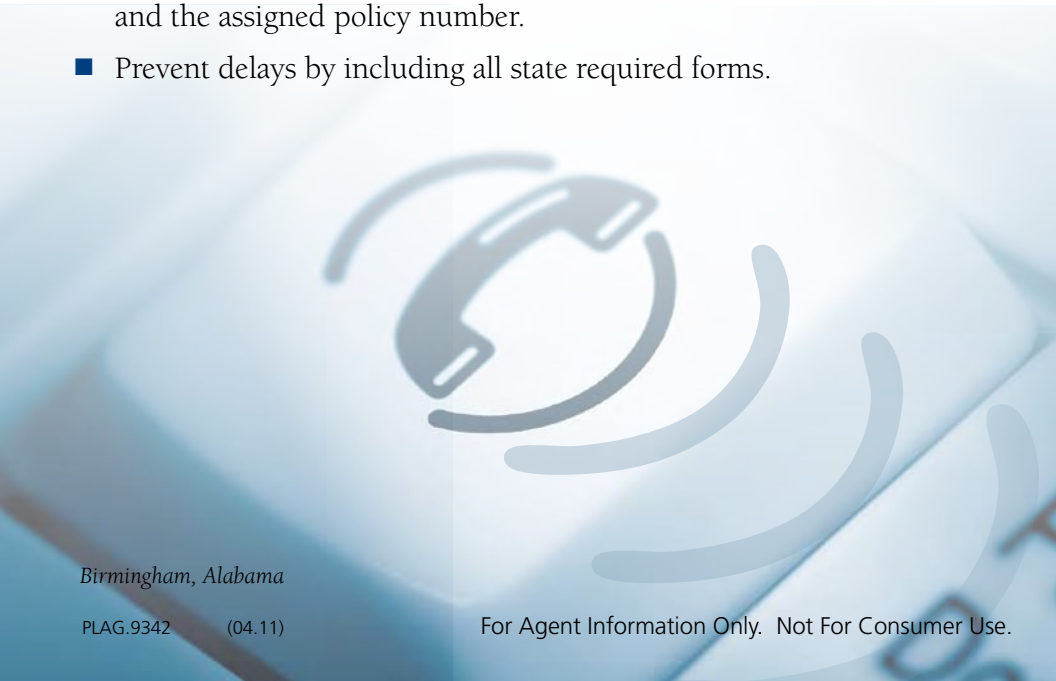
It's as Easy as 1-2-3!

- Complete the pre-application.
- Agent signature required on **all forms**
  (applicant's signature is optional at time of sale).
- For expedited handling fax to TeleLife® at **1-888-615-9619**

Tips:

- Obtain owner's signature, if other than proposed insured, for faster policy delivery.
- Prepare your client for the telephone interview by using the Applicant's Checklist.
- Binding coverage options are bank draft or credit card *(credit card information will be collected during the phone interview)*
- Do not order the paramedical exam. TeleLife will order upon completion of the interview.
- Always fax with a cover sheet in order to receive a confirmation and the assigned policy number.
- Prevent delays by including all state required forms.



Birmingham, Alabama

PLAG.9342 (04.11)

Protective Life Insurance Company
2801 Highway 280 South
Birmingham, AL 35223
(888) 800-6608

Fax to: **1-888-615-9619** (TeleLife – Elgin, IL)

Date: _____ **Applicant's Name**: _____

Number of Pages: _____ **Policy Number**: (to be provided by TeleLife)

Agent Name: _____ _____

Agent Number: _____ **Companion Name**: _____

BGA Number: _____ **Companion Policy Number**: (to be provided by TeleLife)

Fax: _____ _____

Regional Sales Manager: _____ **BGA Sales Rep:** (If other than BGA Contact)

Agent / BGA Contact Name: _____ _____

Contact Information: _____

▶ **Check all included forms; Note that all forms listed may not be applicable. Make sure to provide any state required forms that were included in the TeleLife Fax Application Package signed [at least] by the agent.**

1) Pre-Application ❑ _____
2) Supplement I (*required*) ❑ _____
3) Replacement Form ❑ _____
4) Pre-Auth Withdrawal ❑ _____
5) Conditional Receipt ❑ _____
6) TIADB ❑ _____
7) Additional (Please Specify) ❑ _____
8) Full Illustration, UL Only ❑ _____

Special Instructions:

PROTECTIVE LIFE INSURANCE COMPANY

P.O. Box 830619
Birmingham, AL 35283-0619
TeleLife Fax: 1-888-615-9619

Policy Number

APPLICATION FOR INDIVIDUAL LIFE INSURANCE

Proposed Primary Insured ☐ Proposed Other Insured ☐

Name Last First MI ☐ Male ☐ Female

Street

City State Zip

Social Security Number Occupation

Birthplace Birthdate Driver's License #

Home Phone ( ) Cell Phone ( ) Business Phone ( )

Where do you wish to be reached for additional information?
☐ Home ☐ Work ☐ Cell Best times: ☐ a.m. ☐ p.m.

Annual Income Net Worth

Initial Death Benefit $

Plan of Insurance:

Riders: ☐ WP ☐ ADB ☐ CTR ☐ Other: _____
Indicate Amount for Riders: $ _____

Mode of Premium Payment: ☐ Annual ☐ SA ☐ Qtrly ☐ PAC
Rate Class Quoted: _____ Premium Quoted: _____

Amount remitted with this application, in exchange for this Company receipt: $

Owner, if other than proposed insured | Owner's Address

Relationship to Proposed Insured | Social Security or Tax ID #

Primary Beneficiary (name, relationship and percentage)

Contingent Beneficiary (name, relationship and percentage)

Will this policy replace or change any existing life insurance or annuity in force? ☐ Yes ☐ No

Does the applicant have existing life insurance policies or annuity contracts other than group insurance in force? ☐ Yes ☐ No

Company Names	Face Amount	Year Issued	To Be Replaced?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

Do you have an application pending in another company? ☐ Yes ☐ No

Have you ever had any life or health insurance declined, postponed or offered other than as applied for? ☐ Yes ☐ No

Is Proposed Insured a U.S. Citizen? ☐ Yes ☐ No

Has Proposed Insured used tobacco in any form in the past 12 months? ☐ Yes ☐ No 36 months? ☐ Yes ☐ No
60 months? ☐ Yes ☐ No

Special Request:

The falsity of any statement in the application shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of risk or the hazard assumed by the insurer.

Authorization To Obtain And Disclose Information: I (we) hereby authorize: any licensed physician or medical practitioner; any hospital, clinic or other medical or medically related facility; any insurance company and the Medical Information Bureau, to give Protective Life Insurance Company, its affiliates, or their reinsurers or the Medical Information Bureau, any records or knowledge of me or my health. This authorization is valid for two years from the date this form is signed. An exact copy of this authorization is as valid as the original. **I (we)** have read all the questions and answers in the application. All responses are true and complete to the best of my (our) knowledge and belief. **I (we)** have received the notification about the Federal Fair Credit Reporting Act and the Medical Information Bureau. No coverage will be in effect until: a full application has been signed by the proposed insured; and a policy has been issued; and the full first premium has been received by the company; and any amendments are signed. Any coverage will be subject to the terms and conditions of the policy.

Signed at: (city and state) | Signature of Proposed Insured (if age 18 or over)

Date signed: (month/day/year) | Signature of Owner/Applicant, if other than Proposed Insured

Agent:

To the best of your knowledge will this policy replace or change any existing life insurance or annuity policies? (If "Yes", complete any required replacement forms.) ..... ☐ Yes ☐ No

Has the Owner been provided an illustration which conforms to this application? If "No", agent hereby certifies that no illustration was used in connection with the solicitation of the policy applied for. ☐ Yes ☐ No

Is there any third party other than the proposed insured that will obtain any ownership rights on any policy issued as a result of this application?..... ☐ Yes ☐ No

Print Agent's Name/Social Security Number or Agent Code | Agent's Signature | Date

Agent's Telephone Number | Agent's Email Address

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

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

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

Print Name of Proposed Insured(s): _____

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

SIGNATURES

I (We) have read or have had read to me (us) the completed Supplement before signing below. All statements and answers in the Supplement are correctly recorded to the best of my (our) knowledge and belief. I (We) understand that the information being provided in this Supplement is being relied upon in considering the application for life insurance and is subject to the applicable Fraud Statement as provided in the Application for Life Insurance.

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

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

X _____

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

X _____

Signature of Witness: X _____

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 _____ Producer Signature _____ Producer Name (Print)

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

TEMPORARY LIFE INSURANCE RECEIPT

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

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

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

QUALIFYING SCREENING QUESTIONS

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

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

TERMS AND CONDITIONS

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

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

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

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

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

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

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

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

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

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

(X)_____
Witnessed by Agent

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

_____
Agent's Name Printed

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

_____
Agent's Street Address

(X)_____
Joint Owner Signature

_____
Agent's City, State, Zip

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

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

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

PROTECTIVE LIFE INSURANCE COMPANY

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

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.

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

SUMMARY AND DISCLOSURE STATEMENT FOR CHRONIC ILLNESS ACCELERATED DEATH BENEFIT RIDER

This disclosure form provides a brief description of the important features of the rider. This is not an insurance contract. Only the rider contains the governing contractual provisions setting forth in detail the rights and obligations of both the Owner and the Company.

NOTICE: This rider is intended to provide an accelerated death benefit which will qualify for tax treatment under Section 101 (g)(1)(B) of the Code except as provided in Section 101 (g)(5) of the Code. Accelerated benefit payments due to chronic illness are subject to limits imposed by the federal government and any amounts received in excess of these limits are includible in gross income. This rider is not intended to be a Qualified Long Term Care Insurance contract under section 7702B of the Code nor is it intended to be a Non-Qualified Long Term Care contract. Accelerated benefits under this rider may be taxable as income. There may be tax consequences of accepting an amount above the amount that would be tax qualified under the Code. As with all tax matters, the Owner should consult a personal legal or tax advisor to assess the impact of any benefit received under this rider.

Any benefit received under this rider may impact the recipient's eligibility for Medicaid or other government benefits. Benefits under this rider do not pay or reimburse for expenses including those set forth in 101(g)(3)(A)(ii)(I) of the Code.

Any benefit paid under this rider will impact the policy. Face amount, Policy Values and loan values will be reduced if an accelerated death benefit is paid. The impact on the policy is discussed in the Impact on the Policy section of this rider.

Subject to the terms of the rider, we will pay a portion of the policy's death benefit each benefit period upon receiving Written Certification or Written Re-certification, as applicable, that the Insured is Chronically Ill. The amount we pay is called the Monthly Benefit.

DEFINITIONS

Activities of Daily Living: Means six basic human functions necessary for a person to live independently. Specifically they include: eating, toileting, transferring, bathing, dressing, and continence.

Chronically Ill: Means that the Insured has been certified, within the preceding 12 months, by a Licensed Healthcare Practitioner as: being unable to perform, without Substantial Assistance from another individual, at least two Activities of Daily Living for a period at least equal to the Elimination Period due to a loss of functional capacity; or, Requiring Substantial Supervision to protect the Insured from threats to health and safety due to Severe Cognitive Impairment.

Written Certification: Means written documentation from a Licensed Health Care Practitioner certifying that the Insured is Chronically Ill. The initial Written Certification shall be provided at the Owner's or Insured's expense. Written Certification, after the first shall be at our expense and will not count against the Lifetime Maximum Benefit.

BENEFIT

The Monthly Benefit is subject to a maximum chosen by the Insured. An amount less than then Maximum Monthly Benefit may be requested. You may also choose to receive the accelerated death benefit payment as a present value lump sum. All payments are subject to the Lifetime Maximum Benefit as described in the rider.

ELIGIBILITY

The Insured will become eligible, each Benefit Period, for the Benefit payments during the life of the Insured when each of the following conditions are met: (1) We receive Your written request for the Benefit; (2) We receive Written Certification; (3) The Policy and this Rider are in force; (4) We receive written consent from any irrevocable beneficiaries or assignee of record named in the policy; (5) The Elimination Period has expired; and (6) The benefit payment is made in respect to a month when the insured is Chronically Ill.

We reserve the right to independently assess the Insured's Chronic Illness and benefit eligibility. As part of this assessment we have the right to require that the Insured be examined by a Licensed Health Care Practitioner chosen by us. We will pay for this examination. The Insured must be certified as Chronically Ill for the entire period in which benefits are being paid.

IMPACT ON THE POLICY

Each Monthly Benefit payment will reduce certain current values by a proportional amount. This proportion will equal the Monthly Benefit payment, before reduction for repayment of Policy Debt, divided by the death benefit immediately before the payment. The current values that will be reduced by this provision are: (1) Policy Value; (2) Face amount; (3) Surrender Charges, if any; (4) Values and premiums required to maintain lapse protection, if any; (5) Cumulative premiums paid to date; and (6) Policy Debt, if any.

An amount equal to Policy Debt reduction will be applied to repay Policy Debt, and thus will reduce the net amount of proceeds distributable as an accelerated death benefit. Future charges for the policy will be reduced to the rates that would apply had the policy been issued at the reduced face amount.

Below is a **sample illustration** to demonstrate the effect of an accelerated death benefit payment on a policy. This guaranteed-basis illustration shows the effect on the face amount of the policy before the accelerated death benefit is elected, immediately after the election is made and 12 months after the election is made (assuming the insured is still living). This illustration also assumes:

1. The insured is a Male issue age 35;
2. The face amount is $100,000;
3. A $5000 monthly benefit payment is required following the 9th policy anniversary;
4. A single loan of $500 has been taken at the beginning of Policy Year 9, no withdrawals have been taken, and the Monthly Benefit payments are assumed to begin at the beginning of Policy year 10; and
5. No further loans or withdrawals can be taken during the benefit period (as stipulated in the contract).

Before Election is Made (at the end of Policy Year 9)

Face Amount:	$	100,000.00	Minimum Lapse Protection Premium:	$	47.35
Policy Value:	$	5,171.23	Cumulative Premiums for Lapse Protection:	$	4,442.04
Surrender Charges:	$	458.00	Cumulative Premiums Paid to Date:	$	8,734.05
Lapse Protection Account Value:...	$	6,480.15	Policy Debt:	$	522.87

Immediately After Election is Made (at the beginning of Policy Year 10)

Face Amount:	$	95,000.00	Minimum Lapse Protection Premium:	$	0
Policy Value:	$	4,912.67	Cumulative Premiums for Lapse Protection:	$	4,219.94
Surrender Charges:	$	0	Cumulative Premiums Paid to Date:	$	8,297.35
Lapse Protection Account Value: ...	$	6,156.14	Policy Debt:	$	496.73

Policy Loan Repayment: $26.14
Net Monthly Benefit: $4,973.86

12 Months after Election is Made (at the beginning of Policy Year 11)

Face Amount:	$	40,000.00	Minimum Lapse Protection Premium:	$	0
Policy Value:	$	2,138.77	Cumulative Premiums for Lapse Protection:	$	1,776.82
Surrender Charges:	$	0	Cumulative Premiums Paid to Date:	$	3,493.62
Lapse Protection Account Value: ...	$	2,781.01	Policy Debt:	$	219.61

Effect on Monthly Deduction

During a Benefit Period, all monthly deductions continue. If on any monthly anniversary such deduction would cause the policy to lapse, we will waive the monthly deduction or the monthly lapse protection deduction, if any, as required to maintain the policy. Any waiver of deductions is only effective during a Benefit Period.

Acknowledgement:
I acknowledge that I have received and read the Summary and Disclosure Statement for Chronic Illness Accelerated Death Benefit Rider.

_____ _____
Signature of Insured Date

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

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

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

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

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

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

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

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

_____	_____	_____	_____
Applicant/Proposed Insured's Signature	Date	Owner's Signature (if other than Applicant)	Date
_____	_____	_____	_____
Agent's Signature	Date	Joint Owner's Signature	Date

POLICY INFORMATION SHEET FOR EXISTING INSURANCE

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

Address: _____

Proposed Insured if Other Than Applicant: _____

Application Number of Proposed Insurance: _____

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

POLICY INFORMATION

Insurer: _____

Policy Generic Name: _____

Policy Number: _____

POLICY INFORMATION

Insurer: _____

Policy Generic Name: _____

Policy Number: _____

POLICY INFORMATION

Insurer: _____

Policy Generic Name: _____

Policy Number: _____

POLICY INFORMATION

Insurer: _____

Policy Generic Name: _____

Policy Number: _____

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

NOTICE AND CONSENT FOR AIDS-RELATED TESTING

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

Pre-Testing Considerations

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

Meaning of Positive Test Result

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

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

Confidentiality of Test Results

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

Notification of Test Results

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

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

Address: _____

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

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

Consent

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

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

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

_____	_____
Name of Proposed Insured (Print)	Signature of Proposed Insured or Parent/Guardian
_____	_____
Address	Date Signed

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

NOTIFICATION OF RIGHT TO NAME AT LEAST ONE SECONDARY ADDRESSEE

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

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

Please Print the Following Information:

_____
Policy Number (if known)

_____
Policy Owner's Name

_____
Insured's Name

Secondary Addressee:

_____
Name

_____
Street Address or P.O. Box

_____
City, State, Zip Code

_____
Telephone Number

PROTECTIVE LIFE INSURANCE COMPANY

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

SUPPLEMENTAL APPLICATION – PRE-DETERMINED DEATH BENEFIT PAYOUT ENDORSEMENT

SECTION 1

Name of Proposed Insured:

SECTION 2

a. I wish to elect the Pre-Determined Death Benefit Payout Endorsement.

b. Please indicate the desired Death Benefit Payment Schedule:

Initial Lump Sum (if any): $_____

Benefit Installment Mode / Amount / Duration: *(please select either annual or monthly mode)*

☐ Annual $_____ for _____ Years

☐ Monthly $_____ for _____ Years

For Annual, would you like to specify the date the beneficiary receives benefit? ☐ Yes ☐ No

If Yes, what date? _____ (MM/DD). If no date chosen, beneficiary will receive benefit on the anniversary of the original claim processing date.

For Monthly, would you like to specify the day of the month the beneficiary receives benefit? ☐ Yes ☐ No

If Yes, what day? _____ (1^{st} - 28^{th}). If no day chosen, beneficiary will receive benefit on the day of the month of the original claim processing date.

c. Beneficiary: If multiple beneficiaries named, shares of both the initial lump sum and each installment will be equally divided among the surviving beneficiaries, unless otherwise specified.

Primary	Relationship	% of Initial Lump Sum (if any)	% of Benefit Installment Amount

Contingent	Relationship	% of Initial Lump Sum (if any)	% of Benefit Installment Amount

Signed at (City/State): _____

Signature of Proposed Insured: _____ Date: _____

Signature of Owner: _____ Date: _____

Signature of Agent: _____ Date: _____

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

ELECTRONIC DELIVERY ELECTION FORM

At Protective Life Insurance Company, we're always looking for ways to make your life easier. Receive your policy, related statements and notices faster with electronic delivery, or eDelivery. Some notices may still be shared by first class mail due to regulatory requirements but opting into electronic delivery allows most documents to be accessible online and stored on our secure self-service website at **myaccount.protective.com**.

With an online My Protective account you can:

- View, store, print and download up to 12 months of account documents.
- Conveniently access account communications and statements anytime, anywhere.
- Save time and decrease the amount of paper records you keep at home.
- Update account preferences and profile information, including beneficiary changes.
- Make payments and manage recurring payment information. Your initial payment can be made online by bank draft or credit card.

Register your My Protective account or log in at **myaccount.protective.com**.

By providing my signature and email address, I consent to receive my policy and related statements and notices through electronic delivery from Protective Life Insurance Company. This consent is effective on the date that I affix my signature below. In the event that my email address changes or I determine that there was an error in the information provided, I will notify my representative or the Company of the updates.

_____	_____	_____
Signature of Proposed Insured	Date	Email address for Proposed Insured
_____	_____	_____
Signature of Owner (if other than Proposed Insured)	Date	Email address for Owner