Oklahoma

Application Packet

For use with:
- Universal Life & Term

Forms Included:
- Application
- NAIC/No Illustration
- Replacement
- 1035 Exchange

All other applicable forms should be printed individually from our website at www.protectivelife.com/ppga.

Application for Life Insurance -

Part I

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

☐ New Business
☐ Protective Policy Change from Policy ____________

1. Proposed Insured 1

Name | *Birth Date* | *State of Birth* | *Sex* | *Social Security No.*
Occupation | *Marital Status* | *Driver's Lic. No. & State* | *Home Phone No.* | *Work Phone No.*
Home Address (Street Address - City, State, Zip)
Employer's Name | *Employer's Address* | *Years Employed*

2. Proposed Insured 2 – Relationship to Proposed Insured 1: ____________

Name | *Birth Date* | *State of Birth* | *Sex* | *Social Security No.*
Occupation | *Marital Status* | *Driver's Lic. No. & State* | *Home Phone No.* | *Work Phone No.*
Home Address (Street Address - City, State, Zip)
Employer's Name | *Employer's Address* | *Years Employed*

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

Name | *Relationship* | *Soc. Sec. No. or Tax I.D. No.*
Address (Street Address - City, State, Zip)
Home Phone No. | *Work Phone No.*

All notices and reports will be sent to the Owner unless otherwise specified in Remarks

4. Underwriting Class Quoted: ____________
Protective Life will issue best available UW class, unless otherwise noted in Remarks.

5. Complete for all Non-UL Products
Plan of Insurance | Amount $

☐ Waiver of Premium ☐ Children's Term Rider _____ Units (complete #7 below)
☐ Accidental Death Benefit $_________ ☐ Protected Insurability Rider $______

6. Complete for all UL Products
Plan of Insurance | Amount $

☐ Level Death Benefit
☐ Increasing Death Benefit

☐ Children's Term Rider ______ Units (complete #7 below)
☐ Monthly Disability Rider amount to be credited to policy $ __________
☐ Covered Insured Rider $ _____ (complete #7 and #10)
☐ Estate Benefit Rider $ _____ (Survivor Only)

☐ Flexible Coverage Rider $ ____________
☐ Accidental Death Benefit $ ____________
☐ Protected Insurability Rider $ ____________
☐ Other Rider ____________ $ ____________

Guaranteed Insurability Rider(s) **for both Non-UL and UL Products:**
☐ Survivor's Choice - List:
Amount | Designated Life | Relationship

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

7. Family Members to be covered:

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

8. Premium Mode: ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly Bank Draft
☐ Payroll Deduction Authorization **DIRECT MONTHLY NOT AVAILABLE**
Planned Periodic Premium* $__________ ☐ 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)

**Actual premium amount may be higher or lower based on underwriting.*

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

Primary	Relationship	**Contingent**	Relationship

10. Proposed Insureds Under Covered Insured Rider	Beneficiary	Relationship

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

11. Flexible Coverage Rider	Beneficiary	Relationship

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

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	Prop. Ins. 1 No	Prop. Ins. 2 Yes	Prop. Ins. 2 No	Dependents Yes	Dependents 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 comparison statement, if required.)	☐	☐	☐	☐	☐	☐
(b) Has any person proposed for insurance an application pending in 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?	☐	☐	☐	☐	☐	☐

Life insurance in force (if none, so state):

(d) Person	Company	Policy Number	Replace or Change?	Personal Coverage Amt.	Business Coverage Amt.	Year Issued

13. Annual Income ______________ **Net Worth** ______________
(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	Usage within 36 mos.	Usage within 12 mos.

15. Within the last 24 months has any Person Proposed for Insurance:	Prop. Ins. 1 Yes	Prop. Ins. 1 No	Prop. Ins. 2 Yes	Prop. Ins. 2 No	Dependents Yes	Dependents No
(a) Flown as a pilot, student pilot or crew member? (Complete questionnaire on page 6)	☐	☐	☐	☐	☐	☐
(b) Are any such flights planned in the future?	☐	☐	☐	☐	☐	☐
(c) Engaged in racing or scuba diving? (Complete questionnaire on page 6)	☐	☐	☐	☐	☐	☐
(d) Engaged in ☐ hang gliding ☐ mountain climbing or ☐ sky diving? (Complete appropriate questionnaire)	☐	☐	☐	☐	☐	☐

16. Has any Person Proposed for Insurance: (If any "yes", give full details in Section 18)	Prop. Ins. 1 Yes	Prop. Ins. 1 No	Prop. Ins. 2 Yes	Prop. Ins. 2 No	Dependents Yes	Dependents 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	Prop. Ins. 1 No	Prop. Ins. 2 Yes	Prop. Ins. 2 No	Dependents Yes	Dependents No
(a) Are all Proposed Insureds (PIs) 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 PIs reside more than 6 months a year outside of the US? (If yes, provide city/country)	☐	☐	☐	☐	☐	☐
(c) Are any PIs permanent residents of any country other than the US, Puerto Rico or Canada? (If yes, provide city/country)	☐	☐	☐	☐	☐	☐
(d) Are any PIs planning to travel outside the US, Puerto Rico or Canada? (If yes, complete Foreign Travel Questionnaire)	☐	☐	☐	☐	☐	☐
(e) Have any PIs 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

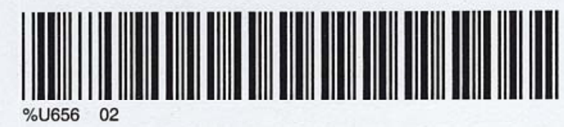
PART 1A NON-MEDICAL DECLARATIONS

1. (a) Proposed Insured 1: Height ____________ Weight ___________ ☐ Gain ☐ Loss in past year?_________ lbs.
(b) Proposed Insured 2: Height ____________ Weight ___________ ☐ Gain ☐ Loss in past year?_________ lbs.

2. Within the past 10 years has any person proposed for insurance been treated or diagnosed by a physician as having: (Circle conditions to which "yes" answer applies and give details in number 5 below.)	EACH PERSON TO BE INSURED					
	Prop. Ins. 1		Prop. Ins. 2		Dependents	
	Yes	**No**	**Yes**	**No**	**Yes**	**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.	☐	☐	☐	☐	☐	☐
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 "yes" answer applies and give details in number 5 below.)						
(a) Other than above, had examination, treatment or consultation with a physician during the past 5 years?	☐	☐	☐	☐	☐	☐
(b) Been on, or are now on any medication or prescribed diet?	☐	☐	☐	☐	☐	☐
(c) Sought 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 or cocaine, 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 cancer, diabetes, stroke or heart disease? (Please show age at onset and/or age at death.)	☐	☐	☐	☐	☐	☐

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

6. Has **any Proposed Insured,** ever been treated for, diagnosed, hospital confined or received medical advice from a physician for (1) kidney disease; (2) stroke; (3) heart attack/heart disease; (4) major organ transplant; (5) total loss of hearing and/or total loss of sight; (6) paralysis; (7) diabetes (not including gestational diabetes occurring during pregnancy); (8) peripheral vascular disease; (9) consistent blood pressure over 145/95; (10) consistent cholesterol level over 240; (11) malignant cancer?	☐	☐	☐	☐	☐	☐
7. For **any Proposed Insured,** have two or more natural parents or brothers or sisters, either living or dead, ever suffered from any of the following conditions (1) heart attack before the age of 55; (2) stroke before the age of 55; (3) malignant cancer; (4) diabetes; (5) kidney disease?	☐	☐	☐	☐	☐	☐



Home Office Endorsements:

Remarks:

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) Acceptance of a policy by the Owner shall constitute ratification of any changes made by the Company under "Home Office Endorsements" above. In those states where it is required, changes as to the plan, amount, age at issue, classification or benefits 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, verify, and record information of its customers. We may ask for information or identifying documents that will allow us to verify the identity of our customers.

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

Signed At ______________________ (City and State)

Date ______________________

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

(X) ______________________ Proposed Insured 1 (Sign Name in Full)

____
**Witness to Signature of Proposed Insured 2 only

(X) ______________________ Proposed Insured 2 (Sign Name in Full)

____
**Witness to Signature of Parent or Guardian Only

(X) ______________________ Signature of Parent or Guardian

____
**Witness to Signature of Owner Only

(X) ______________________ *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 state title

PROTECTIVE LIFE INSURANCE COMPANY
Birmingham, AL 35283-0619

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

1. I (we) authorize Protective Life Insurance Company (Protective Life) and its reinsurers to obtain 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 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 1 to Protective Life or its agents acting on its behalf: (i) my (our) doctor(s); (ii) medical practitioners; (iii) pharmacists; (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 1 to a **CRA**.
3. I (we) authorize Protective Life to draw and test my (our) blood, and/or oral fluids, and urine as may be necessary to obtain information to be used to underwrite my (our) application for insurance. These tests may include, but are not limited to, tests for cholesterol and related blood lipids, diabetes, liver or kidney disorders, immune disorders (other than HIV/AIDS; reference number 5 below), and the presence of drugs, nicotine, or their metabolites. This authorization does not include genetic testing. Unless otherwise required by law or regulation, Protective Life may, but is not obligated to, release any of these test results directly to me or to my spouse and life partner.
4. I (we) authorize Protective Life to release and disclose the information described in paragraphs 1 and 3 to its affiliates, its reinsurers, persons or organizations providing services relating to insurance underwriting for Protective Life, **MIB**, and as otherwise required by law. Protective Life may release and disclose the information described in paragraphs 1 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 1 and 3 to the sales agent representing me on my (our) application for insurance if it is necessary to provide an explanation of the reasons for Protective Life's decision to impose special underwriting requirements, whenever my application cannot be approved as submitted, or in connection with a claim for benefits.
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 law, to disclose the results of those tests to its reinsurers and **MIB**. This is only true if it is in connection with my/our application.
6. The authorizations in paragraphs 1 through 5 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. 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.
8. During the evaluation of my (our) insurance application, I (we) understand that I (we) have the right to revoke the authorizations in paragraphs 1 through 5 by writing to Protective Life at P. O. Box 830619, Birmingham, AL 35283-0619. If this authorization is revoked, this would result in the file being closed and no coverage provided.
9. ☐ I (we) have been given a copy of this authorization form and Protective Life's Description of Information Practices.

   I can revoke this authorization at any time by notifying the Company in writing. However, I realize that any such revocation may be a basis for denying benefits that might be otherwise available under the policy being applied for.

   I realize the failure to sign an authorization statement may impair the ability of a regulated insurance agency to evaluate claims or process applications and may be a basis for denying an application or claim for benefits.

   ☐ 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.)

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.

____
Proposed Insured 1 (Signature)

Date of Authorization: ____________________
When applicable, print name(s) of minor(s) below:

____

____

____
Print Name

____
Proposed Insured 2 (Signature)

____
Print Name

____
Parent or Legal Guardian (Signature)

THIS AUTHORIZATION <u>MUST</u> BE SIGNED <u>WITHOUT MODIFICATION</u> BEFORE THE APPLICATION CAN BE PROCESSED.
PLEASE RETURN THIS AUTHORIZATION WITH THE APPLICATION.

ORIGINAL - HOME OFFICE COPY - APPLICANT

PROTECTIVE LIFE INSURANCE COMPANY
Birmingham, AL 35283-0619

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

1. I (we) authorize Protective Life Insurance Company (Protective Life) and its reinsurers to obtain 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 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 1 to Protective Life or its agents acting on its behalf: (i) my (our) doctor(s); (ii) medical practitioners; (iii) pharmacists; (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 1 to a **CRA**.
3. I (we) authorize Protective Life to draw and test my (our) blood, and/or oral fluids, and urine as may be necessary to obtain information to be used to underwrite my (our) application for insurance. These tests may include, but are not limited to, tests for cholesterol and related blood lipids, diabetes, liver or kidney disorders, immune disorders (other than HIV/AIDS; reference number 5 below), and the presence of drugs, nicotine, or their metabolites. This authorization does not include genetic testing. Unless otherwise required by law or regulation, Protective Life may, but is not obligated to, release any of these test results directly to me or to my spouse and life partner.
4. I (we) authorize Protective Life to release and disclose the information described in paragraphs 1 and 3 to its affiliates, its reinsurers, persons or organizations providing services relating to insurance underwriting for Protective Life, **MIB**, and as otherwise required by law. Protective Life may release and disclose the information described in paragraphs 1 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 1 and 3 to the sales agent representing me on my (our) application for insurance if it is necessary to provide an explanation of the reasons for Protective Life's decision to impose special underwriting requirements, whenever my application cannot be approved as submitted, or in connection with a claim for benefits.
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 law, to disclose the results of those tests to its reinsurers and **MIB**. This is only true if it is in connection with my/our application.
6. The authorizations in paragraphs 1 through 5 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. 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.
8. During the evaluation of my (our) insurance application, I (we) understand that I (we) have the right to revoke the authorizations in paragraphs 1 through 5 by writing to Protective Life at P. O. Box 830619, Birmingham, AL 35283-0619. If this authorization is revoked, this would result in the file being closed and no coverage provided.
9. ☐ I (we) have been given a copy of this authorization form and Protective Life's Description of Information Practices.

   I can revoke this authorization at any time by notifying the Company in writing. However, I realize that any such revocation may be a basis for denying benefits that might be otherwise available under the policy being applied for.

   I realize the failure to sign an authorization statement may impair the ability of a regulated insurance agency to evaluate claims or process applications and may be a basis for denying an application or claim for benefits.

   ☐ 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.)

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.

______________________ Proposed Insured 1 (Signature)	**Date of Authorization:** ______________ When applicable, print name(s) of minor(s) below:
______________________ Print Name	______________________
______________________ Proposed Insured 2 (Signature)	______________________
______________________ Print Name	
______________________ Parent or Legal Guardian (Signature)	

THIS AUTHORIZATION MUST BE SIGNED WITHOUT MODIFICATION BEFORE THE APPLICATION CAN BE PROCESSED.
PLEASE RETURN THIS AUTHORIZATION WITH THE APPLICATION.

ORIGINAL - HOME OFFICE COPY - APPLICANT

PROTECTIVE LIFE INSURANCE COMPANY, P. O. BOX 830619, BIRMINGHAM, ALABAMA 35283-0619

Name of Proposed Insured (Please Print): ____________________

AVIATION QUESTIONNAIRE

1. Purpose of present and future flying:
☐ Pleasure ☐ Student Instruction ☐ Racing
☐ Commercial ☐ Charters ☐ Aerobatic Flight
☐ Military ☐ Test Flying ☐ Stunt Flying
☐ Business ☐ Cropdusting (☐ Ag Plane, ☐ Other)

2. Type of license currently held:
☐ Student ☐ ATR
☐ Private ☐ IFR
☐ Commercial

3. Type of aircraft (i.e., glider, jet, single engine, experimental, ultralight, etc.):

4. Total number of solo hours:

5. Total number of hours flown per year:

6. Ever had an aviation accident or violation? ☐ Yes ☐ No

7. Any flights planned over inaccessible or remote areas? ☐ Yes ☐ No

8. If aviation requires an extra premium or exclusion rider, which would you prefer? ☐ Extra Premium ☐ Exclusion Rider

SCUBA DIVING QUESTIONNAIRE

1. Do you dive for pleasure? ☐ Yes ☐ No
Or commercial purposes? ☐ Yes ☐ No

2. Diving History Last 24 Months

	No. of Dives	Average Time
Less than 50 feet		
50-75 feet		
76-100 feet		
101-130 feet		
131-150 feet		

3. How many dives do you plan to make in the next 12 months?

4. Date of your last dive:

5. Do you engage in:
☐ ice ☐ cave or ☐ night diving?
☐ search or ☐ rescue work?
☐ salvage?

6. (a) What are the locations of your diving activities?
☐ Lakes
☐ Rivers
☐ Pools
☐ Ocean Beaches
☐ Deep Sea
☐ Other (Specify)

(b) How long have you been diving?

7. Will you use mixed gas equipment? (Nitrox, Trimix, Heliox, etc.)
☐ Yes ☐ No
If so, how often?

8. Do you dive alone?
☐ Yes ☐ No
If yes, how often?

(a) Are you a certified diver?
☐ Yes ☐ No
Level of certification:

Date of last certification:

(b) Are you a member of an organized club? ☐ Yes ☐ No
If yes, give details:

9. Have you ever been treated for decompression sickness or arterial gas embolism?
☐ Yes ☐ No

RACING QUESTIONNAIRE

1. Racing vehicle:
☐ automobile ☐ snowmobile
☐ motorcycle ☐ boat

2. Maximum speed attained:
Engine size:

3. What specific types of competition do you engage in?
(Examples: Midget, Sports Car, Stock Car, Drag, Sprint, Cross Country, etc.)

4. What type of fuel is used?

5. Racing Class:
☐ amateur
☐ professional

6. Racing Association: (Examples: NASCAR, IMSA, SCCA, etc.)

All statements and answers to the above questions have been correctly recorded. They are complete and true to the best of my knowledge and belief.

Signed at ____________________ (City & State) Date: ____________________

Witness ____________________ ____________________ (Signature of Proposed Insured)

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 "Disclosure and Comparison Statements"? ☐ Yes ☐ No
If "no", please explain.

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

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

5. Are you related to the Proposed Insured(s)? ☐ Yes ☐ No
Relationship:
Have you represented the Proposed Insured(s) on prior insurance applications to other life insurance companies? ☐ Yes ☐ No

6. Please list (in separate note) any known history of excessive use of alcohol, use of drugs, DUIs, 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.

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

8. Should we need to order a **HOME OFFICE INSPECTION REPORT,** please complete the following:
Convenient Time To Call: ☐ AM ☐ PM
Day (circle): M T W T F   Zone (circle): Eas Cen Mt Pac

Answer these questions only if this is a replacement:
Did you use any pre-printed Company approved sales materials? ☐ Yes ☐ No   If yes, list the name or form number of materials here: ____________
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 material(s) with the application.

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.

Signed at (City and State)		Date
Soliciting Agent's Printed Name	Agent's Number	Percentage
Phone No.	Fax No.	E-mail
Soliciting Agent's Signature	Address	
Soliciting Agent's Printed Name	Agent's Number	Percentage
Phone No.	Fax No.	E-mail
Soliciting Agent's Signature	Address	

ADDITIONAL COMMENTS:

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),
☐ Assignment/Transfer of Ownership for Section 1035 Exchange (1035) from ________________
____ 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 AND MONEY ORDERS 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.**

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.** 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
  (4) by 1035 and the cash surrender value received from the assigned policy(s) is not equal to the first full modal premium for the premium rate class applied for.
(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:________________________ Applicant/Owner:________________________

ORIGINAL - HOME OFFICE COPY - APPLICANT

PRE-AUTHORIZED WITHDRAWAL PLAN AGREEMENT
PROTECTIVE LIFE INSURANCE COMPANY

To:

Name of Bank

Street Address or P. O. Box

City	State	Zip Code

As a convenience to me, I hereby request and authorize you to pay and charge to my checking or savings account checks, drafts or other paper instruments drawn and/or electronic debits initiated by and payable to the order of Protective Life Insurance Company. I agree that your treatment of and rights in respect to each such charge shall be the same as if each check, draft or other paper instrument were signed or electronic debit were initiated by me personally. This Agreement is to remain in effect until you actually receive such notice of revocation. I agree that you shall be fully protected in honoring any such charge.

You are also authorized (but not required) to initiate any electronic or paper debit or credit entries, necessary to correct any incorrect charges made hereunder. I further agree that if any such check, draft or other paper instrument or electronic debit be dishonored, whether with or without cause, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

I also authorize you to furnish Protective Life with any new mailing address at which I may be reached.

Protective Life Insurance Company is hereby requested and authorized by the undersigned Premium Payor to draw against the account indicated below to pay premiums under the policies listed. Premium mode to be ☐ Annually; ☐ Semi-Annually; ☐ Quarterly; or ☐ Monthly.

Policy No.	Name of Insured	Policy No.	Name of Insured

You are authorized to make withdrawal on the ________ of each month. For the purpose of this Agreement "Policy" shall mean each above numbered Policy, and shall mean "Policies" where the use of the plural is appropriate, and "Insured" shall mean the owner of the Policy if the Insured is not the Owner.

Nothing herein contained shall have the effect of altering the anniversary date of the Policy.

Date	Premium Payer-Depositor (Please Print)
Signature of the Insured or Owner (If other than the Depositor)	Signature
Address of Insured or Owner	Account Number ☐ Checking Account ☐ Savings Account

PLEASE ATTACH A VOIDED CHECK

If notice of any premium due under the Policy is required by law, such notice is hereby expressly waived by the Insured for the period that this Agreement remains in effect.

If and when you draw the first check and/or initiate the first electronic debit entry on said bank account and mail to the Insured a Rider setting forth the provisions hereof and the amount and due date of the monthly premium, this Agreement will be accepted by you and the terms of said Rider will be a mutual agreement between us constituting a part of the Policy and modifying same as therein provided, and the Insured agree(s) to attach said Rider to the Policy immediately upon its receipt.

The Premium Payer has authorized said bank to pay and charge to his account checks drawn and/or electronic debits initiated by you each month, and payment thereof by the bank to you in cash or solvent credits within the days of grace shall constitute payment of the premium.

Failure to pay any monthly premium when due, or within one month (not less than 31 days) thereafter, whether or not such failure is due to the dishonor by said bank of any check or electronic debit as provided herein, shall cause the Policy to terminate except as otherwise provided in the Policy.

If while the Policy is in force the Insured (or either of them if more than one) shall (a) give to you at your Home Office written notice terminating this Agreement, or (b) revoke the Agreement to said bank to pay such checks or electronic debits in effect prior to the execution of this Agreement, provided, however, that monthly premiums will continue to be payable until the premium payable in such other manner is due, and provided that you shall incur no liability from the drawing of any check or initiation of an electronic debit on said account after the revocation of the Agreement given to you or to said bank which is done before you receive at your Home Office written notice of such revocation.

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

DESCRIPTION OF INFORMATION PRACTICES

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 (617) 426-3660.

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 ask about personal information which we may have in our files and the right to seek a correction of information you think is wrong.

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 (205) 879-9230

THIS NOTICE MUST BE GIVEN TO PROPOSED INSURED

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, B, 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 process.

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.

_______________________________ _______________
Applicant *Date*

Agent or Authorized Representative - read statements F, G, H, and I and check the **one** that applies; read statement J 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.

I. ☐ 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 - Home Office COPY - Applicant COPY - Agent

PROTECTIVE LIFE INSURANCE COMPANY
POST OFFICE BOX 2606
BIRMINGHAM, ALABAMA 35202
TELEPHONE: (205) 879-9230

NOTICE TO APPLICANTS REGARDING REPLACEMENT OF LIFE INSURANCE OR AN ANNUITY. THIS NOTICE IS FOR YOUR BENEFIT AND IS REQUIRED BY LAW.

1. If you are urged to purchase life insurance and to surrender, lapse, or in any other way change the status of existing life insurance, the agent is required to give you this notice.

2. It may not be advantageous to drop or change existing life insurance in favor of new life insurance, whether issued by the same or a different insurance company. Some of the disadvantages are:

   a. The amount of the annual premium under an existing policy may be lower than that under a new policy having the same or similar benefits.

   b. Generally, the initial costs of life insurance policies are charged against the cash value increases in the earlier policy years, the replacement of an old policy could result in the policyholder sustaining the burden of these costs twice.

   c. The incontestable and suicide clauses begin anew in a new policy. This could result in a claim under a new policy being denied by the company which would have been paid under the old policy.

   d. Existing policies may have favorable provisions than new policies in such areas as settlement options and disability benefits.

   e. An existing policy may have a reserve value in addition to any cash value which may be of some benefit to the insured.

   f. The insurance company carrying your current insurance policy can often make a desired change on terms which would be more favorable than if existing insurance is replaced with new insurance.

3. It may not be advantageous to change an existing policy to reduced paid-up or extended term insurance or to borrow against its loan value beyond your expected ability or intention to repay in order to obtain funds for premiums on a new policy.

4. There may be a situation in which a replacement policy is advantageous. You may want to receive the comments of the present insurance company before deciding this important financial matter.

I hereby acknowledge that I received the above "Notice to Applicants Regarding Replacement of Life Insurance or an Annuity" before I signed the application for the proposed new insurance.

____________________ Date

____________________ Signature of Applicant

Definitions

Premiums: Premiums are the payments you make on the life insurance or annuity contract. They are unlike deposits in a savings or investment program because if you drop the policy you might get back less than you paid in.

Cash Surrender Value: This is the amount of money you can get if you surrender your life insurance policy or annuity. If there is a policy loan, the cash surrender value is the difference between the cash value printed in the policy and the loan value. Not all policies have cash surrender values.

Lapse: A life insurance policy may lapse when you do not pay the premiums within the grace period. If your policy had a cash surrender value, the insurer might change your policy to as much extended term insurance or paid-up insurance as the cash surrender value will buy. Sometimes the policy lets the insurer borrow from the cash surrender value to pay the premiums.

Surrender: You surrender a life insurance policy when you either let it lapse or tell the company you want to drop it. If a policy has a cash surrender value, you can receive such value in cash if you return the policy to the company with a written request.

Place on Extended Term: This means you use your cash surrender value to change your insurance to term insurance with the same insurer. In this case, the net death benefits will be the same as before but you will only be covered for a specified period of time.

Borrow Policy Loan Values: If your life insurance policy has a cash surrender value, you can usually borrow all or part of said amount from the insurer. Interest will be charged according to the terms of the policy, and if the loan and unpaid interest ever exceeds the cash surrender value the policy will be terminated. If you die, the amount of the loan and any unpaid interest due will be subtracted from the death benefits.

Evidence of Insurability: This means proof that you are an acceptable risk. You have to meet the standards of the insurer regarding age, health, occupation, and such other standards as the insurer feels necessary to be eligible for coverage.

Incontestable Clause: This says that after one (1) or two (2) years, according to the provisions of the contract, the insurer shall not resist a claim because you made a false or incomplete statement when you applied for the policy. During the first two (2) years if there are false or incomplete answers on the application and the insurer discovers them, the insurer can deny a claim as if the policy has never existed.

Suicide Clause: This says that if you commit suicide after being insured for less than two (2) years, your beneficiaries will receive only a refund of the premiums that were paid.

PROTECTIVE LIFE
INSURANCE COMPANY

STATEMENT BY APPLICANT REGARDING NOTIFICATION OF REPLACEMENT TO THE REPLACED INSURER

I have read the "NOTICE TO APPLICANTS REGARDING REPLACEMENT OF LIFE INSURANCE OR AN ANNUITY" which was furnished to me by the agent taking the application for this policy.

(Applicant: Please Sign one of the following statements.)

1. Please notify my present insurer(s) regarding this transaction.

________________ ______________________________
Date Signature of Applicant

2. Please do not notify my present insurer(s) regarding this transaction.

________________ ______________________________
Date Signature of Applicant

The signature of the applicant shall be that of the insured unless someone other than the insured is the owner of the policy. If someone other than the insured is the owner of the policy, the owner must sign. If the insured is under eighteen (18) years of age, the parent is deemed to be the owner of the policy.

Certification by the agent:

I hereby certify that nothing was said or done during the sales presentation to influence the decision of the applicant regarding this statement.

________________ ______________________________
Date Signature of Agent

____
Insurance Agency or Agent
License Number

PROTECTIVE LIFE INSURANCE COMPANY

ASSIGNMENT/TRANSFER OF OWNERSHIP
SECTION 1035 EXCHANGE

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

OWNER ______________________________ ______________________

INSURER ______________________________
(NAME OF EXISTING INSURANCE COMPANY)

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

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

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

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

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

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

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

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

I understand that under Section 1035, reporting may be required for federal income tax purposes. The replaced company is required to report all exchanges of insurance contracts on Form 1099-R, including tax-free exchanges under Section 1035 in situations in which a policyholder has an outstanding policy loan at the time of exchange. If there is an outstanding policy loan at the time of the exchange, the transaction may not be characterized as tax-free. In fact, any gain will be taxed to the extent of the outstanding policy loan. Accordingly, I understand that it is advisable when filing my individual federal income tax return that I enclose a copy of the reporting form (Form 1099-R) with an explanation that the policy was exchanged pursuant to Section 1035 of the Internal Revenue Code.

I understand and agree that Protective Life is furnishing this form and is participating in this transaction at my request and as an accommodation to me. I understand that Protective Life makes no representations concerning my tax treatment under Internal Revenue Code Section 1035 or otherwise and that Protective Life has no responsibility for the validity of this Assignment.

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

Insured(s) Signature(s)	Witness	Date
Owner Signature	Witness	Date
Owner Signature	Witness	Date
Collateral Assignee/Irrevocable Beneficiary Signature, if any	Witness	Date

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