Application for Life Insurance

Part I

Life Insurance Company
P-0. BOX 830619 - BIRMINGHAM, AL 35283-0619

☐ New Business
☐ Protective Policy Change from Policy ______________________ *Email address:*

1. **Proposed Insured** 1

Name | *Birth Date* | *Place of Birth* | *Gender* | *Social Security No.*

Occupation | *Marital Status* | *Drivers Lic. No. & State* | *Home Phone No,* | *Work Phone No.*

Home Address *(Street)* *(City)* *(State)* *(zip)*

Employer's Name | *Employers Address* | *Years Employed*

2. **Proposed Insured** 2 **–** Relationship to Proposed Insured 1: ______________________

Name | *Birth Date* | *Place of Birth* | *Gender* | *Social Security No.*

Occupation | *Marital Status* | *Driver's Lic, No. & State* | *Home Phone No.* | *Work Phone No,*

Home Address *(Street)* *(City)* *(State)* *(ZIP)*

Employer's Name | *Employers Address* | *Years Employed*

3. **Applicant (Owner) if other than Proposed Insured** (Owner must sign Page 4)
* If Payor is other than Owner. furnish information in Remarks on Page 4.

Home Phone No, ______________________
Work Phone No. ______________________

Name (If Trust, include date of Trust) | *Relationship* | *Soc. Sec, No. or Tax I.D. No.*

Home Address (Street) (City) (State) (zip)

4. **TO AVOID DELAY IN PROCESSING -- THIS QUESTION MUST BE ANSWERED.**
Have you been offered a cash advance or other consideration as inducement to purchase the life insurance policy or been offered free insurance? If "yes'', please explain under **"Remarks"** ☐ Yes ☐ No

5. **Underwriting Class Quoted:** ______________________
Protective Life will issue best available UW class. unless otherwise noted in Remarks.

6. **Complete for all Non-UL Products**
Plan of Insurance | Face Amount $
☐ Waiver of Premium ☐ Children's Term Rider _____ Units (complete #8 below)
☐ Accidental Death Benefit $__________ ☐ Protected Insurability Rider $__________

7. **Complete for all UL Products**
Plan of Insurance | Face Amount $
☐ Level Death Benefit ☐ Increasing Death Benefit
☐ Other ______________________

☐ Children's Term Rider __________ Units (complete #8 below)
☐ Monthly Disability Rider amount to be credited to policy $__________
☐ Covered Insured Rider $__________ (complete #8 and #11)
Estate Protection Endorsement (Survivorship Plans Only) ☐ Yes ☐ No
☐ Accidental Death Benefit $ __________
☐ Protected Insurability Rider $ __________
☐ Other Rider __________ $ __________

Guaranteed Insurability Rider(s) **for UL Products:**
☐ Survivor's Choice - List:

Amount	Designated Life	Relationship
$		

☐ Variable Option(s) - List:
Amount | Option Dates (Maximum of 6)

8. **Family Members to be covered:** (Use Remarks section if additional space is needed,)

Name	Gender	Date of Birth	Relationship to Proposed Insured	Rider	Place of Birth	(For Children Only) Height	Weight

9. Premium Mode: ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly Bank Draft
☐ Payroll Deduction **Authorization** ☐ List Bill DIRECT MONTHLY NOT AVAILABLE

Planned Periodic Premium $__________ *(Actual premium amount may be higher or lower based on underwriting.)*

☐ Initial Premium $__________

Advance Prem. $__________ # of Years __________

Cash with App. $ __________ Other $__________

Auto Prem Loan? ☐ Yes ☐ No

Section 1035 ☐ Yes ☐ No
Not Available on all plans
1035 Loan Transfer ☐ Yes ☐ No
☐ CVAT (unless CVAT box is checked, the Guideline Premium Test will apply)

For all beneficiary designations: If multiple beneficiaries named, shares will be divided equally among the surviving beneficiaries, unless otherwise specified.

10. **Primary Beneficiary**	Relationship	%	**Contingent Beneficiary**	Relationship	%

11. **Proposed Insureds Under Covered Insured Rider**	**Beneficiary**	Relationship	%

12. **Regarding All Persons Proposed for Insurance:** (if any yes explain and give name of every Company. Use Remarks section if additional space is needed.)

	EACH PERSON TO BE INSURED Prop. Ins. 1 Yes	No	Prop. Ins. 2 Yes	No	Other Ins. Yes	No
(a) Is the Policy applied for to **replace** or **change** any existing insurance or annuities in this or any other Company? Indicate in chart below (If "yes", check which policy and complete replacement notice, if required.)	☐	☐	☐	☐	☐	☐
(b) Does any person proposed for insurance have an application pending with another Company? (If "yes", give Person, Company and Amount in #18 below.)	☐	☐	☐	☐	☐	☐
(c) Has any person proposed for insurance ever been rated, declined or postponed for life or health insurance coverage?	☐	☐	☐	☐	☐	☐

(d) **Regarding all persons proposed for insurance:** List all insurance in force on each proposed insured's life. Include insurance whether owned by the insured or not. **(If none, insert "none".)** Circle R or C, if applicable.

Person	Company	Policy Number	Replace or Change?		Amount	Purpose Bus./Pers,	Issue Date
			R	C	$		
			R	C	$		
			R	C	$		

13. **Annual Income $**__________ **Net Worth** $__________ **Household Income** $__________
(if face amount is greater than $3 million or if applying for business insurance, complete Large Case Supplement.)

14. **Within the last 36 months has anyone proposed for insurance used any form of tobacco or nicotine substitute?** ☐ Yes ☐ No
Indicate usage below:

Name	Cigarettes	Other Tobacco	Nicotine Substitute	Usage within 36 mos.	Usage within 1 2 mos.

15. **Within the last 24 months has any Person Proposed for Insurance:**	Prop. Ins. 1 Yes	No	Prop. Ins, 2 Yes	No	Other ins. Yes	No
(a) Flown as a pilot, student pilot or crew member? (if yes, complete questionnaire)	☐	☐	☐	☐	☐	☐
(b) Are any such flights planned in the future?	☐	☐	☐	☐	☐	☐
(c) Engaged in racing or scuba diving? (If yes, complete questionnaire)	☐	☐	☐	☐	☐	☐
(d) Engaged in ☐ hang gliding El mountain climbing or ☐ sky diving? (if yes, complete questionnaire).	☐	☐	☐	☐	☐	☐

16. **Has any Person Proposed for Insurance:** (If any yes , give full details in Section 18)	Prop. Ins. 1 Yes	No	Prop, Ins. 2 Yes	No	Other Ins. Yes	No
(a) Had any motor vehicle accidents, DUIs, DWIs, speeding tickets, or other traffic violations in the past 7 years?	☐	☐	☐	☐	☐	☐
(b) Been convicted of a felony in the past 10 years?	☐	☐	☐	☐	☐	☐

17. **Regarding All Persons Proposed for Insurance:**	Prop. Ins. 1 Yes	No	Prop. Ins. 2 Yes	No	Other Ins. Yes	No
(a) Are all Proposed Insured(s) US Citizens? (If no, provide copy of visa and/or green card, and include current immigration status. expiration date, visa type and how long the Proposed Insured(s) has/have been residing in the U.S.)	☐	☐	☐	☐	☐	☐
(b) Do any Proposed Insured(s) reside more than 6 months a year outside of the US? (If yes, provide city/country)	☐	☐	☐	☐	☐	☐
(c) Are any Proposed Insured(s) permanent residents of any country other than the US, Puerto Rico or Canada? (If yes, provide city/country)	☐	☐	☐	☐	☐	☐
(d) Are any Proposed Insured(s) planning to travel outside the US, Puerto Rico or Canada? (if yes, complete Foreign Travel Questionnaire)	☐	☐	☐	☐	☐	☐
(e) Have any Proposed Insured(s) traveled outside the US, Puerto Rico or Canada within the last 2 years? (If yes, complete Foreign Travel Questionnaire)	☐	☐	☐	☐	☐	☐

18. **Details to questions 12-17.**

Person	Question	Date of Event	Details

Protective Life Insurance Company

PROTECTIVE LIFE INSURANCE COMPANY

P.O. Box 830619 - Birmingham, AL 35283-0619 - 800-567-8247

PART 1 A - SUPPLEMENTAL APPLICATION - NON-MEDICAL DECLARATIONS

1. (a) ______________________ Proposed Insured 1 (Print name) ______ Height ______ Weight

☐ Gain ☐ Loss in past year?_______ lbs. Reason ______________________

(b) ______________________ Proposed Insured 2 (Print name) ______ Height ______ Weight

☐ Gain ☐ Loss in past year?_______ lbs. Reason ______________________

2. Within the past 10 years has any person proposed for insurance been treated or diagnosed by a physician as having: (Circle conditions to which a "yes" answer applies and give details in number 5 below.)

EACH PERSON TO BE INSURED

	Prop. Ins. 1 Yes	Prop. Ins. 1 No	Prop. Ins. 2 Yes	Prop. Ins. 2 No	Other Ins. Yes	Other Ins. No
(a) Disorder of brain or spinal cord, paralysis, mental disorder, epilepsy, stroke, convulsions. chronic headaches	☐	☐	☐	☐	☐	☐
(b) Asthma, bronchitis, emphysema, tuberculosis or other disorder of the lungs or respiratory system	☐	☐	☐	☐	☐	☐
(c) High blood pressure, heart attack, heart murmur, chest pain or other disorder of the heart or blood vessels	☐	☐	☐	☐	☐	☐
(d) Any disorder of the esophagus, stomach. intestines, liver or pancreas	☐	☐	☐	☐	☐	☐
(e) Sugar or blood in the urine. chronic inflammation or other disorder of the kidneys	☐	☐	☐	☐	☐	☐
(f) Cancer, tumor or disorder of the prostate or reproductive organs	☐	☐	☐	☐	☐	☐
(g) Arthritis. osteoporosis or other disorder of the muscles, skin or bones including joints or spine	☐	☐	☐	☐	☐	☐
(h) Diabetes, recurrent infections. enlarged lymph glands, anemia, excess fatigue or other disorders of the glandular or blood systems.	☐	☐	☐	☐	☐	☐
(i) State the specific date of last medical consultation	mm/dd/yyyy		mm/dd/yyyy		mm/dd/yyyy	

0) Name of Personal Physician ______________________

Address of Personal Physician ______________________

	Prop. Ins. 1 Yes	Prop. Ins. 1 No	Prop. Ins. 2 Yes	Prop. Ins. 2 No	Other ins. Yes	Other ins. No
3. Has any person proposed for insurance been diagnosed by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS) or "AIDS" related complex (ARC)?	☐	☐	☐	☐	☐	☐

4. Has any person proposed for insurance: (Circle conditions to which a "yes" answer applies and give details in number 5 below.)

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

5.

Person's Name	Question Number	Date of Diagnosis	Diagnosis and Medication Prescribed	Full Name, Complete Address and Phone No. of Attending Physician or Hospital

Use Remarks section if additional space is needed.

Remarks: If additional space is needed, please use the Continuation of Information form.

DECLARATIONS

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 understood and agreed that:

(a) 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,

(b) No agent or medical examiner can make. alter or discharge any contract, accept risks, or waive Protective Life's rights or requirements.

(c) Changes will be made only with the Owner's written consent.

(d) 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 agent or medical examiner has any authority to waive or to alter these terms and conditions or to bind coverage under any other circumstances.

(e) 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.

(f) The agent taking this application has made no statement or representation different from, contrary to or in addition to these Declarations and the terms and conditions of the attached Conditional Receipt Agreement.

IMPORTANT INFORMATION ABOUT IDENTIFICATION INFORMATION

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

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

Signed At ______________________________
(City and State)

Date ______________________________

X

☐ **Witness to All Signatures
☐ **Witness to Signature of Proposed Insured 1 only

Proposed Insured 1 (Sign Name in Full)

"Witness to Signature of Proposed Insured 2 only

Proposed Insured 2 (Sign Name in Full)

"Witness to Signature of Parent or Guardian Only

Signature of Parent or Guardian

**Witness to Signature of Owner Only

*Signature of Owner **(Listed on Page 1, question 3)**

Please Be Sure Question 3 Is Complete

**Signature(s) should be witnessed by competent adult(s) who actually see the individual(s) sign the application

*If Owner is Corporation, Partnership or Trust, a Corporate Officer, Partner or the Trustee must sign and **provide Title**

P.O. BOX 830619 - BIRMINGHAM, AL 35283-0619

Continuation of Information for Part I (Non-Medical) and Part 11 (Medical)

Proposed Insured_______________________________________ Policy # ______________________

Last Name First Name Middle Initial

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

Signed at______________________________ this ________ day of ______________ Year ________

Witness Signature__________________________ Signature of Applicant X_________________________

PROTECTIVE LIFE INSURANCE COMPANY · P. 0. Box 830619 * Birmingham, AL 35283-0619

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

1. This authorization to obtain and disclose information complies with HIPAA regulations as they relate to life insurance. I (we) authorize Protective Life Insurance Company (Protective Life) and its reinsurers to obtain directly through ExamOne or other designated third parties and use any information about or relating to me (us) that may affect my (our) insurability. Protective Life and its reinsurers may obtain and use health and medical information, including but not limited to information about chart notes, EKG's, drug use, alcohol use, nicotine use, physical and mental diseases and illness, and psychiatric disorders. Protective Life and its reinsurers may also obtain and use non-health and non-medical information, including but not limited to financial information, credit reports, consumer reports, driving record, criminal record, and information about avocations and aviation activity. All of this information may be used to evaluate an application for insurance, a claim for insurance benefits, or both, Information relating to communicable diseases and other risk factors relating to me or to my spouse and life partner may be used to evaluate an application for insurance on either me or my spouse and life partner. The Protective Life sales agent or regional sales office representing me on my (our) application for insurance may obtain the information described in this paragraph directly from any of the persons or organizations listed in paragraph 2 in order to expedite the delivery of the information to Protective Life.
2. I (we) authorize the following persons and organizations to release and disclose the information described in paragraph I to Protective Life, directly through ExamOne or other designated third parties or its agents acting on its behalf; (i) my (our) doctor(s); (ii) medical practitioners; (iii) pharmacists and Pharmacy Benefit Managers; (iv) medical and related facilities, including hospitals, clinics, facilities run by the Veteran's Administration, Kaiser Permanente, The Cleveland Clinic Foundation and The Mayo Clinic; (v) insurers; (vi) reinsurers; (vii) Medical Information Bureau, Inc. (MIB); (viii) my (our) current and previous employers; and (ix) commercial consumer reporting agencies (CRA). All of these persons and organizations other than MIB may release the information described above to a CRA acting for Protective Life. MIB may not release the information described in paragraph I to a CRA.
3. I (we) authorize Protective life to draw and test my (our) blood, and/or oral fluids, and urine as may be necessary to obtain information to be used to underwrite my (our) application for insurance. These tests may include, but are not limited to, tests for cholesterol and related blood lipids, diabetes, liver or kidney disorders, immune disorders (other than HIV/AIDS; reference number 5 below), and the presence of drugs, nicotine, or their metabolites. This authorization does not include genetic testing. Unless otherwise required by low or regulation, Protective Life may, but is not obligated to, release any of these test results directly to me or to my spouse and life partner.
4. I (we) authorize Protective Life to release and disclose the information described in paragraphs I and 3 to its affiliates, its reinsurers, persons or organizations providing services relating to insurance underwriting for Protective Life, MIB, and as otherwise required by low. Protective Life may release and disclose the information described in paragraphs I and 3 to other insurers if I (we) have applied or apply to the other insurers for insurance. Protective life may release and disclose the information described in paragraphs I and 3 to the sales agent representing me on my (our) application for insurance if it is necessary to provide an explanation of the reasons for Protective Life's decision to impose special underwriting requirements, whenever my application cannot be approved as submitted, or in connection with a claim for benefits.
5. **SPECIAL REQUIREMENT FOR HIV/AIDS TESTING.** If Protective Life intends to test for the presence of antibodies to the Human Immunodeficiency Virus (HIV), which is the virus that has been associated with Acquired Immune Deficiency Syndrome (AIDS), Protective Life may require me (us) to authorize that testing separately. I (we) hereby authorize Protective Life to obtain and use the results of any HIV tests that I (we) separately authorize, and if permitted by low, to disclose the results of those tests to its reinsurers and **MIB.**
6. This authorization shall be valid for 24 months from the date shown below or, in the event of a claim for benefits, for the duration of such claim.
7. During the evaluation of my (our) insurance application, I (we) understand that I (we) have the right to revoke the authorizations in paragraphs I through 5 by writing to Protective Life at P.O. Box 83061 9 - Birmingham, AL 35283-0619.

   If this authorization is revoked, this would result in the file being closed and no coverage provided.

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

☐ I (we) would like to be interviewed if an investigative consumer report will be made.

(Please check The box if you wish to be interviewed if an Investigative consumer report will be made.)

☐ If performed, I (we) would like copies of my (our) blood profile test results.

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

   I acknowledge that any agreements / have made to restrict my protected health information do not apply to this authorization and I instruct my 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 our ability to process this application..

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

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

X

Proposed Insured I (Signature) | **Date of Birth** | **Date of Authorization:**

When applicable, print nome(s) of minor(s) below:

Print Name | **Social Security #**

Proposed Insured 2 (Signature) | Date of Birth

Print Name | Social Security #

Health Care Provider

Parent or Legal Guardian (Signature)

Physician Name

Physician Name

AGENT'S REPORT

1. Did you personally interview Proposed Insured(s) and complete application in his and/or her presence? ☐ Yes ☐ No
   If "no". please explain.

2. (a.) Will this policy replace or change existing policy(ies)? ☐ Yes ☐ No
   (b.) If replacement of existing insurance is involved, have you complied with all relevant state requirements, including any replacement notice? ☐ Yes ☐ No
   If "no", please explain.

Answer questions (c.) and (d.) only if this is a replacement:
   (c.) Did you use any preprinted Company approved sales materials? ☐ Yes ☐ No
   If yes, list name or form # here: ____________________
   (d.) Did you use any Company approved, electronically generated, individualized sales materials (such as illustrations or concept materials)? ☐ Yes ☐ No
   If yes, you must provide a copy of these materials with the application.

3. Has medical examination been ordered? ☐ Yes ☐ No
   Name of examiner: Date of exam:

4. If application is for UL and taken in a Non-NAIC state, have you completed UL Disclosure Form? ☐ Yes ☐ No

5. Are you related to the Proposed Insured(s)? ☐ Yes ☐ No
   If yes, what is your relationship?____________________

6. Have you represented the Proposed Insured(s) on prior insurance applications to other life insurance companies? ☐ Yes ☐ No

7. Are you aware of any known history of excessive use of alcohol, use of drugs, D.U.I.'s, medical history or any other facts which would assist us in evaluating this risk? Include details of prior insurance transactions which resulted in substandard offers, postponements or decline actions.
   If yes, please list in separate note. ☐ Yes ☐ No

8. How long have you known Proposed Insured(s)?

9. Purpose For Coverage:
   ☐ Buy/Sell ☐ Estate Planning ☐ Key Person
   ☐ income Replacement ☐ Creditor ☐ Other ____________

10. Are you aware if the Proposed Insured(s) has (have) been offered a cash advance or other consideration as inducement to purchase the life insurance policy or been offered free insurance? It yes, please explain in Special Requests/Remarks below ☐ Yes ☐ No

Complete Question 11 if Applicant does not speak fluent English.

11. I certify that the application questions were asked and recorded by an individual who is fluent in the language of the applicant. ☐ Yes ☐ No

12. Is Premium Financing involved in this case? ☐ Yes ☐ No
    It yes , please submit a cover letter describing the parameters.

I hereby certify that all statements and answers made in this Agent's Report are full, complete and true to the best of my knowledge and belief and that I know nothing affecting the insurability of the Proposed Insured(s) which is not fully set forth in these papers.

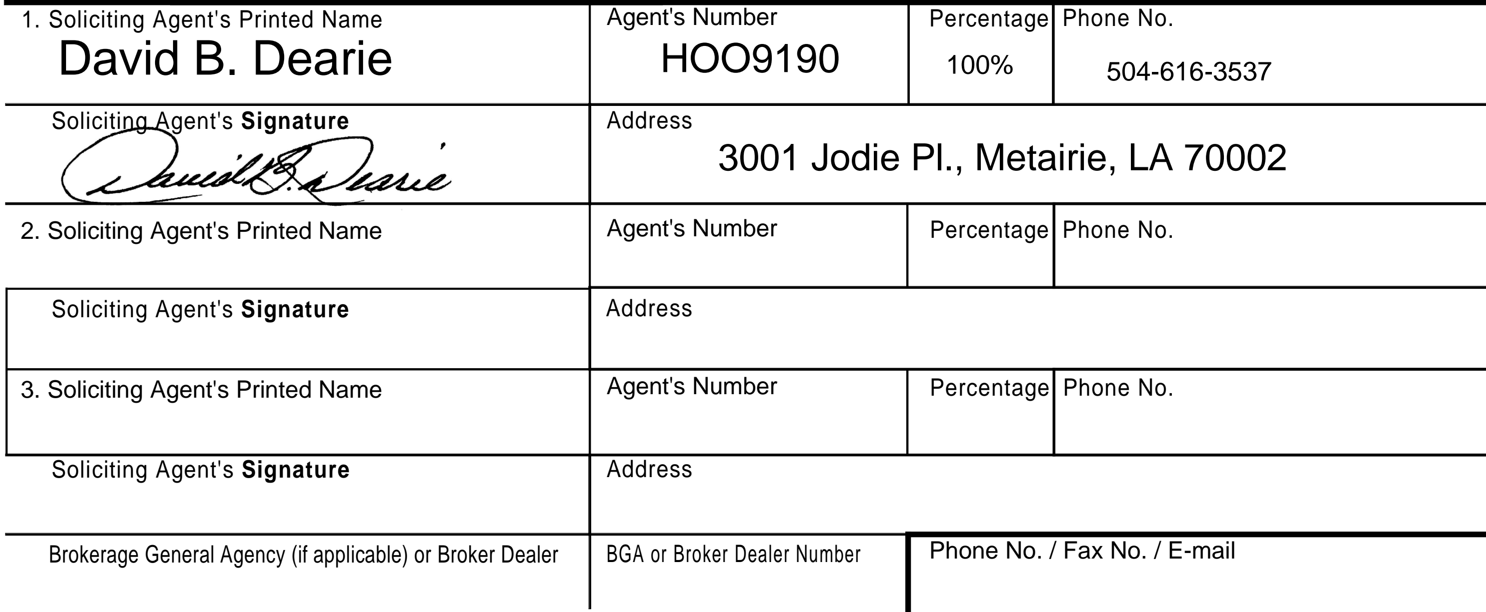
I have verified the identity of the Owner by picture 1. 1). **(Does not apply to direct marketing situations.)**

Identification type: ____________________

Please include Driver's License number if Owner is other than the Proposed Insured. ____________________

(in Georgia, please include a copy of the Driver's License with application)

Signed at	**(City and State)**	**Date**



1. Soliciting Agent's Printed Name	Agent's Number	Percentage	Phone No.
David B. Dearie	HOO9190	100%	504-616-3537
Soliciting Agent's **Signature**	Address		
[signature]	3001 Jodie Pl., Metairie, LA 70002		
2. Soliciting Agent's Printed Name	Agent's Number	Percentage	Phone No.
Soliciting Agent's **Signature**	Address		
3. Soliciting Agent's Printed Name	Agent's Number	Percentage	Phone No.
Soliciting Agent's **Signature**	Address		
Brokerage General Agency (if applicable) or Broker Dealer	BGA or Broker Dealer Number	Phone No. / Fax No. / E-mail	

AGENT'S SPECIAL REQUESTS/REMARKS:

Protective
Life Insurance Company

Conditional Receipt Agreement

This agreement provides only a limited amount of insurance, for a limited period of time, and then only if all the terms and conditions of this agreement are met. No Agent of 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 Insured by suicide. In the event of suicide, the Company's sole liability will be the return of any money received.

Received: ☐ Check in the amount of $____________________
☐ Pre-Authorized Funds Withdrawal Plan (PAW), ☐ Payroll Deduction Authorization (PDA).
☐ 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 Protective Life Insurance 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 CASHIERS CHECKS WILL NOT BE ACCEPTED.

NOTE: Premium may not be collected where the face amount applied for on this application plus any in force Protective Life policies on this Insured exceeds $1,000,000 or on Proposed Insureds under 15 days of age or over age 80. Any money received 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 printed underwriting rules for the plan, amount and premium rate class applied for:

(B) that the amount paid with the application and shown above is equal to the first full modal premium for the 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

The total amount of insurance which may become effective prior to delivery of the policy to the Owner **shall not exceed $1,000,000** with Protective Life or its affiliates. This amount includes other life insurance and accidental death benefits then in force or applied for with this Company.

TERMINATION AND REFUND OF PREMIUM

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

(A) premium payment is

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

(2) by PAW, and the deduction is not honored by the drawee bank;

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

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

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.

Date:____________________ Agent: ____________________

Date:____________________ Owner: X ____________________

ORIGINAL- HOME OFFICE COPY-OWNER

PROTECTIVE LIFE INSURANCE COMPANY
P.O. Box 830619 - Birmingham, Alabama 35283-0619 - Telephone: 800-567-8247

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)
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:

X

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.)

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

i PATIENT NAME (FIRST MI LAST) Birthdate

ADDRESS SSN

CITY STATE Zip

NAME
Exam One A QUEST DIAGNOSTIC SUBSIDIARY
ADDRESS
PO BOX 2340
CITY STATE ZIP
LEE'S SUMMIT Mo 64063

ATTENTION:

This authorization will expire on the following date or event. If date or event are not indicated, authorization will expire within 12 months from date signed.

Event. TWO YEARS FROM DATE SIGNED

Purpose of this Disclosure:
DETERMINE ELIGIBILITY FOR INSURANCE

Description	Start Date	End Date
X All PHI in the record		
☐ Progress Notes		
☐ Laboratory Tests		
☐ X-Ray Tests / Reports		
☐ History and Physical Examination		
☐ Discharge Summary		
☐ Consultation Reports		
☐ Itemized Billing Statement		
☐ Other:		

The following information will be released when included In the above information unless you indicate otherwise:

☐ **AIDS or HIV test results** ☐ Psychiatric or mental care treatment

☐ **Alcohol, drug or substance abuse treatment** ☐ Other (specify):

I UNDERSTAND THAT:

1. I MAY REFUSE TO SIGN THIS AUTHORIZATION AND IT IS STRICTLY VOLUNTARY.
2. MY TREATMENT. PAYMENT, ENROLLMENT OR ELIGIBILITY FOR BENEFITS MAY NOT BE CONDITIONED ON SIGNING THIS AUTHORIZATION.
3. I MAY REVOKE THIS AUTHORIZATION AT ANY TIME IN WRITING TO THE PROVIDER AUTHORIZED TO RELEASE THE PROTECTED HEALTH INFORMATION, BUT IF I DO, IT WILL NOT HAVE ANY AFFECT ON ANY ACTIONS TAKEN PRIOR TO RECEIVING THE REVOCATION-
4. IF THE REQUESTER OR RECEIVER IS NOT A HEALTH PLAN OR HEALTHCARE PROVIDER, THE RELEASED INFORMATION MAY NO LONGER BE PROTECTED BY FEDERAL PRIVACY REGULATIONS AND MAY BE DISCLOSED
5. I HAVE THE RIGHT TO RECEIVE A COPY OF THIS FORM AFTER I SIGN IT.

X Signature of Patient:

Signature of Representative (if necessary):

Personal Representative's Relationship to Patient:

Protective
Protective Life Insurance Company

Notice Regarding the Application for Life Insurance Without a Corresponding Basic Illustration

An "illustration" is a handwritten, verbal, printed, Or computer screen presentation of a life insurance policy in which future Performance is based on policy elements (such as interest, cost of insurance, or premium rates) *that are not guaranteed,*

If an application is taken and a corresponding, printed, basic illustration has not been provided to the applicant, both the applicant and the agent (or authorized representative) of Protective Life Insurance Company must sign and date this NOTICE. **DO NOT use this form in New Jersey; instead, use U.588-NJ. If D and I apply, Do NOT use this form in Maine, New Hampshire, Pennsylvania, and South Dakota; instead, use U-588-ME, U-588-NH, U-588-PA, and U-588-SD.**

Applicant - read statements A, 13, C and D and check the one that applies; read statement E and sign and date the form:

A. ☐ I acknowledge that I applied for life insurance without receiving an illustration. The agent or authorized representative used no handwritten, verbal, printed, or computer screen illustrations during the sales process.

B. ☐ I acknowledge that my application for life insurance does not correspond to the printed basic illustration which I received and that I did not view a computer screen illustration during the sales piocess.

C. ☐ I acknowledge that I applied for life insurance after viewing a Protective Life Insurance Company quotation chart at my place of employment and that I did not view a computer screen illustration during the sales process.

D. ☐ I acknowledge that I applied for life insurance after viewing a computer screen illustration for which no corresponding printed copy was provided to me. However, my application for life insurance does correspond to the last computer screen illustration that I viewed, and for all illustrations shown on the screen, the agent or authorized representative displayed values based on guaranteed, midpoint, and current assumptions.

E. In addition, I understand that the life insurance for which I applied has elements that are not guaranteed. I also acknowledge that the agent or authorized representative explained the non-guaranteed elements to me. I understand that, if my application is approved, I will receive a printed basic illustration corresponding to the issued policy no later than when I receive my policy contract.

X ______________________________ ______________

Applicant *Date*

Agent or Authorized Representative - read statements F, G, H, and I and check the one that applies; read statement i and sign and date the form:

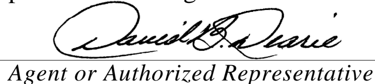
F. ☐ I certify that the application for life insurance was taken without using an illustration: no handwritten, verbal, printed, or computer screen illustrations were used during the sales process.

G. ☐ I certify that the application for life insurance does not Correspond to the printed basic illustration which I gave to the applicant and that no computer screen illustrations were used during the sales process.

H. ☐ I acknowledge that the application for life insurance was taken at the place of employment of the applicant after showing him or her a quotation chart approved by Protective Life Insurance Company and that no computer screen illustrations were used during the sales process.

1. ☐ I certify that the application for life insurance was taken using a computer screen illustration for which no corresponding printed copy was provided to the applicant and that the computer screen illustration was generated using a system approved by Protective Life Insurance Company. The application for life insurance corresponds to the last computer screen illustration that I displayed for the applicant, and for all illustrations shown to the applicant on the screen, I displayed values based on guaranteed, midpoint, and current assumptions.

J. In addition, I certify that I explained to the applicant that the life insurance for which he or she applied has elements that are not guaranteed. I also certify that I explained the non-guaranteed elements to the applicant and that I did not represent the non-guaranteed elements as guaranteed.



Agent or Authorized Representative *Date*

ORIGINAL - Office COPY - Applicant Copy -Agent

SED-4 (R 01/10)

Protective Life

State of Louisiana Employee Payroll Deduction Authorization

Employee Name	Soc. Sec. No.	Employee No. (for agency use)

Agency No.	Department/Agency/Section Name

I hereby authorize my employer to deduct a total of $____________, monthly rate, from my salary until further notice and remit same to **Protective Life** A TOTAL Semi-Monthly Deduction in the amount of $ __________ represents one half of the total monthly premium required for the coverage(s) detailed below.

The Office of State Uniform Payroll and the employing agency are not representatives or agents of the employee or the vendor. It is the responsibility of the **employee** to notify each vendor he/she has a payroll deduction with of address and/or name changes. It is solely the responsibility between the **employee and the vendor** to ensure that the amount of any payroll deduction is correct and is properly credited to the appropriate policy. Cancellation of a policy must be submitted by the employee in a written request to **both** the vendor and his/her agency's payroll office. An employee signed SED-4 stopping the deduction may be required before the deduction can be stopped in the ISIS HR payroll system. Statewide vendor deductions that are not taken due to an employee being on LWOP, not being due any wages, or not being paid enough wages to take the deduction **are the employee's responsibility** to pay directly to the vendor. Payments made outside of the payroll system are not pre-taxed. By signing this form, both the employee and the vendor representative acknowledge that the statements in this section have been read, are understood and are agreed upon.

DEDUCTION DETAIL (Product Names & Codes, 125 Eligible, Premium Arnts.) MENU ELECTIONS

PRODUCT NAME	PLAN PART CD	PLAN PART YES	PLAN PART NO	125 ELIG	Mo PREM.	PAYROLL CODE	INELIGIBLE & NON-PART Semi-Mo.	ELIGIBLE PART Semi-Mo.
Term Life	30		N	N	$	NR	$	
Universal Life	32		N	N	$	NS	$	

Total Mo. Prem.	$
Total Semi-Mo. Ineligible	$
Total Semi-Mo. Non-Part.	
Total Semi-Mo. Part.	
TOTAL SEMI-MONTHLY	$

PP Begin Date

Date Authorized

By: X ______________________
Employee Signature

(THIS FORM SUPERSEDES AND REPLACES ALL OTHER AUTHORITY FOR DEDUCTIONS FOR THIS VENDOR)

Presentation and deduction authorization processed by:

David B. Dearie (signature) — **504-616-3537**

Protective Life Representative — Phone — Date

David Dearie, 3001 Jodie Place, Metairie, LA 70002 **Email: dearie@cox.net**
Address

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

DESCRIPTION OF INFORMATION PRACTICES

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

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

Information regarding your insurability will be treated as confidential. Protective Life. or its reinsurers, may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf Of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such company, the Bureau upon request, will supply such company with the information it may have in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, their telephone number is 866-692-6901 (TTY 866-346-3642).

Protective Life, or its reinsurers, may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

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

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

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

THIS NOTICE MUST BE GIVEN TO PROPOSED INSURED

Producer Compensation Disclosure

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