Fixed Life Insurance Application Packet
PLB-300 (Instructions)

NOT FOR USE WITH VARIABLE UNIVERSAL LIFE PRODUCTS

REQUIRED FORMS FOR ALL APPLICATIONS:				
	Form Number	**Form Name**	**Instructions**	**Copy to Client**
☐	PLB-300	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 Life Insurance. If completing by hand, please use a pen with black ink.	
☐	PLB-301	Non-Medical History (Tobacco, Avocation, etc.)	• Must complete on all cases being submitted.	
☐	PLB-306	Broker/Representative Report	• Correct Broker/Representative number (Commission Code) must be included in order to ensure commissions are paid correctly.	
☐	PL-359	Authorization to Obtain and Disclose Information (HIPAA)	• Must complete on all cases being submitted and leave a copy with the applicant. **Signature and date required.**	☐
☐	F-LAD-408	Supplement to Life Insurance Application (Premium Financing)	• Must complete on all cases being submitted.	
☐	U-215-TX	Notice and Consent Form for AIDS (HIV) Testing	• Must complete on all cases and leave a copy with the applicant.	☐
☐	PL-DIP	Description of Information Practices	• This notice MUST be given to the Proposed Insured on all cases submitted.	☐

	Form Number	Form Name	Instructions	Copy to Client
FORMS THAT MAY ALSO BE REQUIRED *(Read Instructions)*				
☐	PL-102	Part 1A-Supplemental Application (Non-Medical Declarations)	• If the Proposed Insured is not being examined, must complete.	
☐	PL-CR	Conditional Receipt Agreement	• If payment is submitted with application, must complete/sign the Conditional Receipt and leave a copy with the applicant.	☐
☐	PL-105R	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 protectivelifebrokerage.com.	
			• If applying for Child Rider - complete form **# F-LAD-436-UT**.	
			• If applying for Income Provider Option - complete form **# P-U-437R**.	
☐	PL-108	Continuation of **Information Form** for Part I (Non-Medical) and Part II (Medical)	• If additional space is needed for **information, must complete.**	
☐	PL-104	Pre-Authorized Withdrawal Agreement	• Use in cases where the client elects to have premiums drafted.	
☐	A-2043-N (TX)	NAIC Replacement Form	• If there is existing coverage, must complete, sign and leave a copy with the Proposed Insured.	☐
☐	F-LAD-277	Assignment/Transfer of Ownership (Section 1035 Exchange)	• Must complete on 1035 Exchange/Transfer cases and leave a copy with the owner. **Send the Original to the Home Office.**	☐
☐	F-LAD-428	Confidential Financial Statement	• Required if the Proposed Insured is under age 65 and the face amount is $3,000,000 or greater or the Proposed Insured is 65 or older and the face amount is $1,000,000 or greater.	

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

Mailing Addresses:

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

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

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

DESCRIPTION OF INFORMATION PRACTICES

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

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 thereon to the MIB, Inc., 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 (TTY 866-346-3642). 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 and copy the information, or we will send it to you, whichever you prefer. You also have the right to request correction of personal information we may have about you which you think is wrong. To exercise these rights, please write to us at the address appearing at the end of this notice.

Ask our agent for assistance, or call or write us at Protective Life Insurance Company, Attention: Vice President-Underwriting, P.O. Box 830619, Birmingham, Alabama 35283-0619. Telephone 800-567-8247

THIS NOTICE MUST BE GIVEN TO 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.

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

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

Residence: ____

Street Address Apt. No.

____

City State Zip Code Telephone Number Number of Years

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

____

Street Address City State Zip Code

Insured Email Address *(Optional)* : ______________________ Insured Cell Phone: ______________

Owner Email Address *(Optional)* : ______________________ Owner Cell Phone: ______________

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

SECTION II: PLAN OF INSURANCE

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

Plan of Insurance *(Name of Product)* ______________________________

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

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

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

Section 1035: ☐ Yes ☐ No

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

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

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

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

Premium Payment: ☐ Annual $__________ ☐ Semi-Annual $__________ ☐ Quarterly $__________ ☐ Monthly $__________

☐ Cash with Application $______________

SECTION III: BENEFICIARY DESIGNATIONS

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

Primary Beneficiary	Relationship	%	Contingent Beneficiary	Relationship	%

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

(Must be answered completely on all cases.)

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

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

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

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

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

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

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

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

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

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

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

i. If Owner is other than the Proposed Insured, must complete box below.*

*

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

Relationship to Insured — Address — City — *State* — *Zip Code*

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

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

If personal insurance, omit questions b - f below.

If business insurance, complete questions b - f below.

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

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

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

e. What year was the business established? ________

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

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

SECTION VI: REMARKS AND SPECIAL REQUESTS

DECLARATIONS

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

1. All such statements and answers shall be the basis of any insurance issued, and my (our) answers are material to the decision as to whether the risk is accepted by Protective Life.
2. No representative or medical examiner can make, alter or discharge any contract, accept risks, or waive Protective Life's rights or requirements.
3. Acceptance of a policy by the Owner shall constitute ratification of any changes made by the Company. In those states where it is required, changes as to plan, amount, age at issue, classification or benefits will be made only with the Owner's written consent.
4. No insurance shall take effect unless: (1) a policy is delivered to the Owner; (2) the full first premium is paid while the proposed insured(s) is (are) alive; and (3) there has been no change in health and insurability from that described in this application. However, if the premium is paid as set forth in the attached Conditional Receipt Agreement and the Conditional Receipt Agreement is delivered to the Owner, the terms of the Conditional Receipt Agreement shall apply. No representative or medical examiner has any authority to waive or to alter these terms and conditions or to bind coverage under any other circumstances.
5. I have reviewed the attached Conditional Receipt Agreement and understand and agree that it provides a limited amount of life insurance for a limited period of time, and that such coverage is subject to the terms and conditions set forth in the Conditional Receipt Agreement.
6. The representative taking this application has made no statement or representation different from, contrary to or in addition to these Declarations and the terms and conditions of the attached Conditional Receipt Agreement.

IMPORTANT INFORMATION ABOUT IDENTIFICATION INFORMATION

To help the government fight the funding of terrorism and money laundering activities, Federal law requires all financial institutions to obtain, verify, and record information of its customers. We may ask for information or identifying documents that will allow us to verify the identity of our customers.

Any person who knowingly with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties according to state law.

Signed At ______________________________ (City and State) Date ______________________________

(X) ______________________________ Signature of Proposed Insured

(X) ______________________________ Signature of Spouse, If Proposed for Insurance

Signed At ______________________________ (City and State) Date ______________________________

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

(X) ______________________________ Signature of Representative

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MUST BE COMPLETED WITH EVERY APPLICATION

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

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

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

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

SIGNATURES

Signed at:________________City ______ State Proposed Insured ________________________________ Date __________

Signed at:________________City ______ State Spouse (If Proposed Insured) ________________________ Date __________

Signed at:________________City ______ State Witness ____ Date __________

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BROKER / REPRESENTATIVE REPORT

1. In what language were the questions on the application asked? ☐ English ☐ Spanish ☐ Other* ___________________
   * *Please remember that Protective Life cannot accept or service any application from an applicant who does not speak English or Spanish.*
2. Is the Proposed Insured a relative or does the Proposed Insured have a business relationship with you? ☐ Yes ☐ No
   If "Yes", provide details. ______________________________
3. (a) Will this policy replace or change existing policy(ies)? ☐ Yes ☐ No
   (b) If replacement of existing insurance is involved, have you complied with all relevant state requirements, including any "Disclosure and Comparison Statements"? ☐ Yes ☐ No
   If "No", please explain. ______________________________
   Answer questions (c) and (d) *only* if this is a replacement:
   (c) Did you use any pre-printed company approved sales materials? ☐ Yes ☐ No
   If "Yes", list name or form number here: ______________________________
   (d) Did you use any Company approved, electronically generated, individualized sales materials (such as illustrations or concept materials)? If "Yes", you must provide a copy of these materials with the application. ☐ Yes ☐ No
4. Have you advised the proposed policyowner or do you know of any advice that has been given to the policyowner to transfer ownership of the policy to be issued, or its death benefits, to a life settlement company, investor, offshore trust, investment trust, or entity associated with stranger owned or investment owned life insurance (commonly called SOLI or IOLI) or are you otherwise aware that the policyowner may be contemplating such a transfer? ☐ Yes ☐ No
   If "Yes", please explain in Special Requests/Remarks below.
5. Has a mortality analysis or life expectancy analysis been performed on the Proposed Insured? ☐ Yes ☐ No
6. Has a medical examination been ordered? ☐ Yes ☐ No
   Name of Examiner: ______________________________ Date of Exam: ________________
7. Is Premium Financing involved in this case? ☐ Yes ☐ No
   If "Yes", please submit a cover letter describing the parameters.

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

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

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

Identification type: ______________________________

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

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

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

Broker/Representative Special Requests / Remarks:

PROTECTIVE LIFE INSURANCE COMPANY
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PART 1A - SUPPLEMENTAL APPLICATION - NON-MEDICAL DECLARATIONS

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

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

2. Within the past 10 years has any person proposed for insurance been treated or diagnosed by a physician as having: (**Circle** conditions to which "yes" answer applies and give details in number 5 below.)	Prop Ins 1 Yes	Prop Ins 1 No	Prop Ins 2 Yes	Prop Ins 2 No	Prop Ins 3 Yes	Prop Ins 3 No
(a) Disorder of brain or spinal cord, paralysis, mental disorder, epilepsy, stroke, convulsions, chronic headaches......	☐	☐	☐	☐	☐	☐
(b) Asthma, bronchitis, emphysema, tuberculosis or other disorder of the lungs or respiratory system....................	☐	☐	☐	☐	☐	☐
(c) High blood pressure, heart attack, heart murmur, chest pain or other disorder of the heart or blood vessels........	☐	☐	☐	☐	☐	☐
(d) Any disorder of the esophagus, stomach, intestines, liver or pancreas..	☐	☐	☐	☐	☐	☐
(e) Sugar or blood in the urine, chronic inflammation or other disorder of the kidneys..	☐	☐	☐	☐	☐	☐
(f) Cancer, tumor or disorder of the prostate or reproductive organs..	☐	☐	☐	☐	☐	☐
(g) Arthritis, osteoporosis or other disorder of the muscles, skin or bones including joints or spine........................	☐	☐	☐	☐	☐	☐
(h) Diabetes, recurrent infections, enlarged lymph glands, anemia, excess fatigue or other disorders of the glandular or blood systems..	☐	☐	☐	☐	☐	☐
(i) State the specific date of last medical consultation..	__/__/__ mmddyyyy		__/__/__ mmddyyyy		__/__/__ mmddyyyy	
(j) Name of Personal Physician ______________________ Address of Personal Physician ______________________						

3. Has any person proposed for insurance been diagnosed by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS) or "AIDS" related complex (ARC)?......................	Yes	No	Yes	No	Yes	No
	☐	☐	☐	☐	☐	☐

4. Has any person proposed for insurance: **(Circle)** conditions to which "yes" answer applies and give details in number 5 below.)	Prop Ins 1 Yes	Prop Ins 1 No	Prop Ins 2 Yes	Prop Ins 2 No	Prop Ins 3 Yes	Prop Ins 3 No
(a) Other than above, had examination, treatment or consultation with a physician during the past 5 years?..............	☐	☐	☐	☐	☐	☐
(b) Been on, or advised to be on any medication or prescribed diet?..	☐	☐	☐	☐	☐	☐
(c) Sought or been advised to seek advice or treatment, or been arrested for the use of drugs or alcohol?................	☐	☐	☐	☐	☐	☐
(d) Ever used narcotics, sedatives, depressants, stimulants or hallucinogens, other than under a doctor's prescription and direction?..	☐	☐	☐	☐	☐	☐
(e) Ever used marijuana, cocaine, or any illegal drug or been arrested for the possession of drugs?.........................	☐	☐	☐	☐	☐	☐
(f) Ever been or is currently a member of any alcohol or drug rehabilitation program?..	☐	☐	☐	☐	☐	☐
(g) Ever attempted suicide?..	☐	☐	☐	☐	☐	☐
(h) Had a parent, brother or sister who had and/or died from cancer, diabetes, stroke, heart or kidney disease, or who committed suicide? (Please show age of onset and/or age death occurred.).....................................	☐	☐	☐	☐	☐	☐

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

The above statements and answers are true and complete to the best of my knowledge and belief. I agree that such statements and answers shall be part of the application and shall be considered the basis of any insurance issued.

_______________________ Date

_______________________ Proposed Insured 1 (Sign Name in Full) Date

_______________________ Witness

_______________________ Proposed Insured 2 (Sign Name in Full) Date

_______________________ Signature of Parent or Guardian Date

Rider Worksheet

Required if Riders are applied for. Please print using black ink.

☐ **New Business**

☐ **Protective Policy Change from Policy** ________________________

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____

Print Proposed/Primary Insured's Name

____

Proposed/Primary Insured's Social Security Number

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

1. ADDITIONAL BENEFITS

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

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

☐ Death Benefit Plus Rider ______% *(Optional Interest Rate)*

☐ Disability Benefit *(Universal Life Only)*
Monthly Benefit Amount $ ____________

☐ Enhanced Cash Surrender Value Rider

☐ Estate Protection Endorsement *(Survivorship Plans Only)*

☐ * Income Provider Option

☐ Protected Insurability Rider $ ____________

☐ Return of Substandard Charges Option (ROSCO)

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

☐ Other ______________________________________

2. GUARANTEED INSURABILITY RIDER(S)
(Maximum of six)
(Universal Life Only - Maximum of $2.5 million including face amount)

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

Amount	*Option Date*

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

Amount	*Designated Life*	*Relationship*

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

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

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

Name	Relationship	Date of Birth	Gender	Place of Birth	Height	Weight

_______________________ *Owner Signature* _________ *Date* _______________________ *Witness to All Signatures*

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

_______________________ *Signature of Parent or Guardian* _________ *Date*

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

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

Proposed Insured: ____ Policy Number: __________________
Last Name First Name M.I.

The above statements and answers are true and complete to the best of my knowledge and belief. I agree that such statements and answers shall be part of the application and shall be considered the basis of any insurance issued.

Any person who knowingly with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties, according to state law.

Signed at ____this _______ day of ______________________, 20 _____
(City, State)

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

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

Supplement to Life Insurance Application

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

Print Name of Proposed Insured(s): ____

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

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

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

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

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

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

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

☐ Term
☐ UL
☐ VUL

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

CONDITIONAL RECEIPT AGREEMENT

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 PAW, and the deduction is not honored by the drawee bank;
  (3) by PDA and the Employer does not make payroll deductions as authorized by the Employee; or
(B) if the application to which this Agreement was attached is not approved as applied for by the Company within ninety days from its date, the Company's only liability in such event(s) will be to return any money received.

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

Date: ____________________________ Agent Signature: ____

Date: ____________________________ Owner Signature: ____

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

☐ **Term**
☐ **UL**
☐ **VUL**

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

CONDITIONAL RECEIPT AGREEMENT

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.

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NOTE: Premium may not be collected (1) where the face amount applied for <u>plus</u> 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.

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(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.

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

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

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 <u>and</u> 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 PAW, and the deduction is not honored by the drawee bank;
  (3) by PDA and the Employer does not make payroll deductions as authorized by the Employee; or
(B) if the application to which this Agreement was attached is not approved as applied for by the Company within ninety days from its date, the Company's only liability in such event(s) will be to return any money received.

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

Date: ____________________________ Agent Signature: ____

Date: ____________________________ Owner Signature: ____

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

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

PRE-AUTHORIZED WITHDRAWAL AGREEMENT

FOR DRAFTING OF PREMIUM PAYMENTS

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

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

Policy Number: ____________________________ Name of Insured: ____

Name of Bank: ____

Street Address or P. O. Box: ____

City: _______________________________ State: ____________________________ Zip Code: _________________

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

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

Account Number: ____

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

☐ **Semi-Annually** ☐ **Annually**

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

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

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

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

____
Premium Payer - Depositor (Please Print)

____ ____
Date **Signature**

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

PL-104 (05/11)

PROTECTIVE LIFE INSURANCE COMPANY

P.O. Box 830619 • Birmingham, Alabama 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, if there is one, and a copy left with the applicant.

You are contemplating the purchase of a policy or 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 policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or 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 policy values, including accumulated dividends, of an existing policy, to pay all or part of any premium or payment due on the new 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 policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing 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 policy or contract? ☐ Yes ☐ No
2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? ☐ Yes ☐ No

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

	INSURER NAME	CONTRACT or 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 policy or contract. If you request one, an in-force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer. Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you make an informed decision.

The existing policy or 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
Producer's 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 policy or contract and the proposed policy or contract. One way to do this is to ask the company or agent that sold you your existing policy or contract to provide you with information concerning your existing policy or contract. This may include an illustration of how your existing policy or 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 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 policy?
How long will you have to pay premiums on the new policy? On the old policy?

POLICY VALUES:

New policies usually take longer to build cash values and to pay dividends.
Acquisition costs for the old 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 policy?
Does the new policy provide more insurance coverage?

INSURABILITY:

If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down.
You may need a medical exam for a new 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 POLICY AS WELL AS THE NEW POLICY:

How are premiums for both policies being paid?
How will the premiums on your existing policy be affected?
Will a loan be deducted from death benefits?
What values from the old 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 contract?
What are the interest rate guarantees for the new contract?
Have you compared the contract charges or other policy expenses?

OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:

What are the tax consequences of buying the new policy?
Is this a tax-free exchange? (See your tax advisor.)
Is there a benefit from favorable "grandfathered" treatment of the old policy under the Federal Internal Revenue Tax Code?
Will the existing insurer be willing to modify the old 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, Alabama 35283-0619 • Telephone: 800-366-9378

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

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

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

OWNER: ______________________ ______________________

INSURER: ______________________

(NAME OF EXISTING INSURANCE COMPANY)

______________________ $ ______________________

(STREET ADDRESS OF EXISTING INSURANCE COMPANY) (ESTIMATED VALUE)

______________________ ______________________

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

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

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

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

I hereby designate Protective Life as beneficiary of the above listed policy(ies) to the extent of the cash surrender value thereof at the date of death of the Insured(s) named above. All other beneficiary designations under the above listed policy(ies) will remain in effect. I further understand that the policy(ies) to be issued by Protective Life will have the same designated Insured(s) and Owner(s) as the above listed policy(ies).

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

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

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

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

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

(If the Owner resides in the Community Property states of Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington or Wisconsin, we recommend that the Owner's spouse also sign this form. Signatures must be witnessed by a disinterested party of legal age.)*

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

INSURED: ______________________________ **POLICY NUMBER(S):** ____________________

OWNER: ______________________________ ____________________

INSURER: ______________________________
(NAME OF EXISTING INSURANCE COMPANY)

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

______________________________ ____________________
(CITY/STATE/ZIP) (PHONE NO.)

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

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

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

I hereby designate Protective Life as beneficiary of the above listed policy(ies) to the extent of the cash surrender value thereof at the date of death of the Insured(s) named above. All other beneficiary designations under the above listed policy(ies) will remain in effect. I further understand that the policy(ies) to be issued by Protective Life will have the same designated Insured(s) and Owner(s) as the above listed policy(ies).

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

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

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

(If the Owner resides in the Community Property states of Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington or Wisconsin, we recommend that the Owner's spouse also sign this form. Signatures must be witnessed by a disinterested party of legal age.)*

PROTECTIVE LIFE INSURANCE COMPANY • P. O. Box 830619 • Birmingham, AL 35283-0619
AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

1. This authorization to obtain and disclose information complies with HIPAA regulations that exempt the minimum necessary rules as they apply to life insurance. I (we) authorize Protective Life Insurance Company (Protective Life) and its reinsurers to obtain directly through designated third parties and use any information about or relating to me (us) that may affect my (our) insurability. Protective Life and its reinsurers may obtain and use health and medical information to include all dates of service, including but not limited to information about chart notes, EKG's, drug use, alcohol use, nicotine use, physical and mental diseases and illness, and psychiatric disorders. Protective Life and its reinsurers may also obtain and use non-health and non-medical information, including but not limited to financial information, credit reports, consumer reports, driving record, criminal record, and information about avocations and aviation activity. All of this information may be used to evaluate an application for insurance, a claim for insurance benefits, or both. Information relating to communicable diseases and other risk factors relating to me or to my spouse or life partner may be used to evaluate an application for insurance on either me or my spouse or life partner. The Protective Life sales agent or regional sales office representing me on my (our) application for insurance may obtain the information described in this paragraph directly from any of the persons or organizations listed in paragraph 2 in order to expedite the delivery of the information to Protective Life.
2. I (we) authorize the following persons and organizations to release and disclose the information described in paragraph 1 to Protective Life, directly through designated third parties or its agents acting on its behalf; (i) my (our) doctor(s); (ii) medical practitioners; (iii) pharmacists and Pharmacy Benefit Managers; (iv) medical and related facilities, including hospitals, clinics, facilities run by the Veteran's Administration, Kaiser Permanente, The Cleveland Clinic Foundation including all satellite facilities and The Mayo Clinic; (v) insurers; (vi) reinsurers; (vii) Medical Information Bureau, Inc. (**MIB**); (viii) my (our) current and previous employers; and (ix) commercial consumer reporting agencies **(CRA)**. All of these persons and organizations other than **MIB** may release the information described above to a **CRA** acting for Protective Life. **MIB** may not release the information described in paragraph 1 to a **CRA**.
3. I (we) authorize Protective Life to draw and test my (our) blood, and/or oral fluids, and urine as may be necessary to obtain information to be used to underwrite my (our) application for insurance. These tests may include, but are not limited to, tests for cholesterol and related blood lipids, diabetes, liver or kidney disorders, immune disorders (other than HIV/AIDS; reference number 7 below), and the presence of drugs, nicotine, or their metabolites. This authorization does not include genetic testing. Unless otherwise required by law or regulation, Protective Life may, but is not obligated to, release any of these test results directly to me or to my spouse or life partner.
4. I (we) authorize Protective Life to release and disclose the information described in paragraphs 1 and 3 to its affiliates, its reinsurers, persons or organizations providing services relating to insurance underwriting for Protective Life, **MIB**, and as otherwise required by law. I (we) authorize Protective Life to release and disclose the information described in paragraphs 1 and 3 to other duly licensed life insurers if I (we) have applied or apply to the other insurers for insurance.
5. I (we) authorize Protective Life to release and disclose the information described in paragraphs 1 and 3 to the Agent and their Representative representing me to duly licensed specific life insurers for the purpose of applying for life insurance if my (our) application with Protective Life is declined or if Protective Life is unable to offer coverage at an acceptable rate.
6. I (we) authorize Protective Life to release and disclose the information described in paragraphs 1 and 3 to the sales agent representing me on my (our) application for insurance if it is necessary to provide an explanation of the reasons for Protective Life's decision to impose special underwriting requirements, whenever my application cannot be approved as submitted, or in connection with a claim for benefits.
7. **SPECIAL REQUIREMENT FOR HIV/AIDS TESTING**. If Protective Life intends to test for the presence of antibodies to the Human Immunodeficiency Virus (HIV), which is the virus that has been associated with Acquired Immune Deficiency Syndrome (AIDS), Protective Life may require me (us) to authorize that testing separately. I (we) hereby authorize Protective Life to obtain and use the results of any HIV tests that I (we) separately authorize, and if permitted by law, to disclose the results of those tests to its reinsurers and **MIB**.

8. This authorization shall be valid for 12 months from the Date of Authorization shown below or, in the event of a claim for benefits, for the duration of such claim.
9. During the evaluation of my (our) insurance application, I (we) understand that I (we) have the right to revoke the authorizations in paragraphs 1 through 7 by writing to Protective Life at P.O. Box 830619 • Birmingham, AL 35283-0619. If this authorization is revoked, this would result in the file being closed and no coverage provided.
10. I understand I do not have to sign this authorization in order to obtain **health care benefits (treatment, payment or enrollment).**
11. I (we) understand that information about me (us) may be disclosed under this authorization to persons or organizations that are not subject to the Health Insurance Portability and Accountability Act **(HIPAA)** and that the information would then no longer be protected by **HIPAA** and any related regulations.
12. *I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction. Any modifications to this authorization may preclude Protective Life's ability to process this application.*
13. ☐ I (we) have been given a copy of this authorization form and Protective Life's Description of Information Practices.
    ☐ I (we) would like to be interviewed if an investigative consumer report will be made. *(Please check if you wish to be interviewed.)*
    ☐ If performed, I (we) would like copies of my (our) blood profile test results.

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

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

PROTECTIVE LIFE INSURANCE COMPANY • P. O. Box 830619 • Birmingham, AL 35283-0619
AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

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2. I (we) authorize the following persons and organizations to release and disclose the information described in paragraph 1 to Protective Life, directly through designated third parties or its agents acting on its behalf; (i) my (our) doctor(s); (ii) medical practitioners; (iii) pharmacists and Pharmacy Benefit Managers; (iv) medical and related facilities, including hospitals, clinics, facilities run by the Veteran's Administration, Kaiser Permanente, The Cleveland Clinic Foundation including all satellite facilities and The Mayo Clinic; (v) insurers; (vi) reinsurers; (vii) Medical Information Bureau, Inc. (**MIB**); (viii) my (our) current and previous employers; and (ix) commercial consumer reporting agencies **(CRA)**. All of these persons and organizations other than **MIB** may release the information described above to a **CRA** acting for Protective Life. **MIB** may not release the information described in paragraph 1 to a **CRA**.
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8. This authorization shall be valid for 12 months from the Date of Authorization shown below or, in the event of a claim for benefits, for the duration of such claim.
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    ☐ If performed, I (we) would like copies of my (our) blood profile test results.

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

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

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

NOTICE AND CONSENT FOR HIV-RELATED TESTING

U215TX R

To evaluate your insurability, the Insurer named above, Protective Life Insurance Company, has requested that you provide a sample of your blood, oral fluid extracted from cheek and gum tissue, or urine, for testing and analysis to determine the presence of human immunodeficiency virus (HIV) antibodies. By signing and dating this form you agree that this test may be done and that underwriting decisions will be based on the test result. A series of three tests will be performed by a licensed laboratory through a medically accepted procedure.

Pre-Testing Considerations

Many public health organizations have recommended that before taking an HIV-related test a person seek counseling to become informed concerning the implications of such a test. You may wish to consider counseling, at your expense, prior to being tested.

Meaning of Positive Test Result

The test is not a test for AIDS. It is a test for antibodies to the HIV virus, the causative agents for AIDS, and shows whether you have been exposed to the virus. A positive test result does not mean that you have AIDS but that you are at significantly increased risk of developing problems with your immune system. The test for HIV antibodies is very sensitive. Errors are rare, but they do occur. Your private physician, a public health clinic, or an AIDS information organization in your city might provide you with further information on the medical implications of a positive test.

Positive HIV antibody test results will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged, or that other policy changes may be necessary.

Confidentiality of Test Results

All test results are required to be treated confidentially. They will be reported by the laboratory to the Insurer. The test results may be disclosed as required by law or may be disclosed to employees of the Insurer who have the responsibility to make underwriting decisions on behalf of the Insurer or to outside legal counsel who needs such information to effectively represent the Insurer in regard to your application. The results may be disclosed to a reinsurer, if the reinsurer is involved in the underwriting process. The test may be released to an insurance medical information exchange under procedures that are designed to assure confidentiality, including the use of general codes that also cover results of tests for other diseases or conditions not related to AIDS, or for the preparation of statistical reports that do not disclose the identity of any particular person.

Notification of Test Result

If your test results are negative, no routine notification will be sent to you. If your test results are reported by the laboratory to the Insurer as being positive, you will receive written notification of such results from a physician you have designated or, in the absence of such designation, from the Texas Department of Health. Because a trained person should deliver that information so that you can understand clearly what the test result means, please list your private physician so that the Insurer can have him or her tell you the test result and explain its meaning.

Name of physician for reporting a possible positive test result: ______________________________

Address: ______________________________

In the event the test is positive and you are denied coverage because of that fact and you request the reason for the denial, the insurer may require you to name a physician at that time in order to receive the information.

If the test indicates a positive result, but you do not designate a private physician, the test results will be provided to you by a representative of the Texas Department of Health.

Consent

I have read and I understand this Notice and consent for HIV-Related Testing. I voluntarily consent to the withdrawal of blood, oral fluid extracted from cheek and gum tissue, or urine from me, the testing of that sample, and the disclosure of the test results as described above. I have read the information on this form about what a test result means.

I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

____
Name of Proposed Insured

____
Signature of Proposed Insured or Parent/Guardian

____
Address

Date Signed: ______________________________

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

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I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

______________________________ Name of Proposed Insured

______________________________ Signature of Proposed Insured or Parent/Guardian

______________________________ Address

Date Signed: ______________________________

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

CONFIDENTIAL FINANCIAL STATEMENT

Required if the Proposed Insured is under age 65 and the face amount is $3,000,000 or greater or the Proposed Insured is 65 or older and the face amount is $1,000,000 or greater.

Name of Proposed Insured: ____________________

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

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

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

Additional Details: ____________________

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

____

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

____________________ ____________________
Date Signature of Proposed Insured

F-LAD-428 (7/09)