whom should I tell if I am HIV-positive?

A: If you test positive, you need to know that this infection is not passed to another person through casual contact. Michigan law requires that you must notify any new sexual partner prior to having sex with them. Past sexual and needle-sharing partners are to be notified so that they can also be counseled and offered testing. If requested, your local health department will provide you assistance in notifying partners.

Inform all health care providers, both medical and dental, who are providing you treatment, about your HIV infection. This will help them care for you.

The law prohibits health care providers from refusing to treat you based upon your HIV infection.

New guidelines indicate that HIV-infected pregnant women should undergo treatment for HIV disease. This treatment may reduce the risk of transmission to the newborn by 60-70%.

Finally, be careful about discussing your HIV status with others. Some people may not understand the nature of the infection or how it is actually spread. This may lead to misunderstanding and create problems for you with friends, co-workers, or others.

Q: What if I have more questions?

A: Please ask the health professional who gave you this booklet. Your health professional will have the answers to your questions or will get the answers for you.

You should feel free to call the statewide AIDS information hotline (1-800-872-AIDS; Spanish 1-800-862-SIDA; TDD 1-800-332-0849) or your local health department at any time, if you have questions or need help.

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

CONSENT FORM FOR THE HUMAN IMMUNODEFICIENCY VIRUS (HIV) ANTIBODY TEST

I have been informed that my blood, an oral sample from my mouth, or my urine will be tested for antibodies to the Human Immunodeficiency Virus (HIV), the virus that causes AIDS.

I acknowledge that I have been given an explanation of the test, including its uses, benefits, limitations, and the meaning of test results.

I have been informed that the HIV test results are confidential and shall not be released without my written permission, except to ____,* and as permitted under state law.

I understand that I have the right to have this test done without the use of my name. If my private physician does not provide anonymous testing, I understand I may obtain anonymous testing at a Michigan Department of Community Health-approved HIV counseling and testing site.

I understand that I have the right to withdraw my consent for the test at any time before the test is complete.

I acknowledge that I have been given a copy of the booklet *Important Health Information* . I have been given the opportunity to ask questions concerning the test for HIV antibodies, and I acknowledge that my questions have been answered to my satisfaction.

I authorize Protective Life Insurance Company or its reinsurers to make a brief report of any personal health information to the MIB.

By my signature below, I consent to be tested for HIV.

____ ______________________________

Signature of Proposed Insured or Parent/Guardian Date

____ ______________________________

Witness Date

AT THIS TIME, I DO NOT WANT TO BE TESTED FOR THE HUMAN IMMUNODEFICIENCY VIRUS.

____ ______________________________

Signature of Proposed Insured or Parent/Guardian Date

____ ______________________________

Witness Date

*** Please write in the physician or health facility name who will receive the HIV test results.**

Name of Physician or Health Facility: ____

Address: ____

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PROTECTIVE LIFE INSURANCE COMPANY

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

CONSENT FORM FOR THE HUMAN IMMUNODEFICIENCY VIRUS (HIV) ANTIBODY TEST

I have been informed that my blood, an oral sample from my mouth, or my urine will be tested for antibodies to the Human Immunodeficiency Virus (HIV), the virus that causes AIDS.

I acknowledge that I have been given an explanation of the test, including its uses, benefits, limitations, and the meaning of test results.

I have been informed that the HIV test results are confidential and shall not be released without my written permission, except to ____,* and as permitted under state law.

I understand that I have the right to have this test done without the use of my name. If my private physician does not provide anonymous testing, I understand I may obtain anonymous testing at a Michigan Department of Community Health-approved HIV counseling and testing site.

I understand that I have the right to withdraw my consent for the test at any time before the test is complete.

I acknowledge that I have been given a copy of the booklet *Important Health Information* . I have been given the opportunity to ask questions concerning the test for HIV antibodies, and I acknowledge that my questions have been answered to my satisfaction.

I authorize Protective Life Insurance Company or its reinsurers to make a brief report of any personal health information to the MIB.

By my signature below, I consent to be tested for HIV.

____ ______________________________
Signature of Proposed Insured or Parent/Guardian Date

____ ______________________________
Witness Date

AT THIS TIME, I DO NOT WANT TO BE TESTED FOR THE HUMAN IMMUNODEFICIENCY VIRUS.

____ ______________________________
Signature of Proposed Insured or Parent/Guardian Date

____ ______________________________
Witness Date

*** Please write in the physician or health facility name who will receive the HIV test results.**

Name of Physician or Health Facility: ____

Address: ____

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PROTECTIVE LIFE INSURANCE COMPANY

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

INDIVIDUAL LIFE INSURANCE APPLICATION – RIDER WORKSHEET

Required if applying for additional benefits or riders.

☐ New Business ☐ In Force Protective Policy # :____________________________________

______________________________ Print Proposed/Primary Insured's Name

______________________________ Proposed/Primary Insured's Social Security No.

**** If applying for Children's Term Rider, Income Provider Option, ExtendCare Rider or Chronic Illness Accelerated Death Benefit, please complete the rider specific supplemental application(s) per application instructions.***

ADDITIONAL BENEFITS

☐ Accidental Death Benefit Rider *(Range $10,000 - $250,000)* $______________

☐ * Children's Term Rider *(1 Unit Equals $1,000 Death Benefit – 25 Units Maximum)* ______________ Units

☐ * ExtendCare Rider or Chronic Illness Accelerated Death Benefit

Maximum Monthly Benefit Amount $______________

Elimination Period *(Number of Days)* ______________

☐ Guaranteed Insurability Rider $______________

☐ * Income Provider Option

☐ Protected Insurability Rider $______________

☐ Waiver of Premium *(Non-Universal Life Only)*

☐ Waiver of Specified Premium Rider *(Universal Life Only)*

Monthly Benefit Amount $______________

☐ Other ____

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.

Signed at: (City and State) ______________________________ Date ____________________

______________________________ Owner Signature

______________________________ Proposed/Primary Insured Signature

______________________________ Witness to Owner Signature

______________________________ Signature of Parent or Guardian

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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. 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 ______________ *(1st - 28th)* day of the month.

____
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.

PL-104 06/14

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PROTECTIVE LIFE INSURANCE COMPANY

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

CONDITIONAL RECEIPT AGREEMENT

PREMIUM RECEIPT

This Conditional Receipt Agreement ("Agreement") contains the entire terms regarding conditional coverage. The Agreement provides a limited amount of insurance, for a limited period of time, subject to the terms provided hereafter. No Agent of Protective Life Insurance Company ("Company") can alter or waive any of the provisions of this Agreement. Furthermore, in no event will there be conditional coverage unless the first full premium required by the Company has been paid at the time of application.

Premium Amount Received: $________________________

Method of Payment: ☐ Check ☐ Pre-Authorized Withdrawal

☐ Other ____________________________________

The amount received is a conditional payment of the first premium for this insurance policy on the life of the

following Proposed Insured(s) ____.

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO PROTECTIVE LIFE 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.

TERMS AND CONDITIONS

Amount of Coverage

If a premium has been accepted by the Company for an application of insurance and any person proposed for insurance in such application dies while this Agreement is in effect, the Company will pay, subject to the conditions and limitations contained herein, to the beneficiary designated in such application, the lesser of:

(a) The amount of death benefit, if any, which would be payable under the policy covering the life or lives of the Proposed Insured(s) if issued as 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 Proposed Insured's death under any other policy, application, conditional receipt, or temporary life receipt with the Company, or (ii) $50,000.

Date of Conditional Coverage

Conditional coverage will begin when the application is completed, a premium has been accepted, this Agreement has been completed and signed, and all the terms and conditions stated herein have been satisfied.

Limitations

Premium shall not be collected and this Agreement will not be effective if:

(1) The Proposed Insured(s) is under 15 days of age or over age 80;
(2) The Proposed Insured(s), within the past 90 days, has been admitted to a hospital or other medical facility, been advised by a member of the medical profession to be admitted, or had surgery performed or recommended;
(3) Within the past two years, the Proposed Insured(s) has had treatment recommended by a member of the medical profession for heart trouble, stroke or cancer;
(4) The Proposed Insured(s) has been rated or declined for insurance within the past five years; or
(5) The Proposed Insured(s) intends to leave the United States within the next 60 days.

Termination and Refund of Premium

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

(1) Premium payment is by check, and it is not honored by the drawee bank upon presentation;
(2) Premium payment is by Pre-Authorized Withdrawal, and the deduction is not honored by the drawee bank;
(3) If the application to which this Agreement was attached is not approved as applied for by the Company within ninety days from the date of its receipt;
(4) There is a material misrepresentation in the answers to any questions or statements in the application; or
(5) If any Proposed Insured(s) dies by suicide, while sane or insane.

If any of the above-listed conditions do occur, the Company's liability under this Agreement is limited to a refund of the premium payment made.

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.

Full life insurance coverage becomes effective when the policy is delivered and is governed by the policy contract. This Agreement will terminate when the policy contract is delivered.

<u>Notice:</u> You should retain a copy of this Agreement. The Original will be retained by the Company.

<u>SIGNATURES:</u>

I have read this agreement and declare that the answers are true to the best of my knowledge and belief. I understand and agree to the terms, conditions, and limitations of this Agreement.

Proposed Insured's Signature	Date
Owner's Signature (if other than the Proposed Insured)	Date
Joint Owner's Signature	Date
Agent's Signature	Date

PROTECTIVE LIFE INSURANCE COMPANY

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

CONDITIONAL RECEIPT AGREEMENT

PREMIUM RECEIPT

This Conditional Receipt Agreement (“Agreement”) contains the entire terms regarding conditional coverage. The Agreement provides a limited amount of insurance, for a limited period of time, subject to the terms provided hereafter. No Agent of Protective Life Insurance Company (“Company”) can alter or waive any of the provisions of this Agreement. Furthermore, in no event will there be conditional coverage unless the first full premium required by the Company has been paid at the time of application.

Premium Amount Received: $________________________

Method of Payment: ☐ Check ☐ Pre-Authorized Withdrawal

☐ Other ____________________________________

The amount received is a conditional payment of the first premium for this insurance policy on the life of the

following Proposed Insured(s) ____.

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO PROTECTIVE LIFE 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.

TERMS AND CONDITIONS

Amount of Coverage

If a premium has been accepted by the Company for an application of insurance and any person proposed for insurance in such application dies while this Agreement is in effect, the Company will pay, subject to the conditions and limitations contained herein, to the beneficiary designated in such application, the lesser of:

(a) The amount of death benefit, if any, which would be payable under the policy covering the life or lives of the Proposed Insured(s) if issued as 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 Proposed Insured’s death under any other policy, application, conditional receipt, or temporary life receipt with the Company, or (ii) $50,000.

Date of Conditional Coverage

Conditional coverage will begin when the application is completed, a premium has been accepted, this Agreement has been completed and signed, and all the terms and conditions stated herein have been satisfied.

Limitations

Premium shall not be collected and this Agreement will not be effective if:

(1) The Proposed Insured(s) is under 15 days of age or over age 80;
(2) The Proposed Insured(s), within the past 90 days, has been admitted to a hospital or other medical facility, been advised by a member of the medical profession to be admitted, or had surgery performed or recommended;
(3) Within the past two years, the Proposed Insured(s) has had treatment recommended by a member of the medical profession for heart trouble, stroke or cancer;
(4) The Proposed Insured(s) has been rated or declined for insurance within the past five years; or
(5) The Proposed Insured(s) intends to leave the United States within the next 60 days.

Termination and Refund of Premium

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

(1) Premium payment is by check, and it is not honored by the drawee bank upon presentation;
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(3) If the application to which this Agreement was attached is not approved as applied for by the Company within ninety days from the date of its receipt;
(4) There is a material misrepresentation in the answers to any questions or statements in the application; or
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If any of the above-listed conditions do occur, the Company's liability under this Agreement is limited to a refund of the premium payment made.

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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.

Full life insurance coverage becomes effective when the policy is delivered and is governed by the policy contract. This Agreement will terminate when the policy contract is delivered.

Notice: **You should retain a copy of this Agreement. The Original will be retained by the Company.**

SIGNATURES:

I have read this agreement and declare that the answers are true to the best of my knowledge and belief. I understand and agree to the terms, conditions, and limitations of this Agreement.

______________________________ ______________________________
Proposed Insured's Signature Date

______________________________ ______________________________
Owner's Signature (if other than the Proposed Insured) Date

______________________________ ______________________________
Joint Owner's Signature Date

______________________________ ______________________________
Agent's Signature Date

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

INSURANCE DEPARTMENT BULLETINS **NOTICE TO APPLICANTS REGARDING REPLACEMENT OF LIFE INSURANCE**

THIS NOTICE IS FOR YOUR PROTECTION AND IS REQUIRED BY REGULATIONS OF THE MICHIGAN COMMISSIONER OF INSURANCE. PLEASE READ IT CAREFULLY.

Dropping or changing your existing life insurance to replace it with a new life insurance policy may be disadvantageous because:

A company can deny a claim during the first two years if it can be shown that you withheld information from your application which was important to the decision of whether to insure you. This is called the "CONTESTABLE PERIOD". If you drop or change policies, you may have to go through the two year period again.

You may pay HIGHER RATES for identical coverage because of your age. Life insurance rates go up as you get older.

BEFORE YOU DROP, CHANGE OR CASH IN YOUR PRESENT INSURANCE and apply for new insurance, you should:

1. Compare the policy BENEFITS and OPTIONS. The agent is required by law to provide you with all pertinent facts of the change and the insurance company you are considering must notify the company that issued your existing policy.

2. Be aware that you may be required to provide EVIDENCE OF INSURABILITY. If your health condition has changed since the application was taken on your present policy, you may be required to pay additional premiums under the new policy, or be denied coverage.

3. Compare the LOAN INTEREST RATE. The interest rate for new policies is probably higher than for the existing policy. Therefore, you will pay more when you want to borrow the cash value. If you are considering borrowing against your existing policy to pay the premiums on the proposed policy, you should understand that in the event of your death, the amount of any unpaid loan, including unpaid interest, will be deducted from the benefits of your existing policy.

4. Find out if the existing policy and/or the proposed policy offers DIVIDENDS OR EXCESS INTEREST. Dividends or excess interest can have a significant impact on net policy cost. Remember that no company can guarantee the amount of dividends it will pay in the future, nor can excess interest projections be presented as to imply a guarantee.

5. CONTACT THE AGENT OF YOUR PRESENT COMPANY. Your present company can often make changes in your existing insurance on terms which are more favorable to you than can another company.

6. Find out if there are income or estate tax consequences if you drop or change your present policy.

You should not drop or change your existing life insurance coverage until after you have been issued the new policy, examined it and found it to be acceptable to you. REMEMBER, YOU HAVE TEN DAYS AFTER RECEIPT OF THE POLICY TO CANCEL AND OBTAIN A FULL REFUND.

Applicant's Signature ______________________ Date ______________________

A-1128-MI 6/84 ORIGINAL - Home Office COPY - Applicant

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PROTECTIVE LIFE INSURANCE COMPANY

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

INSURANCE DEPARTMENT BULLETINS **NOTICE TO APPLICANTS REGARDING REPLACEMENT OF LIFE INSURANCE**

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4. Find out if the existing policy and/or the proposed policy offers DIVIDENDS OR EXCESS INTEREST. Dividends or excess interest can have a significant impact on net policy cost. Remember that no company can guarantee the amount of dividends it will pay in the future, nor can excess interest projections be presented as to imply a guarantee.

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6. Find out if there are income or estate tax consequences if you drop or change your present policy.

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Applicant's Signature ______________________ Date ______________________

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PROTECTIVE LIFE INSURANCE COMPANY

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

INFORMATION STATEMENT

THE LIFE INSURANCE I INTEND TO PURCHASE FROM ____ INSURANCE COMPANY MAY REPLACE OR ALTER EXISTING LIFE INSURANCE.

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

Insurer *as it appears on the policy*	**Insured** *as it appears on the policy*	**Policy Number**

PROPOSED POLICY

_______________________________ $ _______________________________
Type of Policy - Generic Name Face Amount

_______________________________ _______________________________
Signature of Applicant Date

____
Address of Applicant *(Street, City, State, Zip Code)*

CERTIFICATION BY THE AGENT

I certify that this form and the "Notice to Applicants Regarding Replacement of Life Insurance" were given to and signed by:

____
Applicant *(Please Print or Type)*

prior to taking an application and that I am leaving a signed copy for the applicant.

_______________________________ _______________________________
Signature of Agent Date

____
Address of Agent *(Street, City, State, Zip Code)*

APPLICANT ACKNOWLEDGEMENT

I acknowledge receipt of a copy of this Information Statement.

____
Signature of Applicant

A-1128b MI 4/98 HOME OFFICE COPY

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

INFORMATION STATEMENT

THE LIFE INSURANCE I INTEND TO PURCHASE FROM ________________________________ INSURANCE COMPANY MAY REPLACE OR ALTER EXISTING LIFE INSURANCE.

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

Insurer *as it appears on the policy*	**Insured** *as it appears on the policy*	**Policy Number**

PROPOSED POLICY

Type of Policy - Generic Name ________________________________

$ ________________ Face Amount

Signature of Applicant ________________________________

Date ________________

Address of Applicant *(Street, City, State, Zip Code)* ________________________________

CERTIFICATION BY THE AGENT

I certify that this form and the "Notice to Applicants Regarding Replacement of Life Insurance" were given to and signed by:

Applicant *(Please Print or Type)* ________________________________

prior to taking an application and that I am leaving a signed copy for the applicant.

Signature of Agent ________________________________

Date ________________

Address of Agent *(Street, City, State, Zip Code)* ________________________________

APPLICANT ACKNOWLEDGEMENT

I acknowledge receipt of a copy of this Information Statement.

Signature of Applicant ________________________________

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PROPOSED INSURED COPY

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

ASSIGNMENT/TRANSFER OF OWNERSHIP SECTION 1035 EXCHANGE

Insured(s): ____

Owner(s)/Joint Owner(s): ***(REQUIRED)*** ____

Insurer/Existing Insurance Company Name: ____
(Please include Street Address, City, State, and Zip Code) : ____

Policy Number(s):____

Estimated Cash Surrender Value: $_________________________ Phone Number(s): ______________________________

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

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

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

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

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

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

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

Please Check One: ☐ I have enclosed the original policy(ies) to be exchanged. ☐ I certify that the original policy(ies) has/have been lost or destroyed. To the best of my knowledge, the original policy(ies) is/are not in the possession or control of any other person.

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

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

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

ASSIGNMENT/TRANSFER OF OWNERSHIP SECTION 1035 EXCHANGE

Insured(s): ____

Owner(s)/Joint Owner(s): ***(REQUIRED)*** ____

Insurer/Existing Insurance Company Name: ____
(Please include Street Address, City, State, and Zip Code) : ____

Policy Number(s):____

Estimated Cash Surrender Value: $_________________________ Phone Number(s): ______________________________

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

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

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

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

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

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Please Check One: ☐ I have enclosed the original policy(ies) to be exchanged. ☐ I certify that the original policy(ies) has/have been lost or destroyed. To the best of my knowledge, the original policy(ies) is/are not in the possession or control of any other person.

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

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

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PROTECTIVE LIFE INSURANCE COMPANY

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

INDIVIDUAL LIFE INSURANCE APPLICATION – CONFIDENTIAL FINANCIAL STATEMENT

To be signed by the Proposed Insured if Face Amount is $5,000,001 or greater (for Proposed Insured(s) age 0 - 70) and $3,000,001 or greater (for Proposed Insured(s) age 71 and older) or at the discretion of Underwriting. Complete Part 1 for personal coverage and Part 2 for business coverage. This form should be submitted for all estate tax/liquidity, asset maximization and charitable giving cases, and for any bankruptcy in the last 3 years. Additional documentation may be requested by the Company to verify the agreements and financial disclosures made below.

Name of Proposed Insured	Date of Birth	Social Security Number

Part 1

1. Your Income (before taxes):

	Current Year	Prior Year
Salary or Wages	$	$
Bonuses and/or Commissions	$	$
Net Business or Professional Income *(Gross income less business expenses)*	$	$
Other Earned Income – Explain details in “Remarks” below	$	$
Unearned Income *(interest and dividends, net real estate income, retirement income, etc.)* – Explain details in “Remarks” below	$	$
TOTAL	$	$

2. Your Net Worth:

	Current Year	Prior Year
Investment Assets *(cash, mutual funds, stocks, 401k, etc.)*	$	$
Real Estate *(residence, second home, rental properties, etc.)*	$	$
Business Assets – Explain details in “Remarks” below *(cash, accounts receivable, equipment, inventory, etc.)*	$	$
Liabilities *(wages/interest/dividends payable, loans, etc.)*	$	$
Net Worth	$	$

3. Estimated tax liabilities at death - include potential estate taxes, capital gains taxes, income taxes *(both federal and state)*:

4. How was the need and amount of coverage determined?

Remarks *(questions 1-4)*

Part 2

Complete questions 5-8 only if applying for business coverage.

5. Purpose of business coverage:

☐ Key Person ☐ Buy/Sell ☐ Stock Repurchase ☐ Creditor ☐ Deferred Compensation

☐ Other (explain): ____

6. If buy/sell, is a written buy/sell agreement in effect? *(if Yes, please attach a copy)* ☐ Yes ☐ No

Percentage of Ownership	__________%
Fair Market Value of Company *(Provide details on how value was determined in "Remarks" section below)*	$_________________
Are other partners being covered? *(Provide details in "Remarks" section below)*	☐ Yes ☐ No
Date Business Started	_____ / _____ / ______

7. If Creditor:

Name of Lender	
Amount of Loan	$
Purpose of Loan	
Length of Loan *(how many years?)*	
Will the Loan be Collaterally Assigned?	☐ Yes ☐ No

8. Financial Details of Business:

	Last Year	Prior Year
Total Assets *(cash, accounts receivable, equipment, inventory, etc.)*	$	$
Total Liabilities *(wages/interest/dividends payable, loans, etc.)*	$	$
Gross Sales or Revenue	$	$
Net Income *(before taxes)*	$	$

Remarks *(questions 5-8)*

Part 3

Signatures:

I agree that 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.

Signature of Proposed Insured ______ Date ______ Signature of Agent ______

PROTECTIVE LIFE INSURANCE COMPANY

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

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

SECTION 1

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

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

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

SECTION 2

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

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

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

SECTION 3

Has any person proposed for insurance ever been diagnosed or treated by a member of the medical profession for: (**Circle** conditions to which "Yes" answer applies and give details below)	**Proposed Insured 1** Yes No	**Proposed Insured 2** Yes No
(a) Immune deficiency, anemia, recurrent fever, fatigue or unexplained weight loss, malaise, loss of appetite, diarrhea, fever of unknown origin, severe night sweats; unexplained or unusual infections or skin lesions; unexplained swelling of the lymph glands; Kaposi's Sarcoma or Pneumocystis Carinii Pneumonia…………………………………..	☐ ☐	☐ ☐
(b) Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS)………..……………	☐ ☐	☐ ☐

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

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

SECTION 4

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

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

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

SECTION 5

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

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

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

SECTION 6

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

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

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

SECTION 7

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

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

I have read or have had read to me the completed Supplemental Application before signing below. The above statements and answers are true and complete to the best of my knowledge and belief. I agree that such statements and answers shall be part of the application and shall be considered the basis of any insurance issued.

Proposed Insured 1 (Sign Name in Full) ____ Date ____ Proposed Insured 2 (Sign Name in Full) ____ Date ____

Signature of Parent or Guardian ____ Date ____ Signature of Witness ____ Date ____

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

LIFE INSURANCE ILLUSTRATION CERTIFICATION & ACKNOWLEDGEMENT

- **This certification must be submitted with the Application for Life Insurance if a signed illustration is not submitted for one of the reasons set forth below.**
- **This form must be signed on or before the application signed date in restricted states.**

1. **PROPOSED INSURED** *(please print)*
   First, Middle, Last Name: ______________________________
   Social Security Number: ______________________ Date of Birth *(mm/dd/yyyy)*: ______________________
2. **OWNER** *(if other than Proposed Insured)*
   First, Middle, Last Name: ______________________________
3. **AGENT/REPRESENTATIVE** *(please print)*
   First, Middle, Last Name: ______________________________
   Agent/Representative Number: ______________________ BGA Name *(if applicable)*: ______________________
4. **ELECTRONIC ILLUSTRATION DATA – Complete this section if an electronic illustration is presented and no corresponding printed copy is provided.**

Gender Class: ______________________	Initial Death Benefit: ______________________
Date of Birth *(mm/dd/yyyy)*: ______________________	Premium Amount Illustrated: ______________________
Underwriting Class: ______________________	Premium Mode: ______________________
Plan Type: ______________________	Number of Policy Years Illustrated: ______________________
Product Name: ______________________	Guaranteed Interest Rate: ______________________%
Policy Form Number: ______________________	Non-Guaranteed Illustrated Interest Rate: ___________%
Rider(s): ______________________	Alternate Indexed Interest Rate: *(for Indexed Products)* ___________%

I, the Applicant, hereby acknowledge that *(check only one)*:

- ☐ No policy illustration was provided to me and I understand that a policy illustration conforming to the policy as issued will be provided no later than the time the policy is delivered.
- ☐ The policy applied for is different than the policy illustration shown to me, and I understand that a policy illustration conforming to the policy as issued will be provided no later than at the time the policy is delivered.
- ☐ I viewed a complete electronic illustration which was based on the personal and policy information shown on this form and I understand that a policy illustration conforming to the policy as issued will be provided no later than at the time the policy is delivered. No corresponding printed copy was provided.

Applicant Signature: X______________________________ Date: ______________________

I, the Agent/Representative, hereby certify that *(check only one)*:

- ☐ No illustration was used in the sale of the life insurance applied for.
- ☐ The life insurance applied for is other than as shown in the policy illustration.
- ☐ I displayed a complete electronic illustration to the proposed insured that was based on the personal and policy information shown on this form. I further certify that the policy illustration complies with applicable state requirements and that no corresponding printed copy was provided.

Agent/Representative Signature: X______________________________ Date: ______________________

A SIGNED COPY MUST BE PROVIDED TO THE APPLICANT AND TO THE COMPANY
See Page 2 for State Specific Disclosures

REQUIRED CALIFORNIA DISCLOSURE – For Universal Life Policies with No-Lapse Guarantees

This policy is guaranteed to stay in force for a specified number of years as long as you meet the requirements of the Policy, including the Minimum Monthly Premium provision found in the policy contract. This provision is also known as a no-lapse guarantee, and a general description of the provision is included in the Narrative Summary section of the Basic Illustration.

While this policy provides a no-lapse guarantee, it may provide nonforfeiture benefits, such as cash surrender values, which are less than those that would be provided if the guarantee were issued as a separate policy, such as a term policy. If a separate term policy has higher nonforfeiture benefits, the premiums for the separate policy might be higher than the premiums for the no-lapse guarantee provided in this policy. Therefore, when considering the purchase of this policy, you should compare the value of higher nonforfeiture benefits, such as cash surrender values, versus the premiums required to keep your insurance coverage in force.

REQUIRED SOUTH CAROLINA DISCLOSURE – For Universal Life Policies with No-Lapse Guarantees

If there is no policy debt or partial surrenders, this policy is guaranteed to stay in force during the no lapse period as long as you have paid the required minimum premiums. This guarantee could be provided by a separate policy (such as a term policy). However, the nonforfeiture benefits (such as cash surrender value) in this policy may be significantly less valuable than those provided by the separate policy. So, if you fail to pay a premium within a specified period of time from its due date or otherwise cause this policy to terminate early, the benefits paid to you upon termination could be much less than would customarily be paid if provided by the separate policy.

When thinking about purchasing this policy, you should consider the tradeoff you may be making between having significantly smaller nonforfeiture benefits (such as a cash surrender value) available to you upon surrender of the policy versus the reduction in premium, if any, you may receive for not having these benefits.