Protective Life Insurance Company
P.O. Box 830771
Birmingham, AL 35283-0771

VARIABLE UNIVERSAL LIFE (VUL) INSURANCE APPLICATION PACKET - INSTRUCTIONS

The forms listed on this page are required on all cases submitted.

FORM NUMBER	FORM NAME	INSTRUCTIONS
• PL-DIP	• Description of Information Practices	• This notice MUST be given to the proposed Insured on all cases submitted.
• ICC14-V1APP	• VUL - 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-V1FUND	• VUL – Premium Payment Allocations	• Complete premium payment allocations. **Signatures and dating required.**
• ICC14-PL701	• Supplement to Life Insurance Application	• Must complete on ALL cases being submitted. **Signatures and dating required.**
• ICC12-401	• Authorization to Obtain and Disclose Information (HIPAA)	• Must complete on all cases being submitted. Leave a copy of this form with the applicant. **Signatures and dating required.**
• PLX-V408	• VUL – Broker/Representative Report	• Correct Broker/Representative PLICO Contract Number must be included in order to ensure commissions are paid correctly. Include Split Share Percentage.
• ICC12-406A	• Continuation of Information Form	• Use this form if additional space is needed for information.

The forms listed on this page may be required if circumstances apply.

FORM NUMBER	FORM NAME	INSTRUCTIONS

• ICC14-V403	• VUL – Rider Worksheet	• If applying for any additional benefits or riders, must complete the Rider Worksheet. In addition, the following riders require these supplemental application forms, which can be found online at myprotective.com.
		• Leave a copy of each form with the applicant.
		  • If applying for Children's Term Rider, complete form # ICC12-404.
		  • If applying for Income Provider Option, complete form # P-U-437R.

• PL-104	• Pre-Authorized Withdrawal Agreement	• Use in cases where the client elects to have premium payments drafted.
• PL-CR	• Conditional Receipt Agreement	• If payment is submitted with the application, must complete and sign the Conditional Receipt. Leave a copy of this form with the applicant.
• A-2043-N	• Replacement Form	• Must complete and sign regarding existing coverage. Leave a copy of this form with the Proposed Insured.
• F-LAD-277	• Assignment/Transfer of Ownership (Section 1035 Exchange)	• Must complete on 1035 Exchange/Transfer. Leave a copy of this form with the owner. **Send the Original to the Home Office.** • **ONLY** If there is a loan to be carried over to Protective Life at the time of the 1035 Exchange, must complete and sign the Rescue Loan Agreement, form #VUL-1016, available online at myprotective.com.
• PLX-925	• VUL – Long Term Care Third Party Designation	• Must complete and sign this form if a 2nd person is designated to receive notice of lapse or termination of the long-term care rider.
• ICC12-402	• Part 1A-Supplemental Application (Medical Declarations)	• If the Proposed Insured is **NOT** being examined, this form must be completed.

Email Address: VUL.Apps@protective.com
If emailing 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: VUL New Business
P.O. Box 830771
Birmingham, Alabama 35283-0771
Telephone: (800) 265-1545
Fax: (205) 268-4987

Home Office - Overnight
Protective Life Insurance Company
ATTN: VUL New Business
2801 Highway 280 South
Birmingham, Alabama 35223
Telephone: (800) 265-1545
Fax: (205) 268-4987

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

DESCRIPTION OF INFORMATION PRACTICES

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

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.

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 character, general reputation, personal characteristics and mode of living 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, and 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.

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 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

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.

Protective

Protective Life Insurance Company
P.O. Box 830771
Birmingham, AL 35283-0771

SECTION I: INSURED INFORMATION — VARIABLE UNIVERSAL INDIVIDUAL LIFE INSURANCE APPLICATION

1. Proposed Insured

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

2. Owner *(If other than Proposed Insured)*

Name (First, Middle, Last)			
Gender	*Birthdate*	*Birth State*	*SSN/Tax ID No.*
Name of Trust			*Date of Trust*
Home Phone	*Work Phone*		*Cell Phone*
Email Address			*Relationship*
Address: (Street, City, State, Zip Code)			

3. Employment Information
Proposed Insured

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

4. Send Premium Notices To:
If other than Owner

Name
Relationship
Address: (Street, City, State, Zip Code)

SECTION II: PLAN OF INSURANCE

Plan of Insurance: (Name of Product)	*Initial Premium* $	*Planned Periodic Premium* $	*Initial Face Amount* $
Underwriting Class Quoted: *(Protective will issue best underwriting class.)*	*CVAT:* ☐ *(If not checked, the Guideline Premium Test will apply, subject to product availability.)*		
☐ *Level Face Amount* ☐ *Increasing Face Amount*	*Section 1035:* ☐ *Yes* ☐ *No*	*1035 Loan Transfer* ☐ *Yes* ☐ *No*	

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.

	Primary Beneficiary Name(s)	*Address & Telephone No*	*Birthdate*	*Social Security No*	*Relationship*	*%*
1.						
2.	*Contingent Beneficiary Name(s)*	*Address & Telephone No*	*Birthdate*	*Social Security No*	*Relationship*	*%*

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 the 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 the 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 the Proposed Insured responsible for paying premiums? *If Yes, please explain*..... ☐ Yes ☐ No

7. Will anyone unrelated to the 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 the Proposed Insured?..... ☐ Yes ☐ No

9. Has the 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)

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 the 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 on the Continuation of Information form.

	HAS THE PROPOSED INSURED:	**Yes**	**No**
1.	Used tobacco or nicotine of any kind over the last 5 years?.....	☐	☐

Type	*Frequency*	*Date Last Used*

2.	Consulted a physician or had treatment for the use or possession of:		
	A. Alcohol? *(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.	Has the proposed insured ever been convicted of, or pled guilty or no contest to a felony, or does he/she any such charge pending against him/her?.....	☐	☐
5.	Flown as a pilot, student pilot or crew member, or intend ot fly as such, within the next 2 years? *(If Yes, complete the Aviation Questionnaire.)*……..	☐	☐
6.	Been a member of, or applied to be a member of, or received a notice of required service in, the armed forces, reserves or National Guard? *(If Yes, provide details below)*……	☐	☐

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

7.	Engaged in any of the following activities in the past 2 years? (If Yes, complete the appropriate Questionnaire.)…….	☐	☐
	☐ Racing ☐ Scuba Diving ☐ Hang Gliding ☐ Mountain Climbing ☐ Sky Diving ☐ Parachuting		
8.	Is Proposed Insured: *(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)*……	☐	☐

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

b.	Have you traveled or resided outside of the United States in the past 2 years? *(If Yes provide details)*……...	☐	☐

Travel Details:

c.	Intending to travel or reside outside the United States or Canada within the next 12 months?.....	☐	☐

To Where	*Why*
When	*For How Long*

SECTION VII: IF APPLYING FOR LONG-TERM CARE OR CHRONIC ILLNESS ACCELERATED DEATH BENEFIT RIDER

		Yes	No
1.	Do you have another long-term care insurance policy or certificate in force (including health care service contract, health maintenance organization contract)?	☐	☐
2.	Did you have another long-term care insurance policy or certificate in force during the last 12 months?	☐	☐
	If Yes, with which company? _____		
	If that policy or certificate lapsed, when did it lapse? _____		
3.	Are you covered by Medicaid?	☐	☐

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 right 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.

AUTHORIZATIONS:

		Yes	No
1.	Do you want to be interviewed if an investigative consumer report will be made?	☐	☐
2.	Do you believe that this policy will meet your insurance needs and financial objectives?	☐	☐
3.	Did you receive the prospectus for the policy applied for and the prospectus for each of the funds?	☐	☐
4.	Do you understand that the amount and duration of the death benefit and the amount of policy values may vary, depending on the investment experience of the variable accounts?	☐	☐
5.	Are you purchasing this insurance to replace or change any in-force life insurance, annuities, long-term care insurance or health insurance policies or will the premium for this policy be funded by a withdrawal from an existing life insurance policy or annuity?	☐	☐
	If Yes, Company(ies)_____ Estimated transfer amount $_____		
6.	If we are unable to issue a life insurance policy, do you wish to apply for a deferred annuity?	☐	☐

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, State) _____(Date).

(X) _____
Signature of Proposed Insured

(X) _____
Signature of Owner *(If other than Proposed Insured)*

(X) _____
Witness to All Signatures

(X) _____
Signature of Covered Insured or Parent or Guardian

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VARIABLE UNIVERSAL LIFE – PREMIUM PAYMENT ALLOCATIONS

Policy Number: _____

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

2. TELEPHONE TRANSFERS: *Protective Life Insurance Company will not be held liable for any loss, liability, cost or expense for acting on telephone instructions.* By checking this box, I authorize the:
☐ Company to honor telephone instructions to transfer account values among Sub-Accounts, subject to conditions of the prospectus.
☐ Registered Representative who signs this application to transfer account values among Sub-Accounts, subject to conditions of the prospectus.

Monthly Purchase Allocation	Monthly Deduction Allocation	**Category 1 – Conservative** (Minimum allocation of 35% is required for Protective Investors Choice VUL)
_____%	_____%	Fidelity VIP Investment Grade Bond
_____%	_____%	Franklin U.S. Government Securities VIP
_____%	_____%	Goldman Sachs VIT Core Fixed Income
_____%	_____%	Invesco V.I. Government Securities
_____%	_____%	Lord Abbett Series Bond Debenture
_____%	_____%	OppenheimerFunds Global Strategic Income/VA
_____%	_____%	OppenheimerFunds Government Money/VA
_____%	_____%	PIMCO VIT Long-Term U.S. Government
_____%	_____%	PIMCO VIT Low Duration
_____%	_____%	PIMCO VIT Real Return
_____%	_____%	PIMCO VIT Short-Term
_____%	_____%	PIMCO VIT Total Return
_____%	_____%	Templeton Global Bond VIP

		Category 2 -Moderate (Allocations are limited to a maximum of 65% for Protective Investors Choice VUL)
_____%	_____%	American Funds IS Asset Allocation
_____%	_____%	Fidelity VIP Contrafund®
_____%	_____%	Fidelity VIP Index 500
_____%	_____%	Franklin Income VIP
_____%	_____%	Franklin Mutual Shares VIP
_____%	_____%	Franklin Rising Dividends VIP
_____%	_____%	Goldman Sachs VIT Strategic Growth
_____%	_____%	Invesco V.I. Comstock
_____%	_____%	Invesco V.I. Equity & Income
_____%	_____%	Invesco V.I. Growth and Income
_____%	_____%	Lord Abbett Series Calibrated Dividend Growth
_____%	_____%	Lord Abbett Series Classic Stock
_____%	_____%	Lord Abbett Series Fundamental Equity
_____%	_____%	OppenheimerFunds Main Street®/VA

Monthly Purchase Allocation	Monthly Deduction Allocation	**Category 3 – Aggressive** (Allocations are limited to a maximum of 30% for Protective Investors Choice VUL)
_____%	_____%	American Funds IS Blue Chip Income and Growth
_____%	_____%	American Funds IS Global Growth
_____%	_____%	American Funds IS Global Small Capitalization
_____%	_____%	American Funds IS Growth
_____%	_____%	American Funds IS International
_____%	_____%	American Funds IS New World
_____%	_____%	ClearBridge Small Cap Growth
_____%	_____%	ClearBridge Variable Mid Cap
_____%	_____%	Fidelity VIP Mid Cap
_____%	_____%	Franklin Flex Cap Growth VIP
_____%	_____%	Franklin Small Cap Value VIP
_____%	_____%	Franklin Small-Mid Cap Growth VIP
_____%	_____%	Goldman Sachs VIT Growth Opportunities
_____%	_____%	Goldman Sachs VIT Mid Cap Value
_____%	_____%	Goldman Sachs VIT Strategic International Equity
_____%	_____%	Invesco V.I. American Value
_____%	_____%	Invesco V.I. Global Real Estate
_____%	_____%	Invesco V.I. International Growth
_____%	_____%	Invesco V.I. Mid Cap Growth
_____%	_____%	Invesco V.I. Small Cap Equity
_____%	_____%	Lord Abbett Series Growth Opportunities
_____%	_____%	Lord Abbett Series Mid Cap Stock
_____%	_____%	OppenheimerFunds Capital Appreciation/VA
_____%	_____%	OppenheimerFunds Global/VA
_____%	_____%	PIMCO VIT All Asset
_____%	_____%	Royce Capital Fund - Micro-Cap
_____%	_____%	Royce Capital Fund - Small-Cap
_____%	_____%	Templeton Developing Markets VIP
_____%	_____%	Templeton Foreign VIP
_____%	_____%	Templeton Growth VIP

Protective Life General Account
(Not available for Protective Investors Choice VUL)

_____%	_____%	Fixed Account
_____%	_____%	DCA Fixed Account (For Dollar Cost Averaging as "Source Fund" only, 12 month maximum. Only Offered on SPVL.)

Protective Life Model Portfolios – Do not allocate to more than one model portfolio

☐ Conservative Growth ☐ Moderate Growth ☐ Growth & Income ☐ Aggressive Growth (Not available for Protective Investors Choice VUL)
☐ Other: _____
(Protective Investors Choice VUL must meet Allocation by Investment Category Guidelines)

TOTAL ALLOCATIONS MUST EQUAL 100%

3. DOLLAR COST AVERAGING

Transfer the amount indicated below:

☐ Monthly ☐ Quarterly _____ Months *(minimum 6 months)* _____ Day *(1 – 28)*

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

To Destination Fund	**Amount *(Minimum $100)***	***Percentage***
_____	$ _____	_____%
_____	$ _____	_____%
_____	$ _____	_____%
_____	$ _____	_____%
_____	$ _____	_____%
_____	$ _____	_____%
_____	$ _____	_____%

4. PORTFOLIO REBALANCING

Rebalancing to begin on: _____/_____/_____ (date) (Rebalancing due date can only be days 1 – 28.)

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

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

SIGNATURES:

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

_____ _____

Proposed Insured *(Sign Name in Full)* Applicant/Owner(s) *(if other than Proposed Insured)*

_____ _____

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

Protective

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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 _____ SIGN HERE

X _____ SIGN HERE

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

X _____ SIGN HERE

Signature of Witness: X _____ SIGN HERE

PRODUCER CERTIFICATION

By signing below, I hereby certify that to the best of my knowledge and belief, the information provided herein is complete, accurate, and correct and that the life insurance being applied for conforms to the Company's guidelines.

Signed at: _____ (City and State) _____ Date

X _____ SIGN HERE Producer Signature _____ Producer Name (Print)

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

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

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

2. I (we) authorize the following persons and organizations to release and disclose the information described in paragraph 1 to Protective Life, directly through designated third parties or its agents acting on its behalf; (i) my (our) doctor(s); (ii) medical practitioners; (iii) pharmacists and Pharmacy Benefit Managers; (iv) medical and related facilities, including hospitals, clinics, facilities run by the Veteran's Administration, Kaiser Permanente, The Cleveland Clinic Foundation including all satellite facilities and The Mayo Clinic; (v) insurers; (vi) reinsurers; (vii) MIB, Inc. (MIB); (viii) my (our) current and previous employers; and (ix) commercial consumer reporting agencies (CRA). All of these persons and organizations other than MIB may release the information described above to a CRA acting for Protective Life. MIB may not release the information described in paragraph 1 to a CRA.

3. I (we) authorize Protective Life to draw and test my (our) blood, and/or oral fluids, and urine as may be necessary to obtain information to be used to underwrite my (our) application for insurance. These tests may include, but are not limited to, tests for cholesterol and related blood lipids, diabetes, liver or kidney disorders, immune disorders (other than HIV/AIDS; reference number 7 below), and the presence of drugs, nicotine, or their metabolites. This authorization does not include genetic testing. Unless otherwise required by law or regulation, Protective Life may, but is not obligated to, release any of these test results directly to me or to my spouse or life partner.

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

5. I (we) authorize Protective Life to release and disclose the information described in paragraphs 1 and 3 to the Agent and their Representative representing me to duly licensed specific life insurers for the purpose of applying for life insurance if my (our) application with Protective Life is declined or if Protective Life is unable to offer coverage at an acceptable rate.

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

7. SPECIAL REQUIREMENT FOR HIV/AIDS TESTING. If Protective Life intends to test for the presence of antibodies to the Human Immunodeficiency Virus (HIV), which is the virus that has been associated with Acquired Immune Deficiency Syndrome (AIDS), Protective Life may require me (us) to authorize that testing separately. I (we) hereby authorize Protective Life to obtain and use the results of any HIV tests that I (we) separately authorize, and if permitted by law, to disclose the results of those tests to its reinsurers and MIB.

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

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

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

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

12. *I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction. Any modifications to this authorization may preclude Protective Life's ability to process this application.*

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

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

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

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

Home Office - ORIGINAL Applicant - COPY

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

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

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

2. I (we) authorize the following persons and organizations to release and disclose the information described in paragraph 1 to Protective Life, directly through designated third parties or its agents acting on its behalf; (i) my (our) doctor(s); (ii) medical practitioners; (iii) pharmacists and Pharmacy Benefit Managers; (iv) medical and related facilities, including hospitals, clinics, facilities run by the Veteran's Administration, Kaiser Permanente, The Cleveland Clinic Foundation including all satellite facilities and The Mayo Clinic; (v) insurers; (vi) reinsurers; (vii) MIB, Inc. (MIB); (viii) my (our) current and previous employers; and (ix) commercial consumer reporting agencies (CRA). All of these persons and organizations other than MIB may release the information described above to a CRA acting for Protective Life. MIB may not release the information described in paragraph 1 to a CRA.

3. I (we) authorize Protective Life to draw and test my (our) blood, and/or oral fluids, and urine as may be necessary to obtain information to be used to underwrite my (our) application for insurance. These tests may include, but are not limited to, tests for cholesterol and related blood lipids, diabetes, liver or kidney disorders, immune disorders (other than HIV/AIDS; reference number 7 below), and the presence of drugs, nicotine, or their metabolites. This authorization does not include genetic testing. Unless otherwise required by law or regulation, Protective Life may, but is not obligated to, release any of these test results directly to me or to my spouse or life partner.

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

5. I (we) authorize Protective Life to release and disclose the information described in paragraphs 1 and 3 to the Agent and their Representative representing me to duly licensed specific life insurers for the purpose of applying for life insurance if my (our) application with Protective Life is declined or if Protective Life is unable to offer coverage at an acceptable rate.

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

7. SPECIAL REQUIREMENT FOR HIV/AIDS TESTING. If Protective Life intends to test for the presence of antibodies to the Human Immunodeficiency Virus (HIV), which is the virus that has been associated with Acquired Immune Deficiency Syndrome (AIDS), Protective Life may require me (us) to authorize that testing separately. I (we) hereby authorize Protective Life to obtain and use the results of any HIV tests that I (we) separately authorize, and if permitted by law, to disclose the results of those tests to its reinsurers and MIB.

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

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

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

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

12. *I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction. Any modifications to this authorization may preclude Protective Life's ability to process this application.*

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

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

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

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

Home Office - ORIGINAL Applicant - COPY

Protective

Protective Life Insurance Company
P.O. Box 830771
Birmingham, AL 35283-0771

VARIABLE UNIVERSAL LIFE INSURANCE APPLICATION - 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.	a) Is the Proposed Insured a relative or does the Proposed Insured have a business relationship with you?..... If Yes, Details: _____	☐	☐
	b) Are you requesting a special buyer's version?.....	☐	☐
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: _____	☐	☐
5.	Has a mortality analysis or life expectancy analysis been performed on the Proposed Insured?.....	☐	☐
	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.	☐	☐
	Is the Proposed Insured applying for Long Term Care? (If Yes, you must attach Training Certificate)……..	☐	☐

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.

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

	REGISTERED REPRESENTATIVE 1	REGISTERED REPRESENTATIVE 2
Signature(s) of Broker/Representative:	_____	_____
Print Name of Broker/Representative:	_____	_____
PLICO Contract Number:	_____	_____
Share Percentage:	_____	_____
Business Phone Number:	_____	_____
Email Address:	_____	_____
BGA/Broker Dealer Name:	_____	_____
PLICO Contract Number:	_____	_____
New Business Key Contact and Email Address:	_____	_____

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) *(if other than Proposed Insured)*	Date		

Taxpayer Identification Number and Certification

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

Business name/disregarded entity name, if different from above

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

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

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

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

☐ Other ►

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

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

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

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

City, State, and ZIP code

Requester's name and address (optional)

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

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

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

Social security number

			-		-				

Employer identification number

		-							

Part II Certification

Under penalties of perjury, I certify that:

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

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

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

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

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

Protective Life Insurance Company
P.O. Box 830771
Birmingham, AL 35283-0771

VARIABLE UNIVERSAL LIFE INSURANCE APPLICATION – RIDER WORKSHEET

Required if applying for additional benefits or riders.

☐ New Business ☐ Protective Policy Change from Policy: _____

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

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

1. ADDITIONAL BENEFITS

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

☐ *Child Rider

☐ *Chronic Illness Accelerated Death Benefit
Maximum Monthly Benefit Amount $_____
Elimination Period *(Number of Days)* _____

☐ Disability Benefit Rider *(Not available on Preserver II)*
Monthly Benefit Amount $_____

☐ Flexible Coverage Rider $_____

☐ *Income Provider Option Endorsement

☐ Lapse Protection Rider *(Preserver II and Premier III Only)*

☐ Long Term Care Accelerated Death Benefit Rider

☐ Protected Insurability Rider $_____

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

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

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.

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

_____ Signature of Owner	_____ Signature of CIR
_____ Signature of Proposed/Primary Insured	_____ Signature of CIR
_____ Signature of Parent or Guardian	_____ Witness to All Signatures

Protective

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.

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

I request future drafts be made on the _____ *(1^{st} – 28^{th})* 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 (VUL) 06/2014

Protective

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

CONDITIONAL RECEIPT AGREEMENT

☐ Term Life Insurance ☐ Universal Life Insurance ☐ Variable Universal Life Insurance

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

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

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

_____.

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

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

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

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

CONDITIONS UNDER WHICH INSURANCE MAY BECOME EFFECTIVE PRIOR TO POLICY DELIVERY

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

(A) on the Effective Date the Proposed Insured(s) is (are) insurable exactly as applied for under the Company's published underwriting rules for the plan, amount and premium rate class applied for;
(B) the amount paid with the application and shown above is equal to the first full modal premium for the plan, amount and premium rate class applied for; and
(C) the Proposed Insured(s) has/have completed all examinations and/or tests requested by the Company.

EFFECTIVE DATE OF COVERAGE

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

(A) the date of the application;
(B) the date requested in the application; or
(C) the date of the last of any medical examinations or tests required under the rules and practices of the Company.

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

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

TERMINATION AND REFUND OF PREMIUM

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

(A) premium payment is
  (1) by check, and it is not honored by the drawee bank upon presentation;
  (2) by Pre-Authorized Withdrawal, and the deduction is not honored by the drawee bank;
  (3) by Payroll Deduction Authorization and the Employer does not make payroll deductions as authorized by the Employee; or
(B) if the application to which this Agreement was attached is not approved as applied for by the Company within ninety days from its date, the Company's only liability in such event(s) will be to return any money received.

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

Agent Signature	Date	Owner Signature	Date

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

PL-CR (03/10) Original – HOME OFFICE Copy - OWNER

Protective

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

CONDITIONAL RECEIPT AGREEMENT

☐ Term Life Insurance ☐ Universal Life Insurance ☐ Variable Universal Life Insurance

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

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

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

_____.

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

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

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

CONDITIONS UNDER WHICH INSURANCE MAY BECOME EFFECTIVE PRIOR TO POLICY DELIVERY

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

(A) on the Effective Date the Proposed Insured(s) is (are) insurable exactly as applied for under the Company's published underwriting rules for the plan, amount and premium rate class applied for;
(B) the amount paid with the application and shown above is equal to the first full modal premium for the plan, amount and premium rate class applied for; and
(C) the Proposed Insured(s) has/have completed all examinations and/or tests requested by the Company.

EFFECTIVE DATE OF COVERAGE

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

(A) the date of the application;
(B) the date requested in the application; or
(C) the date of the last of any medical examinations or tests required under the rules and practices of the Company.

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

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

TERMINATION AND REFUND OF PREMIUM

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

(A) premium payment is
  (1) by check, and it is not honored by the drawee bank upon presentation;
  (2) by Pre-Authorized Withdrawal, and the deduction is not honored by the drawee bank;
  (3) by Payroll Deduction Authorization and the Employer does not make payroll deductions as authorized by the Employee; or
(B) if the application to which this Agreement was attached is not approved as applied for by the Company within ninety days from its date, the Company's only liability in such event(s) will be to return any money received.

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

Agent Signature	Date	Owner Signature	Date

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

PL-CR (03/10) Original – HOME OFFICE Copy - OWNER

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

IMPORTANT NOTICE: REPLACEMENT OF LIFE INSURANCE OR ANNUITIES

This document must be signed by the applicant and the insurance producer/agent, if there is one, and a copy left with the applicant.

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new life insurance policy or annuity contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing life insurance policy or annuity contract, or an existing life insurance policy or annuity contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the life insurance policy values, including accumulated dividends, of an existing life insurance policy, to pay all or part of any premium or payment due on the new life insurance policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interests. You will pay acquisition costs and there may be surrender costs deducted from your life insurance policy or annuity contract. You may be able to make changes to your existing life insurance policy or annuity contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing life insurance policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements and ask that you answer the following questions and consider the questions on the back of this form.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing life insurance policy or annuity contract? ☐ Yes ☐ No
2. Are you considering using funds from your existing policies or annuity contracts to pay premiums due on the new life insurance policy or annuity contract? ☐ Yes ☐ No

If you answered "Yes" to either of the above questions, list each existing life insurance policy or annuity contract you are contemplating replacing (include the name of the insurer, the insured or annuitant, and the life insurance policy or annuity contract number if available) and whether each life insurance policy or annuity contract will be replaced or used as a source of financing:

	INSURER NAME	ANNUITY CONTRACT OR LIFE INSURANCE POLICY #	INSURED OR ANNUITANT	REPLACED (R) or FINANCING (F)
1.				
2.				
3.				

Make sure you know the facts. Contact your existing company or its insurance producer/agent for information about the old life insurance policy or annuity contract. If you request one, an in-force illustration, life insurance policy summary or available disclosure documents must be sent to you by the existing insurer. Ask for and keep all sales material used by the insurance producer/agent in the sales presentation. Be sure that you make an informed decision.

The existing life insurance policy or annuity contract is being replaced because _____.

I certify that the responses herein are, to the best of my knowledge, accurate:

Applicant's Signature	Printed Name	Date
Insurance Producer's/Agent Signature	Printed Name	Date

I do not want this notice read aloud to me _____ (Applicants must initial only if they do not want the notice read aloud.)

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing life insurance policy or annuity contract and the proposed life insurance policy or annuity contract. One way to do this is to ask the company or insurance producer/agent that sold you your existing life insurance policy or annuity contract to provide you with information concerning your existing life insurance policy or annuity contract. This may include an illustration of how your existing life insurance policy or annuity contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or annuity contracts. You should discuss the following with your agent to determine whether replacement or financing your purchase makes sense:

PREMIUMS:

Are they affordable?
Could they change?
You're older - are premiums higher for the proposed new life insurance policy?
How long will you have to pay premiums on the new life insurance policy? On the old life insurance policy?

POLICY VALUES:

New policies usually take longer to build cash values and to pay dividends.
Acquisition costs for the old life insurance policy may have been paid; you will incur costs for the new one.
What surrender charges do the policies have?
What expense and sales charges will you pay on the new life insurance policy?
Does the new life insurance policy provide more insurance coverage?

INSURABILITY:

If your health has changed since you bought your old life insurance policy, the new one could cost you more, or you could be turned down.
You may need a medical exam for a new life insurance policy.
(Claims on most new policies for up to the first two years can be denied based on inaccurate statements. Suicide limitations may begin anew on the coverage.)

IF YOU ARE KEEPING THE OLD LIFE INSURANCE POLICY AS WELL AS THE NEW LIFE INSURANCE POLICY:

How are premiums for both policies being paid?
How will the premiums on your existing life insurance policy be affected?
Will a loan be deducted from death benefits?
What values from the old life insurance policy are being used to pay premiums?

IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST SENSITIVE LIFE PRODUCT:

Will you pay surrender charges on your old annuity contract?
What are the interest rate guarantees for the new annuity contract?
Have you compared the annuity contract charges or other life insurance policy expenses?

OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:

What are the tax consequences of buying the new life insurance policy?
Is this a tax-free exchange? (See your tax advisor.)
Is there a benefit from favorable "grandfathered" treatment of the old life insurance policy under the Federal Internal Revenue Tax Code?
Will the existing insurer be willing to modify the old life insurance policy?
How does the quality and financial stability of the new company compare with your existing company?

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

IMPORTANT NOTICE: REPLACEMENT OF LIFE INSURANCE OR ANNUITIES

This document must be signed by the applicant and the insurance producer/agent, if there is one, and a copy left with the applicant.

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new life insurance policy or annuity contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing life insurance policy or annuity contract, or an existing life insurance policy or annuity contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the life insurance policy values, including accumulated dividends, of an existing life insurance policy, to pay all or part of any premium or payment due on the new life insurance policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interests. You will pay acquisition costs and there may be surrender costs deducted from your life insurance policy or annuity contract. You may be able to make changes to your existing life insurance policy or annuity contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing life insurance policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements and ask that you answer the following questions and consider the questions on the back of this form.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing life insurance policy or annuity contract? ☐ Yes ☐ No
2. Are you considering using funds from your existing policies or annuity contracts to pay premiums due on the new life insurance policy or annuity contract? ☐ Yes ☐ No

If you answered "Yes" to either of the above questions, list each existing life insurance policy or annuity contract you are contemplating replacing (include the name of the insurer, the insured or annuitant, and the life insurance policy or annuity contract number if available) and whether each life insurance policy or annuity contract will be replaced or used as a source of financing:

	INSURER NAME	ANNUITY CONTRACT OR LIFE INSURANCE POLICY #	INSURED OR ANNUITANT	REPLACED (R) or FINANCING (F)
1.				
2.				
3.				

Make sure you know the facts. Contact your existing company or its insurance producer/agent for information about the old life insurance policy or annuity contract. If you request one, an in-force illustration, life insurance policy summary or available disclosure documents must be sent to you by the existing insurer. Ask for and keep all sales material used by the insurance producer/agent in the sales presentation. Be sure that you make an informed decision.

The existing life insurance policy or annuity contract is being replaced because _____.

I certify that the responses herein are, to the best of my knowledge, accurate:

Applicant's Signature	Printed Name	Date
Insurance Producer's/Agent Signature	Printed Name	Date

I do not want this notice read aloud to me _____ (Applicants must initial only if they do not want the notice read aloud.)

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing life insurance policy or annuity contract and the proposed life insurance policy or annuity contract. One way to do this is to ask the company or insurance producer/agent that sold you your existing life insurance policy or annuity contract to provide you with information concerning your existing life insurance policy or annuity contract. This may include an illustration of how your existing life insurance policy or annuity contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or annuity contracts. You should discuss the following with your agent to determine whether replacement or financing your purchase makes sense:

PREMIUMS:

Are they affordable?
Could they change?
You're older - are premiums higher for the proposed new life insurance policy?
How long will you have to pay premiums on the new life insurance policy? On the old life insurance policy?

POLICY VALUES:

New policies usually take longer to build cash values and to pay dividends.
Acquisition costs for the old life insurance policy may have been paid; you will incur costs for the new one.
What surrender charges do the policies have?
What expense and sales charges will you pay on the new life insurance policy?
Does the new life insurance policy provide more insurance coverage?

INSURABILITY:

If your health has changed since you bought your old life insurance policy, the new one could cost you more, or you could be turned down.
You may need a medical exam for a new life insurance policy.
(Claims on most new policies for up to the first two years can be denied based on inaccurate statements. Suicide limitations may begin anew on the coverage.)

IF YOU ARE KEEPING THE OLD LIFE INSURANCE POLICY AS WELL AS THE NEW LIFE INSURANCE POLICY:

How are premiums for both policies being paid?
How will the premiums on your existing life insurance policy be affected?
Will a loan be deducted from death benefits?
What values from the old life insurance policy are being used to pay premiums?

IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST SENSITIVE LIFE PRODUCT:

Will you pay surrender charges on your old annuity contract?
What are the interest rate guarantees for the new annuity contract?
Have you compared the annuity contract charges or other life insurance policy expenses?

OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:

What are the tax consequences of buying the new life insurance policy?
Is this a tax-free exchange? (See your tax advisor.)
Is there a benefit from favorable "grandfathered" treatment of the old life insurance policy under the Federal Internal Revenue Tax Code?
Will the existing insurer be willing to modify the old life insurance policy?
How does the quality and financial stability of the new company compare with your existing company?

Protective

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

ASSIGNMENT/TRANSFER OF OWNERSHIP SECTION 1035 EXCHANGE

INSURED: _____

OWNER: _____

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

POLICY NUMBER(S): _____

ESTIMATED VALUE: $_____

PHONE NUMBER(S): _____

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

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

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

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

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

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

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

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

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

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

Protective

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

ASSIGNMENT/TRANSFER OF OWNERSHIP SECTION 1035 EXCHANGE

INSURED: _____

OWNER: _____

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

POLICY NUMBER(S): _____

ESTIMATED VALUE: $_____

PHONE NUMBER(S): _____

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

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

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

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

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

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

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

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

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

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

Protective Life Insurance Company
P.O. Box 830771
Birmingham, AL 35283-0771

VARIABLE UNIVERSAL LIFE INSURANCE APPLICATION – LONG TERM CARE THIRD PARTY DESIGNATION

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

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

Name: _____

Social Security No: _____

Street Address: _____

City, State, Zip Code: _____

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

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

_____
Signature of Registered Representative

_____
Signature of Proposed Insured

_____
Signature of Proposed Owner
(if other than Proposed Insured)

_____
Registered Representative Number
(for Protective Life Insurance Company)

PLX-925 04/2014

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	Proposed Insured 1 No	Proposed Insured 2 Yes	Proposed Insured 2 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	Proposed Insured 1 No	Proposed Insured 2 Yes	Proposed Insured 2 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	Proposed Insured 1 No	Proposed Insured 2 Yes	Proposed Insured 2 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