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

INDIVIDUAL LIFE INSURANCE APPLICATION PACKET - INSTRUCTIONS

These forms are required on all cases submitted.

FORM NUMBER	FORM NAME	INSTRUCTIONS
• PL-DIP	• Description of Information Practices	• This notice MUST be given to the Proposed Insured on all cases submitted.
• ICC12-400	• Individual Life Insurance Application	• Protective Life can only accept or service an application from an applicant who speaks English or Spanish. Spanish speaking applicants must go through our TeleLife process. • Complete each question in the Application for Insurance. If completing by hand, please use a pen with black ink. • If applying for any riders see instructions for Rider Worksheet on Page 2.
• ICC14-PL701	• Supplement to Life Insurance Application	• Must complete on ALL cases being submitted. • **NEW – Signatures and dating now required.**
• ICC16-HIPAA	• 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	• Correct Broker/Representative PLICO Contract Number must be included in order to ensure commissions are paid correctly. Include Split Share Percentage.
• ICC12-406A	• Continuation of Information Form	• Use this form if additional space is needed for Information.
• U-422	• Notice and Consent Form for AIDS (HIV) Testing	• Must complete on all cases submitted. • Leave a copy of this form with the applicant.

NOT FOR USE WITH VARIABLE UNIVERSAL LIFE PRODUCTS

These forms may be required if circumstances apply.

FORM NUMBER	FORM NAME	INSTRUCTIONS

• ICC12-403	• 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.
		• Leave a copy of each form with the applicant.
		  • If applying for Children's Term Rider, Complete form # ICC12-404.
		  • If applying for Income Provider Option, Complete form # P-U-437R.

• PL-104	• Pre-Authorized Withdrawal Agreement	• Use in cases where the client elects to have premium payments drafted.
• PL-CR	• Conditional Receipt Agreement	• If payment is submitted with the application, must complete and sign the Conditional Receipt. • Leave a copy of this form with the applicant.
• A-2043-N	• Replacement Form	• Must complete and sign regarding existing coverage. • Leave a copy of this form with the Proposed Insured.
• F-LAD-277	• Assignment/Transfer of Ownership (Section 1035 Exchange)	• Must complete on 1035 Exchange/Transfer cases. • Leave a copy of this form with the owner. **Send the Original to the Home Office.**
• ICC12-405	• 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.
• ICC12-402	• Part 1A-Supplemental Application (Medical Declarations)	• If the Proposed Insured is NOT being examined, this form must be completed.

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

Mailing Addresses:

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

Home Office - Overnight
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.

Protective

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 Yrs.* ☐ *15 Yrs.* ☐ *20 Yrs.* ☐ *25 Yrs.* ☐ *30 Yrs.*	*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		Proposed Insured 2	
	Yes	No	Yes	No
1. Used tobacco or nicotine of any kind over the last 5 years?	☐	☐	☐	☐
Type / *Frequency* / *Date Last Used*				
2. Consulted a physician or had treatment for the use or possession of:				
A. Alcohol? (*If Yes, complete the Alcohol Usage Questionnaire.*)	☐	☐	☐	☐
B. Narcotics, stimulants, sedatives, hallucinogenic drugs? (*If Yes, complete the Drug Use Questionnaire.*)	☐	☐	☐	☐
3. In the past 5 years, been convicted of (i) two or more moving violations, (ii) driving under the influence of alcohol or other drugs, or (iii) had their driver's license suspended or revoked?	☐	☐	☐	☐
4. 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, to the best of my (our) knowledge and belief. It is agreed that:

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

IMPORTANT INFORMATION ABOUT IDENTIFICATION VERIFICATION

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

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

Signed At _____ 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 and are full, complete and true to the best of my (our) knowledge and belief. I (We) understand that the information being provided in this Supplement is being relied upon in considering the application for life insurance and is subject to the applicable Fraud Statement as provided in the Application for Life Insurance.

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

Signature(s) of Proposed Insured(s): X _____ SIGN HERE

X _____ SIGN HERE

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

X _____ SIGN HERE

Signature of Witness: X _____ SIGN HERE

PRODUCER CERTIFICATION

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

Signed at: _____ (City and State) _____ Date

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

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

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

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 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.

SPECIAL REQUIREMENT FOR HIV/AIDS TESTING

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

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

GENERAL INFORMATION

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

AUTHORIZATIONS AND INVESTIGATIVE CONSUMER REPORT

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

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

THIS AUTHORIZATION <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 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.

SPECIAL REQUIREMENT FOR HIV/AIDS TESTING

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

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

GENERAL INFORMATION

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

AUTHORIZATIONS AND INVESTIGATIVE CONSUMER REPORT

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

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

THIS AUTHORIZATION <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

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)*	
Insurance Nationwide Services, Inc	T000910			
BGA/Broker Dealer Name	*PLICO Contract Number*			
Trish Rosiere			303-674-1641	
New Business Key Contact	*Email Address*		*Phone Number*	

Broker/Representative Special Requests/Remarks:

Protective

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

NOTICE AND CONSENT FOR AIDS VIRUS (HIV) TESTING

Acquired Immunodeficiency Syndrome (AIDS) is a life-threatening disorder of the immune system, caused by a virus, HIV. The virus is transmitted by sexual contact with an infected person, from an infected mother to her newborn infant, or by exposure to infected blood (as in needle sharing during IV drug use). Persons at high risk of contracting AIDS include males who have had sexual contact with another man, intravenous drug users, hemophiliacs, and sexual contacts with any of these persons. AIDS does not typically develop until a person has been infected with HIV for several years. A person may remain free of symptoms for years after becoming infected. Infected persons have a 25 percent to 50 percent chance of developing AIDS over the next 20 years. Symptoms which may develop include fever (including night sweats), weight loss, swollen lymph glands, fatigue, diarrhea and white spots or unusual blemishes in the mouth.

1. **PURPOSE OF THE HIV TEST.** To evaluate your insurability, the Insurer named above, Protective Life Insurance Company, has requested that you provide a sample of your blood, urine or other body fluids for testing and analysis to determine the presence of human immunodeficiency virus (HIV) antibodies or antigens. This is not a test for AIDS; AIDS can only be diagnosed by medical evaluation.
2. **PRE-TEST COUNSELING.** 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.
3. **METHOD AND ACCURACY OF THE HIV TEST.** The HIV antibody test that is to be performed is actually a series of tests done by a medically accepted procedure. Your blood, urine or other body fluids sample will first be subjected to a test known as ELISA (enzyme-linked immunosorbent assay). If the result of this test is positive, the ELISA test will be repeated. If this repeat ELISA test is also positive your blood, urine or other body fluids specimen will then be subjected to another, more specific technique called the Western blot test, for confirmation. Your test result is considered positive only after positive results are obtained on two ELISA tests and a Western Blot test.
   The HIV antibody test is extremely accurate. However, in rare instances the test may be positive in persons who are not infected with the virus (a false positive). This may include persons who have not engaged in high risk behavior. These individuals are encouraged to seek retesting to help confirm the validity of the positive test. Additionally, the test may occasionally be negative in persons who are infected with HIV (a false negative) especially when the infection occurred recently; it takes at least 4-12 weeks for a positive test result to develop after a person is infected.
4. **CONFIDENTIALITY OF HIV TEST RESULTS.** All test results will be treated confidentially. They will be reported by the laboratory to the Insurer. When necessary for business reasons in connection with insurance you have or have applied for with the Insurer, the Insurer may disclose test results to others such as its affiliates, reinsurers, employees, or contractors. If the Insurer is a member of the MIB, Inc. and if the test results for HIV antibodies/antigens are other than normal, the Insurer will report to the MIB, Inc. a generic code which signifies only a non-specific laboratory test abnormality. If your HIV test is normal, no report will be made about it to the MIB, Inc. Other test results may be reported to the MIB, Inc. in a more specific manner. The organizations described in this paragraph may maintain the test results in a file or data bank. There will be no other disclosure of test results or even that the tests have been done except as may be required or permitted by law or as authorized by you.
5. **POSITIVE TEST RESULTS.** Positive HIV antibody/antigen test results do not mean that you have AIDS, but that you are at significantly increased risk of developing AIDS or AIDS-related conditions. Federal authorities say that persons who are HIV antibody/antigen positive should be considered infected with the AIDS virus and capable of infecting others.

   Positive HIV antibody or antigen test results or other significant laboratory test abnormalities 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.
6. **NOTIFICATION OF HIV TEST RESULTS.** If the test results are negative, no routine notification will be sent to you. Positive or indeterminate test results will be provided to the private physician you indicate below:

   _____ _____
   Physician's Name Physician's Address

   In absence of a designated physician, positive or indeterminate test results will be communicated in accordance with the rules of your state. Some states will require notification of positive or indeterminate test results to the local health department in addition to or in lieu of notification to your private physician.

CONSENT: I have read and I understand this Notice and consent for HIV (AIDS)-Related Testing. I voluntarily consent to testing and disclosure as described above. I understand that I have the right to withdraw this consent prior to being tested and that I may request and receive a copy of this form. A photocopy of this form will be as valid as the original. In addition, I authorize Protective Life Insurance Company or its reinsurers to make a brief report of any personal health information to the MIB.

_____ _____
Proposed Insured (PRINT) Date of Birth

_____ _____ _____
Signature of Proposed Insured or Parent/Guardian Date State of Residence

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

NOTICE AND CONSENT FOR AIDS VIRUS (HIV) TESTING

Acquired Immunodeficiency Syndrome (AIDS) is a life-threatening disorder of the immune system, caused by a virus, HIV. The virus is transmitted by sexual contact with an infected person, from an infected mother to her newborn infant, or by exposure to infected blood (as in needle sharing during IV drug use). Persons at high risk of contracting AIDS include males who have had sexual contact with another man, intravenous drug users, hemophiliacs, and sexual contacts with any of these persons. AIDS does not typically develop until a person has been infected with HIV for several years. A person may remain free of symptoms for years after becoming infected. Infected persons have a 25 percent to 50 percent chance of developing AIDS over the next 20 years. Symptoms which may develop include fever (including night sweats), weight loss, swollen lymph glands, fatigue, diarrhea and white spots or unusual blemishes in the mouth.

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4. **CONFIDENTIALITY OF HIV TEST RESULTS.** All test results will be treated confidentially. They will be reported by the laboratory to the Insurer. When necessary for business reasons in connection with insurance you have or have applied for with the Insurer, the Insurer may disclose test results to others such as its affiliates, reinsurers, employees, or contractors. If the Insurer is a member of the MIB, Inc. and if the test results for HIV antibodies/antigens are other than normal, the Insurer will report to the MIB, Inc. a generic code which signifies only a non-specific laboratory test abnormality. If your HIV test is normal, no report will be made about it to the MIB, Inc. Other test results may be reported to the MIB, Inc. in a more specific manner. The organizations described in this paragraph may maintain the test results in a file or data bank. There will be no other disclosure of test results or even that the tests have been done except as may be required or permitted by law or as authorized by you.
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   Physician's Name Physician's Address

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CONSENT: I have read and I understand this Notice and consent for HIV (AIDS)-Related Testing. I voluntarily consent to testing and disclosure as described above. I understand that I have the right to withdraw this consent prior to being tested and that I may request and receive a copy of this form. A photocopy of this form will be as valid as the original. In addition, I authorize Protective Life Insurance Company or its reinsurers to make a brief report of any personal health information to the MIB.

_____ _____
Proposed Insured (PRINT) Date of Birth

_____ _____ _____
Signature of Proposed Insured or Parent/Guardian Date State of Residence

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

CONDITIONAL RECEIPT AGREEMENT

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

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

Received: ☐ Check in the amount of $_____, ☐ Pre-Authorized Funds Withdrawal, ☐ Other _____ as conditional payment of the first premium for an insurance policy on the life of Proposed Insured(s)_____

_____.

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

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

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

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

CONDITIONS UNDER WHICH INSURANCE MAY BECOME EFFECTIVE PRIOR TO POLICY DELIVERY

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

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

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

(C) the Proposed Insured(s) has/have completed all examinations and/or tests requested by the Company.

EFFECTIVE DATE OF COVERAGE

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

(A) the date of the application;

(B) the date requested in the application; or

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

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

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

TERMINATION AND REFUND OF PREMIUM

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

(A) premium payment is

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

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

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

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

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

Agent Signature	Date	Owner Signature	Date

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

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

CONDITIONAL RECEIPT AGREEMENT

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

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

Received: ☐ Check in the amount of $_____, ☐ Pre-Authorized Funds Withdrawal, ☐ Other _____ as conditional payment of the first premium for an insurance policy on the life of Proposed Insured(s)_____

_____.

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

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

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

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

CONDITIONS UNDER WHICH INSURANCE MAY BECOME EFFECTIVE PRIOR TO POLICY DELIVERY

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

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

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

(C) the Proposed Insured(s) has/have completed all examinations and/or tests requested by the Company.

EFFECTIVE DATE OF COVERAGE

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

(A) the date of the application;

(B) the date requested in the application; or

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

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

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

TERMINATION AND REFUND OF PREMIUM

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

(A) premium payment is

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

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

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

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

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

Agent Signature	Date	Owner Signature	Date

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

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

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

IMPORTANT NOTICE: REPLACEMENT OF LIFE INSURANCE OR ANNUITIES

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

PREMIUMS:

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

POLICY VALUES:

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

INSURABILITY:

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

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

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

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

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

OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:

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

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

IMPORTANT NOTICE: REPLACEMENT OF LIFE INSURANCE OR ANNUITIES

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

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

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

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

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

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

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

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

	INSURER NAME	ANNUITY CONTRACT OR LIFE INSURANCE POLICY #	INSURED OR ANNUITANT	REPLACED (R) or FINANCING (F)
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Make sure you know the facts. Contact your existing company or its insurance producer/agent for information about the old life insurance policy or annuity contract. If you request one, an in-force illustration, life insurance policy summary or available disclosure documents must be sent to you by the existing insurer. Ask for and keep all sales material used by the insurance producer/agent in the sales presentation. Be sure that you make an informed decision.

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

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

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

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