DON BOOZER & ASSOCIATES
P: 800-543-0886 F: 940-315-8434
Email: NewBusiness@DonBoozer.com

TeleLife® Application Transmittal

Agent Information

Agent Name:	*Appointment #:*
Agent Phone:	*Email:*

Required Forms

- ☐ Pre-Application
- ☐ Replacement
- ☐ Pre-Authorized Withdrawal
- ☐ Application Supplement Part 1
- ☐ Full Illustration, (UL only)
- ☐ Checklist provided to client

Signature Requirements: Agent signature required on all forms [applicants signature optional at time of sale] Include any State Required forms contained in packet. Note: all forms provided may not be applicable

General Compliance

- ☐ Insured & Owner personal information complete & correct
- ☐ Indicate Death Benefit, Plan of Insurance, Rate Class & Premium Quoted
- ☐ Mark the 3 Agent Attestation Questions on the bottom of the pre-app. Print Agent Name, Agent code, Sign and Date
- ☐ Obtain Owner's signature if other than proposed insured

Do Not Order the Exam. TeleLife will order upon completion of the interview

Premium Source

- Pre-Authorized Withdrawal [PAW] of premium – Include a completed PAW form [PL-104]
- Indicate Initial and Future draft dates

Binding Coverage – options are bank draft [PAW] or credit card. [Credit card information will be collected during the phone interview]

Special Instructions

TeleLife®

Protective
Life Insurance Company
Protect Tomorrow. Embrace Today.℠

Applicant's Checklist

Thank you for using TeleLife to apply for life insurance. A Protective Life representative will contact you soon to complete your application by phone.

During the phone interview, you will be asked some routine questions [name, address, employer, income, etc.] along with several questions about your medical history. To complete the phone interview as quickly as possible, please have the following information available:

Personal Information

- Social Security and Driver's License number
- Other existing or pending life insurance policies, including company name coverage amounts, and policy numbers if available
- Type of Visa, Visa number and expiration date, if you are not a U.S. Citizen
- Payment information for initial or recurring premium payment(s) [checking, savings, or credit card account information,] if applicable.

Medical Information

- Name, address and phone number of your doctor(s) and hospitals(s)
- Current treatment you receive by any doctor or hospital; including your medications, dosages, and reasons
- Reasons for past treatment, with date(s)
- Additional tests you have been advised to take and elective exam(s) or procedure(s) that have been scheduled.

PROCESSING CENTER CONTACT INFORMATION

Phone Interview number: 1-888-800-6608

Hours of Operation M-F 7:00am – 8:00pm CT
Saturday 9:00am -2pm CT

Policy Number

Protective
Life Insurance Company
Elgin, Illinois 60124

TeleLife®
FAX # 1-888-543-0886

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

Country of Citizenship 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

If yes, list below:

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:

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.

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; the Medical Information Bureau; and any other organization, institution or person that has any records or knowledge of me or my health, to give Protective Life Insurance Company, its affiliates, or their reinsurers or the Medical Information Bureau, any such information. 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 policy(ies)? ❑ Yes ❑ No
(If "Yes," complete any required replacement forms.)
Has the Owner been provided an illustration which conforms to this application? ❑ Yes ❑ No
If "no," agent hereby certifies that no illustration was used in connection with the solicitation of the policy applied for.
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 and are full, complete and true to the best of my (our) knowledge and belief. I (We) understand that the information being provided in this Supplement is being relied upon in considering the application for life insurance and is subject to the applicable Fraud Statement as provided in the Application for Life Insurance.

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

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

X _____ SIGN HERE

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

X _____ SIGN HERE

Signature of Witness: X _____ SIGN HERE

PRODUCER CERTIFICATION

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

Signed at: _____ (City and State) _____ Date

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

☐ **Term**
☐ **UL**
☐ **VUL**

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

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 Protective Life Insurance Company (the Company) can alter or waive any of the provisions of this Agreement. No life insurance is provided under the terms of this document in the event of the death of the proposed insured(s) by suicide. In the event of suicide, while sane or insane, the Company's sole liability will be the return of any money received.

Initial Payment Method Received: ☐ Pre-Authorized Funds Withdrawal

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

DO NOT MAKE CHECKS PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK. CASH, MONEY ORDERS AND CASHIER'S CHECKS WILL NOT BE ACCEPTED. ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO PROTECTIVE LIFE INSURANCE COMPANY.

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

CONDITIONS UNDER WHICH INSURANCE MAY BECOME EFFECTIVE PRIOR TO POLICY DELIVERY

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

(A) on the Effective Date the Proposed Insured(s) is (are) insurable exactly as applied for under the Company's published underwriting rules for the plan, amount and premium rate class applied for;
(B) the amount paid with the application and shown above is equal to the first full modal premium for the plan, amount and premium rate class applied for; and
(C) the Proposed Insured(s) has/have completed all examinations and/or tests requested by the Company.

EFFECTIVE DATE OF COVERAGE

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

(A) the date of the application;
(B) the date requested in the application; or
(C) the date of the last of any medical examinations or tests required under the rules and practices of the Company.

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

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

TERMINATION AND REFUND OF PREMIUM

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

(A) premium payment is
  (1) by Pre-Authorized Funds Withdrawal, and the deduction is not honored by the financial institution.
  (2) by Check, and the deduction is not honored by the financial institution.

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

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

By my signature I am attesting that I understand the terms and conditions of the Conditional Receipt Agreement. I am also authorizing the Company to withdraw the amount of $_____ from my account to pay the initial premium for the application on (Name of Proposed Insured) _____.

Date: _____ Agent Signature: _____

Date: _____ Owner Signature: _____

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

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

INFORMED CONSENT AND AGREEMENT TO HIV TESTING

EXAMINER: _____ ADDRESS: _____

_____

I understand the following information, which I have read or has been read to me.

Blood, or another body fluid or tissue sample, will be tested for the human immunodeficiency virus (HIV), the virus that causes AIDS; Consent to be tested for HIV should be given FREELY; Results of this test, like all medical records, are confidential, but cannot be guaranteed; If positive test results become known, an individual may experience discrimination from family or friends and at school or work.

WHAT A NEGATIVE RESULT MEANS:
A negative test means that HIV infection has not been found at the time of the test.

WHAT A POSITIVE RESULT MEANS:
A positive HIV test means that a person is infected with HIV and can transmit the virus by having sex, sharing needles, childbearing (from mother to child), breastfeeding, or donating organs, blood, plasma, tissue, or breast milk. A positive HIV test DOES NOT mean a diagnosis of AIDS. Other tests are needed.

WHAT WILL HAPPEN IF THE TEST IS POSITIVE:
A copy of the Department of Health and Mental Hygiene's publication "Information for HIV Infected Persons" will be provided; The local health department or my doctor will offer advice about services which are available; Women who are pregnant or may become pregnant will be told of treatment options which may reduce the risk of transmitting HIV to the unborn child; My unique identifying number **(UI)**, *see below*; will be given to the health department *for tests that indicate HIV infection. This includes, but is not limited to: HIV Antibody (Western blot), HIV Viral Load (RNA or DNA quantification), HIV viral sequencing or HIV p24 antigen tests*; My name will be reported to the local health department if my doctor finds that I have AIDS; The health department or my doctor will offer assistance in notifying and referring my partners for service. If I refuse to notify my partners, my doctor may notify them or have the local health department do so. If local health department staff notify my partners, my name will not be used. Maryland law requires that when the local health department knows of my partners, it must refer them for care, support, and treatment.

I have checked below if I do not want the last 4 digits of my Social Security number used to create a unique identifying (UI) number.

☐ I DO NOT authorize the use of the last 4 digits of my Social Security number to create a unique identifier.

I have had a chance to have my questions about this test answered.

I hereby agree to be tested for HIV.

Print Name of Person(s) Tested: _____

_____ _____ _____
Signature of Person or Authorized Substitute Date Signature of Counselor

****

UI NUMBER

LAST 4 DIGITS SSN	**DATE OF BIRTH**	**RACE-ETHNICITY**	**SEX**
☐☐☐☐	☐☐☐☐☐☐☐☐	☐	☐
	m m d d y y y y		

CODES:
RACES/ETHNICITY: 1-White, Not Hispanic; 2-Af. Am., Not Hispanic; 3-Hispanic; 4-Asian/Pacific; 5-Am. Indian/AK. Native; 6-Other; 9-Undetermined
SEX: 1-Male; 2-Female

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 once a policy has been issued. 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 _____ day of the month. **(The draft date must be on or before the policy effective date.)** (1st-28th)

_____
Premium Payer - Depositor (Please Print)

_____ _____
Date **Signature**

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

PL-104 (05/11)

COMPLETE IF SELECTING INCOME PROVIDER UL

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

Supplemental Application - Pre-Determined Death Benefit Payout Endorsement

Proposed Insured: _____

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

2. Please indicate the desired Death Benefit Payment Schedule:

   Initial Lump Sum (if any): $ _____

   Benefit Installment Mode / Amount / Duration: ___ Annual $ _____ for _____ Years
   (please select either annual or monthly mode) ___ 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? _____ (1-28). If no day chosen, beneficiary will receive benefit on the day of the month of the original claim processing date.

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

ELECTRONIC POLICY DELIVERY ELECTION FORM

Protective Life offers Electronic Policy Delivery (EPD), the option to receive your policy in an electronic printable format instead of paper. The policy will be electronically sent to you by email and stored on our secure Customer Service website, www.myaccount.protective.com, which is available 24 hours a day.

How Electronic Policy Delivery will work for you:

- The EPD process is quick, easy and safe.
- You can save, print, and review your policy online 24 hours a day, 7 days a week.
- Your policy will be safely stored on our secure website for convenient easy access.
- You can make your initial payment online by bank draft or credit card.

How to sign up for Electronic Policy Delivery:

1. Provide your email address below.
2. Return this form with your application for life insurance.

By providing my email address, I am requesting my policy to be delivered through Electronic Policy Delivery.

_____
Email Address for Proposed Insured

_____
Email Address for Owner
(If the owner is other than the proposed insured)