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

INDIVIDUAL LIFE INSURANCE APPLICATION PACKET - INSTRUCTIONS

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

FORM NUMBER	FORM NAME	INSTRUCTIONS
DIP-CA	Description of Information Practices	This notice MUST be given to the Proposed Insured on all cases submitted.
PL-400-TLR	Individual Life Insurance Application	Protective Life can only accept or service an application from an applicant who speaks English or Spanish. Spanish speaking applicants must go through our TeleLife process. Complete each question in the Application for Insurance. If completing by hand, please use a pen with black ink. If applying for any riders see instructions for Rider Worksheet on Page 2.
PL-701-CA	Supplement to Life Insurance Application (STOLI)	Must complete on all cases being submitted.
PL-HIPAA2	Authorization to Obtain and Disclose Information (HIPAA)	Must complete on all cases being submitted. Leave a copy of this form with the applicant. **Signature and date is required.**
PLX-408	Broker/Representative Report	The correct Broker/Representative PLICO Contract Number must be included in order to ensure commissions are paid correctly. Include Split Share Percentage.
PL-406A	Continuation of Information	Use this form if additional space is needed for information.
U-592-CA	Notice and Consent Form for AIDS (HIV) Testing	Must complete on all cases submitted. Leave a copy of this form with the applicant.
U-645-CA	Notice to Applicants Age 65 or Older	If applicant is age 65 or older and elects the sale or liquidation of any stock, bond, IRA, certificate of deposit, mutual fund, annuity or other asset to fund the purchase of this life insurance product. Leave this notice with the applicant.
CA-SA-AN	Notification of Right to Name a Secondary Addressee	Must complete on all cases being submitted. Leave this notice with the applicant.
PLX-588	Life Insurance Illustration Certification & Acknowledgement	Only required for illustrated UL products when an illustration is not obtained. Illustrations are required prior to issue.

NOT FOR USE WITH VARIABLE UNIVERSAL LIFE PRODUCTS

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

FORM NUMBER	FORM NAME	INSTRUCTIONS
PL-403R	Rider Worksheet	If applying for any additional benefits or riders, the Rider Worksheet must be completed. In addition, the following riders require these supplemental application forms, which can be found online at MyProtective.com forms site. Leave a copy of each form with the applicant. If applying for the Children's Term Rider, complete form number PL-404R-CA. If applying for the Income Provider Option, complete form number P-U-437R.
PL-104	Pre-Authorized Withdrawal Agreement	Use in cases where the applicant elects to have premium payments drafted from a bank account.
PL-TLR for CA	Temporary Life Insurance Receipt	If payment is submitted with the application, must complete and sign the Temporary Life Insurance Receipt. Leave a copy of this form with the applicant.
A-2043	Replacement Form	Must complete and sign regarding existing coverage. Leave a copy of this form with the applicant.
F-LAD-277	Assignment/Transfer of Ownership (Section 1035 Exchange)	Must complete on 1035 Exchange/Transfer cases. Leave a copy of this form with the owner. **Send the Original to the Home Office.**
PL-405R	Confidential Financial Statement	To be signed by the Proposed Insured if Face Amount is $5,000,001 or greater (for Proposed Insured(s) age 0-70) and $3,000,001 or greater (for Proposed Insured(s) age 71 and older) or at the discretion of underwriting.
PL-402	Part 1A Supplemental Application (Medical Declarations)	If the Proposed Insured is NOT being examined, this form must be completed.

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

Mailing Addresses:

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

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

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)

DISCLOSURE OF INFORMATION

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

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

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

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

INVESTIGATIVE CONSUMER REPORT

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

YOU CAN REVIEW AND CORRECT YOUR INFORMATION

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

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

THIS NOTICE MUST BE GIVEN TO THE PROPOSED INSURED

AGENT/PRODUCER COMPENSATION DISCLOSURE

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

DIP-CA 03/2016

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

SECTION I: INSUREDS — INDIVIDUAL LIFE INSURANCE APPLICATION

1. Proposed Insured 1

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

Proposed Insured 2

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

2. Employment Information

Proposed Insured 1

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

Proposed Insured 2

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

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

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

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

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

SECTION II: PLAN OF INSURANCE

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

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

SECTION III: BENEFICIARY DESIGNATIONS

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

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

SECTION IV: EXISTING COVERAGE/PENDING INSURANCE AND REPLACEMENT

(Must be answered completely on all cases.)

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

2. Regarding all persons proposed for insurance, list all life insurance in force on each proposed insured's life.
Please be sure to list insurance policy information, whether owned by any proposed insured or not. **If None, insert None.**

Name of Insured	*Company*	*Policy Number*

Replace or Change?	*Amount*	*Purpose: Business/Personal*	*Issue Date*

Name of Insured	*Company*	*Policy Number*

Replace or Change?	*Amount*	*Purpose: Business/Personal*	*Issue Date*

Name of Insured	*Company*	*Policy Number*

Replace or Change?	*Amount*	*Purpose: Business/Personal*	*Issue Date*

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

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

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

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

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

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

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

9. Has any Proposed Insured discussed transfer of the policy to be issued, or its death benefits, to a life settlement company, investor, offshore trust, investment trust, or entity associated with stranger owned or investment owned life insurance (commonly called SOLI or IOLI) or have you considered such a transfer? *If Yes, please explain.* ……..…… ☐ Yes ☐ No

Remarks and Explanations to any Yes answers in Section IV.

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

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

6. Please complete the information below:

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

SECTION VI: PERSONAL HISTORY

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

HAS PROPOSED INSURED: (*Must be answered for all Proposed Insureds.*)

	Proposed Insured 1 Yes	Proposed Insured 1 No	Proposed Insured 2 Yes	Proposed Insured 2 No
1. Used tobacco or nicotine of any kind over the last 5 years?	☐	☐	☐	☐
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. Have any proposed insureds ever been convicted of, or pled guilty or no contest to a felony, or do they have any such charge pending against them?	☐	☐	☐	☐
5. Flown as a pilot, student pilot or crew member, or intend to fly as such? (*If Yes, complete the Aviation Questionnaire.)*	☐	☐	☐	☐
6. Been a member of, or applied to be a member, or received a notice of required service in the armed forces, reserves or National Guard? (*If Yes, provide details below.*)	☐	☐	☐	☐
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: SPECIAL REMARKS AND DETAILS TO ANY YES ANSWERS

(Must be answered if applicable.)

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

DECLARATIONS

I (We) have read or have had read to me (us) the completed Application before signing below. I (We) represent that all statements and answers made in all parts of this application are full, complete and true. It is agreed that:

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

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 _____ Date _____
(City and State)

(X) _____ (X) _____
Signature of Proposed Insured 1 Signature of Proposed Insured 2

Signed At _____ Date _____
(City and State)

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

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

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

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

Print Name of Proposed Insured(s): _____

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

SIGNATURES

I (We) have read or have had read to me (us) the completed Supplement before signing below. All statements and answers in the Supplement are correctly recorded 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 _____, this _____ day of _____, _____.
(State) (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

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

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

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

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

RELEASE AND DISCLOSE INFORMATION FROM THIRD PARTIES

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

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

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

TESTING OF BLOOD, ORAL FLUIDS AND URINE

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

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

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

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

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

a. to its affiliates, its reinsurers, persons or organization providing services relating to insurance underwriting for Protective Life, **MIB** and as otherwise required by law.
b. to release and disclose the information to other duly licensed life insurers if I (we) have applied or apply to the other insurers for insurance.
c. to its reinsurers, to make a brief report of my personal health information to **MIB**.
d. to the Life Insurance Representative(s) representing me to duly licensed specific life insurers for the purpose of applying for life insurance if my (our) application with Protective Life is declined or if Protective Life is unable to offer coverage at an acceptable rate.
e. to the Life Insurance Representative(s) and its staff, affiliated companies and/or entities, insurance companies and their re-insurers representing me on my (our) application for life insurance.

Home Office – ORIGINAL Applicant - COPY

SPECIAL REQUIREMENT FOR HIV/AIDS TESTING

If Protective Life intends to test for the presence of antibodies to the Human Immunodeficiency Virus (HIV), which is the virus that has been associated with Acquired Immune Deficiency Syndrome (AIDS), Protective Life may require a separate authorization. I (we) hereby authorize Protective Life:

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

GENERAL INFORMATION

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

AUTHORIZATIONS AND INVESTIGATIVE CONSUMER REPORT

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

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

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

SIGNATURES

Date of Authorization: X_____

_____
List Health Care Providers

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

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

Home Office – ORIGINAL Applicant - COPY

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

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

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

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

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

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

RELEASE AND DISCLOSE INFORMATION FROM THIRD PARTIES

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

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

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

TESTING OF BLOOD, ORAL FLUIDS AND URINE

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

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

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

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

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

a. to its affiliates, its reinsurers, persons or organization providing services relating to insurance underwriting for Protective Life, **MIB** and as otherwise required by law.
b. to release and disclose the information to other duly licensed life insurers if I (we) have applied or apply to the other insurers for insurance.
c. to its reinsurers, to make a brief report of my personal health information to **MIB**.
d. to the Life Insurance Representative(s) representing me to duly licensed specific life insurers for the purpose of applying for life insurance if my (our) application with Protective Life is declined or if Protective Life is unable to offer coverage at an acceptable rate.
e. to the Life Insurance Representative(s) and its staff, affiliated companies and/or entities, insurance companies and their re-insurers representing me on my (our) application for life insurance.

Home Office – ORIGINAL Applicant - COPY

SPECIAL REQUIREMENT FOR HIV/AIDS TESTING

If Protective Life intends to test for the presence of antibodies to the Human Immunodeficiency Virus (HIV), which is the virus that has been associated with Acquired Immune Deficiency Syndrome (AIDS), Protective Life may require a separate authorization. I (we) hereby authorize Protective Life:

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

GENERAL INFORMATION

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

AUTHORIZATIONS AND INVESTIGATIVE CONSUMER REPORT

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

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

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

SIGNATURES

Date of Authorization: X_____

_____
List Health Care Providers

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

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

Home Office – ORIGINAL Applicant - COPY

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

BROKER / REPRESENTATIVE REPORT

		Yes	No
1.	In what language were the questions on the application asked? *Please remember that Protective Life cannot accept or service any application from an applicant who does not speak English or Spanish. ☐ English ☐ Spanish ☐ Other* **List Other Language* : _____		
2.	Is the Proposed Insured a relative or does the Proposed Insured have a business relationship with you? *If Yes, Details:* _____	☐	☐
3.	(a) Will this policy replace or change existing policy(ies)?	☐	☐
	(b) If replacement of existing insurance is involved, have you complied with all relevant state requirements, including any Disclosure and Comparison Statements? *If No, Explain:* _____	☐	☐
	Answer questions (c) and (d) *only* if this is a replacement:		
	(c) Did you use any pre-printed company approved sales materials? *If Yes, List Name or Form Number:* _____	☐	☐
	(d) Did you use any Company approved, electronically generated, individualized sales materials (such as illustrations or concept materials)? *(If Yes, you must provide a copy of these materials with the application.)*	☐	☐
4.	Have you advised the proposed policyowner or do you know of any advice that has been given to the policyowner to transfer ownership of the policy to be issued, or its death benefits, to a life settlement company, investor, offshore trust, investment trust, or entity associated with stranger owned or investment owned life insurance (commonly called SOLI or IOLI) or are you otherwise aware that the policyowner may be contemplating such a transfer? *If Yes, please explain in Special Requests/Remarks below.*	☐	☐
5.	Has a mortality analysis or life expectancy analysis been performed on the Proposed Insured?	☐	☐
6.	Has a medical examination been ordered? *If Yes, Name of Examiner:* _____ *Date of Exam:* _____	☐	☐
7.	Is Premium Financing involved in this case? (If Yes, please submit a cover letter describing the parameters.)	☐	☐
	I have verified the identity of the Owner by picture I.D. (*Authorized Representative if Business or Trustee if Trust)* *Identification Type:* _____ *Driver's License Number:* _____ Please include Driver's License Number if Owner is an individual and is other than the Proposed Insured. NOTE: Does not apply to direct marketing situations	☐	☐

I certify that:

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

Signature of Broker/Representative	*Date*	*PLICO Contract Number*	*Share %*	*Business Phone Number*
Print Name of Above Signature	*Email Address*		*Signed at (City and State)*	
Signature of Additional Broker/Representative	*Date*	*PLICO Contract Number*	*Share %*	*Business Phone Number*
Print Name of Above Additional Signature	*Email Address*		*Signed at (City and State)*	
BGA/Broker Dealer Name	*PLICO Contract Number*			
New Business Key Contact	*Email Address*		*Phone Number*	

Broker/Representative Special Requests/Remarks:

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

NOTICE AND CONSENT FOR AIDS-RELATED TESTING

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

Pre-Testing Considerations

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

Meaning of Positive Test Result

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

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

Confidentiality of Test Results

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

Notification of Test Result

If your test results are negative, no routine notification will be sent to you. If your test results are reported by the laboratory to the Insurer as being positive, you are entitled to that information if you so desire. Because a trained person shold deliver that information so that you can understand clearly what the test result means, you are asked to list your private physician so that the Insurer can have him or her tell you the test result and explain its meaning.

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

Address: _____

If you do not wish to know the results of the test, initial here: _____. In the event the test is positive and you are denied coverage because of the fact and you request the reason for the denial, the insurer may require you to name a physician at that time in order to receive the information.

If you want to know the results of the test but do not at present have a private physician, initial here: _____ The result will be sent to you at the address provided by registered mail with delivery restricted to you only.

Consent

I have read and I understand this Notice and Consent for AIDS-Related Testing. I voluntarily consent to the withdrawal of blood, urine, or saliva from me, the testing of that blood, urine, or saliva, and the disclosure of the test results as described above. I have read the information on this form about what a test result means and understand that I should contact a local AIDS service group or my private physician for further information and counseling if the test result is positive.

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

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

_____	_____
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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Address: _____

If you do not wish to know the results of the test, initial here: _____. In the event the test is positive and you are denied coverage because of the 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.

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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.

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

_____	_____
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

NOTICE TO APPLICANTS AGED 65 OR OLDER - CALIFORNIA

The sale or liquidation of any stock, bond, IRA, certificate of deposit, mutual fund, annuity or other asset to fund the purchase of this life insurance product may have tax consequences, early withdrawal penalties, or other costs or penalties as a result of the sale or liquidation. You may wish to consult your independent legal or financial advisor prior to selling or liquidating any assets and prior to the purchase of any life or annuity products being solicited, offered for sale or sold.

U-645 CA (7/01)

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

PRE-AUTHORIZED WITHDRAWAL AGREEMENT

FOR DRAFTING OF PREMIUM PAYMENTS

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

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

Policy Number: _____ Name of Insured: _____

Name of Bank: _____

Street Address or P.O. Box: _____

City: _____ State: _____ Zip Code: _____

Type of Account: ☐ Checking ☐ Savings

Routing Number: ____ ____ ____ ____ ____ ____ ____ ____ ____

Account Number: _____

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

☐ Semi-Annually ☐ Annually

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

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

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

I request future drafts be made on the _____ *(1st - 28th)* day of the month.

_____
Premium Payer - Depositor (Please Print)

_____ _____
Date Signature

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

PL-104 06/14

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

TEMPORARY LIFE INSURANCE RECEIPT

THIS RECEIPT PROVIDES A LIMITED AMOUNT OF LIFE INSURANCE COVERAGE, FOR A LIMITED PERIOD OF TIME, SUBJECT TO THE TERMS OF THIS RECEIPT.

Premium payment in the amount of $_____ is made for Life Insurance on each person proposed for insurance.

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO PROTECTIVE LIFE INSURANCE COMPANY.
DO NOT MAKE CHECKS PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.

QUALIFYING SCREENING QUESTIONS

		Yes	No
1.	Has any person proposed for insurance in this application:		
a.	within the past 90 days been admitted to a hospital or other medical facility, been advised to be admitted, or had surgery performed or recommended?.....	☐	☐
b.	within the past 2 years, been treated for heart trouble, stroke, or cancer, or had such treatment recommended by a physician or other practitioner?.....	☐	☐
2.	Is any person proposed for insurance in this application under 15 days of age or over the age of 80 years (nearest birthday)?..	☐	☐

If any of the above questions, including any subpart thereof, is answered YES or LEFT BLANK, no representative of Protective Life Insurance Company is authorized to accept a premium and NO COVERAGE will take effect under this Receipt. No one is authorized to accept a premium on Proposed Insureds under 15 days of age or over age 80 and NO COVERAGE will take effect under this Receipt.

TERMS AND CONDITIONS

AMOUNT OF COVERAGE - $1,000,000 OVERALL MAXIMUM FOR ALL POLICIES, APPLICATIONS, AND RECEIPTS

If a premium has been accepted by Protective Life Insurance Company for an application for Life Insurance and any person proposed for Insurance in such application dies while this temporary life receipt is in effect, Protective Life will pay, subject to the conditions and limitations contained herein, to the beneficiary designated in such application a death benefit equal to the lesser of:

a. the amount of life insurance applied for under such application, or
b. the greater of (i) $1,000,000 less the amount of death benefits due and payable by virtue of the insured's death under any other Protective Life policy, application, temporary receipt or the life, or (ii) $50,000.

In no event shall Protective Life's liability under this Receipt exceed $1,000,000. Any money received will be refunded.

DATE COVERAGE BEGINS: Temporary Life Insurance under this Receipt will begin on the date this Receipt is executed and the Application has been completed.

DATE COVERAGE TERMINATES: Temporary Life Insurance under this Receipt will terminate automatically on the earlier of:

a. the date that Protective Life mails notice of termination of coverage and refund of the advance premium payment to the Applicant at the address designated in this application, or
b. the date that Protective Life approves for issue the policy applied for at the rate class and for the amount indicated in this application. In no event shall coverage be provided under this Receipt if the policy applied for has been issued.

LIMITATIONS: This receipt does not provide benefits for disability. If Temporary Life Insurance is terminated in accordance with (a) above, Protective Life's liability under this Receipt is limited to a refund of the premium payment made. If any person proposed for insurance dies by suicide, Protective Life's liability under this Receipt is limited to a refund of the payment made. There is no coverage under this Receipt if the check submitted as payment is not honored by the bank on first presentation. No one is authorized to waive or modify any of the provisions of this Receipt.

COVERAGE UNDER THIS RECEIPT SHALL BE VOID IF THERE IS FRAUD OR A MATERIAL MISREPRESENTATION IN THE APPLICATION FOR LIFE INSURANCE OR IN ANY ANSWER TO THE QUALIFYING SCREENING QUESTIONS OF THIS RECEIPT. I (WE) HAVE RECEIVED A COPY OF AND HAVE READ THIS TEMPORARY LIFE INSURANCE RECEIPT AND DECLARE THAT THE ANSWERS ARE TRUE TO THE BEST OF MY (OUR) KNOWLEDGE AND BELIEF. I (WE) UNDERSTAND AND AGREE TO ALL ITS TERMS.

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

(X)_____
Witnessed by Agent

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

_____
Agent's Name Printed

(X)_____
*Applicant/Owner Signature (If Other than Proposed Insured)

_____
Agent's Street Address

(X)_____
Joint Owner Signature

_____
Agent's City, State, Zip

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

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

NOTICE TO APPLICANT: You should retain the copy of this Receipt. The original will be retained by Protective Life. If you do not hear from us regarding the insurance applied for within 100 days from the date of this Receipt, notify us at P.O. Box 830619, Birmingham, AL 35283-0619.

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

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Premium payment in the amount of $_____ is made for Life Insurance on each person proposed for insurance.

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DO NOT MAKE CHECKS PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.

QUALIFYING SCREENING QUESTIONS

		Yes	No
1.	Has any person proposed for insurance in this application:		
a.	within the past 90 days been admitted to a hospital or other medical facility, been advised to be admitted, or had surgery performed or recommended?.....	☐	☐
b.	within the past 2 years, been treated for heart trouble, stroke, or cancer, or had such treatment recommended by a physician or other practitioner?.....	☐	☐
2.	Is any person proposed for insurance in this application under 15 days of age or over the age of 80 years (nearest birthday)?..	☐	☐

If any of the above questions, including any subpart thereof, is answered YES or LEFT BLANK, no representative of Protective Life Insurance Company is authorized to accept a premium and NO COVERAGE will take effect under this Receipt. No one is authorized to accept a premium on Proposed Insureds under 15 days of age or over age 80 and NO COVERAGE will take effect under this Receipt.

TERMS AND CONDITIONS

AMOUNT OF COVERAGE - $1,000,000 OVERALL MAXIMUM FOR ALL POLICIES, APPLICATIONS, AND RECEIPTS

If a premium has been accepted by Protective Life Insurance Company for an application for Life Insurance and any person proposed for Insurance in such application dies while this temporary life receipt is in effect, Protective Life will pay, subject to the conditions and limitations contained herein, to the beneficiary designated in such application a death benefit equal to the lesser of:

a. the amount of life insurance applied for under such application, or
b. the greater of (i) $1,000,000 less the amount of death benefits due and payable by virtue of the insured's death under any other Protective Life policy, application, temporary receipt or the life, or (ii) $50,000.

In no event shall Protective Life's liability under this Receipt exceed $1,000,000. Any money received will be refunded.

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DATE COVERAGE TERMINATES: Temporary Life Insurance under this Receipt will terminate automatically on the earlier of:

a. the date that Protective Life mails notice of termination of coverage and refund of the advance premium payment to the Applicant at the address designated in this application, or
b. the date that Protective Life approves for issue the policy applied for at the rate class and for the amount indicated in this application. In no event shall coverage be provided under this Receipt if the policy applied for has been issued.

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

(X)_____
Witnessed by Agent

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

_____
Agent's Name Printed

(X)_____
*Applicant/Owner Signature (If Other than Proposed Insured)

_____
Agent's Street Address

(X)_____
Joint Owner Signature

_____
Agent's City, State, Zip

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

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

NOTICE TO APPLICANT: You should retain the copy of this Receipt. The original will be retained by Protective Life. If you do not hear from us regarding the insurance applied for within 100 days from the date of this Receipt, notify us at P.O. Box 830619, Birmingham, AL 35283-0619.

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

REPLACING YOUR LIFE INSURANCE POLICY OR ANNUITY? NOTICE REGARDING REPLACEMENT

Are you thinking about buying a new life insurance policy or annuity and discontinuing or changing an existing one? If you are, your decision could be a good one - or a mistake. You will not know for sure unless you make a careful comparison of your existing benefits and the proposed benefits.

Make sure you understand the facts. You should ask the company or agent that sold you your existing policy to give you information about it.

Hear both sides before you decide. This way you can be sure you are making a decision that is in your best interest.

We are required by law to notify your existing company that you may be replacing your policy.

You are urged not to take action to terminate, assign or alter your existing policy until your new policy has been issued and you have examined it and found it acceptable.

Applicant's Signature _____ Date _____ Agent's Signature _____

POLICY INFORMATION SHEET FOR EXISTING INSURANCE

Name of Applicant: _____ D.O.B. _____

Address: _____

Proposed Insured if Other Than Applicant: _____

Application Number of Proposed Insurance: _____

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

POLICY INFORMATION

Insurer: _____

Policy Generic Name: _____

Policy Number: _____

POLICY INFORMATION

Insurer: _____

Policy Generic Name: _____

Policy Number: _____

POLICY INFORMATION

Insurer: _____

Policy Generic Name: _____

Policy Number: _____

POLICY INFORMATION

Insurer: _____

Policy Generic Name: _____

Policy Number: _____

A-2043 Original - HOME OFFICE Copy - APPLICANT

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

REPLACING YOUR LIFE INSURANCE POLICY OR ANNUITY? **NOTICE REGARDING REPLACEMENT**

Are you thinking about buying a new life insurance policy or annuity and discontinuing or changing an existing one? If you are, your decision could be a good one - or a mistake. You will not know for sure unless you make a careful comparison of your existing benefits and the proposed benefits.

Make sure you understand the facts. You should ask the company or agent that sold you your existing policy to give you information about it.

Hear both sides before you decide. This way you can be sure you are making a decision that is in your best interest.

We are required by law to notify your existing company that you may be replacing your policy.

You are urged not to take action to terminate, assign or alter your existing policy until your new policy has been issued and you have examined it and found it acceptable.

Applicant's Signature _____ Date _____ Agent's Signature _____

POLICY INFORMATION SHEET FOR EXISTING INSURANCE

Name of Applicant: _____ D.O.B. _____

Address: _____

Proposed Insured if Other Than Applicant: _____

Application Number of Proposed Insurance: _____

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

POLICY INFORMATION

Insurer: _____

Policy Generic Name: _____

Policy Number: _____

POLICY INFORMATION

Insurer: _____

Policy Generic Name: _____

Policy Number: _____

POLICY INFORMATION

Insurer: _____

Policy Generic Name: _____

Policy Number: _____

POLICY INFORMATION

Insurer: _____

Policy Generic Name: _____

Policy Number: _____

A-2043 Original - HOME OFFICE Copy - APPLICANT

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

NOTIFICATION OF RIGHT TO NAME AT LEAST ONE SECONDARY ADDRESSEE

California policyholders have the right to designate at least one secondary addressee to receive notice of policy lapse or termination for nonpayment of premium. If you would like to make a designation, please complete the information below and return it to us at P.O. Box 830619, Birmingham, Alabama 35283-0619. If you do not wish to name a secondary addressee at this time, simply do not return the form. Note that this form will be provided on an annual basis should you reconsider.

If you have any questions about your right to name at least one secondary addressee, please call us at 1-800-366-9378, fax us at 1-205-268-5807, or write us at P.O. Box 830619, Birmingham, Alabama 35283-0619.

Please Print the Following Information:

_____
Policy Number (if known)

_____
Policy Owner's Name

_____
Insured's Name

Secondary Addressee:

_____
Name

_____
Street Address or P.O. Box

_____
City, State, Zip Code

_____
Telephone Number

PROTECTIVE LIFE AND ANNUITY INSURANCE COMPANY
PROTECTIVE LIFE INSURANCE COMPANY[1]

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

LIFE INSURANCE ILLUSTRATION CERTIFICATION & ACKNOWLEDGEMENT

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

1. PROPOSED INSURED *(please print)*

First, Middle, Last Name: _____

Social Security Number: _____ Date of Birth *(mm/dd/yyyy)*: _____

2. OWNER *(if other than Proposed Insured)*

First, Middle, Last Name: _____

3. AGENT/REPRESENTATIVE *(please print)*

First, Middle, Last Name: _____

Agent/Representative Number: _____ BGA Name *(if applicable)*: _____

4. ELECTRONIC ILLUSTRATION DATA – Complete this section if an electronic illustration is presented and no corresponding printed copy is provided.

Gender Class:_____ Initial Death Benefit: _____

Date of Birth *(mm/dd/yyyy)*: _____ Premium Amount Illustrated: _____

Underwriting Class: _____ Premium Mode: _____

Plan Type: _____ Number of Policy Years Illustrated: _____

Product Name: _____ Guaranteed Interest Rate: _____%

Policy Form Number: _____ Non-Guaranteed Illustrated Interest Rate: _____%

Rider(s): _____ Alternate Indexed Interest Rate: _____%
(for Indexed Products)

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

☐ No policy illustration was provided to me and I understand that a policy illustration conforming to the policy as issued will be provided no later than the time the policy is delivered.

☐ The policy applied for is different than the policy illustration shown to me, and I understand that a policy illustration conforming to the policy as issued will be provided no later than at the time the policy is delivered.

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

Applicant Signature: X_____ Date: _____

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

☐ No illustration was used in the sale of the life insurance applied for.

☐ The life insurance applied for is other than as shown in the policy illustration.

☐ I displayed a complete electronic illustration to the proposed insured that was based on the personal and policy information shown on this form. I further certify that the policy illustration complies with applicable state requirements and that no corresponding printed copy was provided.

Agent/Representative Signature: X_____ Date: _____

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

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

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

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

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

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

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

[1] Not authorized in New York