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

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

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

NOTICE AND CONSENT FOR BLOOD, SALIVA AND/OR URINE TESTING WHICH MAY INCLUDE AIDS VIRUS (HIV) ANTIBODY/ANTIGEN TESTING

EXAMINER: _____ ADDRESS: _____

_____

To determine your insurability, the Insurer named above, Protective Life Insurance Company, is requesting that you provide a sample of your blood, saliva and/or urine for testing and analysis. All tests will be performed by a licensed laboratory.

Tests may be performed to determine the presence of antibodies or antigens to the Human Immunodeficiency Virus (HIV), also known as the AIDS virus. The HIV antibody test that we perform is actually a series of tests done by a medically accepted procedure. The HIV antigen test directly identifies AIDS viral particles. These tests are extremely reliable. Other tests which may be performed include determinations of blood cholesterol and related lipids (fats) and screening for liver or kidney disorders, diabetes, and immune disorders.

All test results will be treated confidentially. They will be reported by the laboratory to the Insurer. When necessary for business reasons in connection with insurance you have or have applied for with the Insurer, the Insurer may disclose test results to others involved in the underwriting and claims review process. Your test results will not be disclosed to your agent or broker. If the HIV test is positive, the results will be reported to the local health department or the State Department of Health and if the Insurer is a member of the Medical Information Bureau (MIB, Inc.), the Insurer may report the results in a generic code which signifies only non-specific blood test abnormalities. If your HIV test is normal, no report will be made about it to the MIB, Inc. Other test results may be reported to the MIB, Inc. in a more specific manner. The organizations described in this paragraph may maintain the test results in a file or data bank. There will be no other disclosure of test results or even that the tests have been done except as may be required or permitted by law or as authorized by you.

If your HIV test results are normal, no routine notification will be sent to you. If the HIV test results are other than normal, the Insurer or your designated physician will contact you. The Insurer may also contact you if there are other abnormal test results which, in the Insurer's opinion, are significant. The Insurer may ask you for the name of a physician to whom you may authorize disclosure and with whom you may wish to discuss the results.

Positive HIV antibody/antigen test results do not mean that you have AIDS, but that you are at significantly increased risk of developing AIDS or AIDS-Related conditions. Federal medical authorities have concluded that persons who are HIV antibody/antigen positive should be considered infected with the AIDS virus and capable of infecting others.

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

I have read and I understand this Notice and Consent For Blood, Saliva and/or Urine Testing Which May Include HIV Antibody/Antigen Testing. I voluntarily consent to the withdrawal of saliva, urine or of blood from me by needle, the testing of that saliva, urine or blood and the disclosure of the test results as described above.

In the event of a positive HIV test result, I authorize Protective Life Insurance Company to send the test results to the following health care professional for post-test counseling and for Health Department reporting purposes:

Physician: _____ Address: _____

_____

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.

_____ _____
Proposed Insured (Print) Date of Birth

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

Protective Life Insurance Company

"we, us, our"

SUMMARY DISCLOSURE STATEMENT for ACCELERATED DEATH BENEFIT

Benefit:

Subject to the terms of this Benefit, we will pay a portion of the death benefit upon receiving proof that the insured is terminally ill. An accelerated death benefit can only be paid one time.

Consequences of Receiving Accelerated Death Benefit:

The receipt of an accelerated death benefit may be considered a taxable event under the Internal Revenue Code. The receipt of an accelerated death benefit may also affect eligibility to receive, or continue to receive Medicaid benefits, or other state or federal government benefits and entitlements. Before you elect to receive any accelerated benefits, you should consult with your tax advisor.

Amount You May Elect:

You may elect the amount of the accelerated death benefit to be paid. The limits are outlined in the Benefit but are generally limited to the lesser of 60% of the death benefit of the policy or $1,000,000. We will charge an administrative fee of not more than $250, deducted from any payment made.

When Eligible for Payment of Benefit:

You are entitled to receive the accelerated death benefit when we have determined that the insured is terminally ill and has a life expectancy of 6 months or less.

Notice and Proof of Qualifying Event:

We will require proof that the insured is terminally ill. The diagnosis must be made by a physician as defined in the Benefit. Any diagnosis must be the result of clinical, radiological, histological, or laboratory evidence of the terminal illness. We may require a second medical opinion by a physician of our choice at our expense. If there is a conflict of opinion, we reserve the right to make the final determination.

Effect of an Accelerated Death Benefit:

When you elect to receive an accelerated death benefit, it will be treated as a lien against your policy. We will charge you interest on the accelerated death benefit paid to you. The Accelerated Death Benefit does not have an effect on the Premium and/or Cost of Insurance Charges of the base policy.

The maximum interest rate we may charge you is the greater of:

1. The interest rate charged on policy loans; or

2. the current 90 day U.S. Treasury Bill rate in effect on the date that the accelerated death benefit is paid.

The maximum interest rate we will charge on the portion of the lien which is equal to the cash surrender value of the policy at the time the accelerated death benefit is requested will be no greater than the rate we charge on policy loans.

The accelerated death benefit will first be used to repay any outstanding policy loans and any unpaid accrued interest thereon. Your access to the cash surrender value of your policy, if any, will be limited to the excess of the cash surrender value over the lien. The death benefit will also be reduced by the amount of the lien. There will be no effect on any benefits not used to determine the accelerated death benefit.

Any irrevocable beneficiaries or assignees must send us a written consent to the accelerated death benefit payment. The written request must be in a form satisfactory to us.

Below is a **sample illustration** of the effect of an accelerated death benefit on a **UNIVERSAL LIFE** policy. This 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 Face Amount is $100,000; (2) a 50% accelerated death benefit is elected; (3) we are charging 6% on the lien; and (4) for **UNIVERSAL LIFE**, the cash surrender value does not change after the accelerated death benefit is elected.

UNIVERSAL LIFE

Before Election is Made		
Face Amount	$	100,000.00
Cash Surrender Value	$	30,000.00
Policy Loan	$	5,000.00
Death Benefit Payable	$	95,000.00
Net Cash Surrender Value	$	25,000.00

Accelerated Death Benefit Election		
Face Amount	$	100,000.00
50% Election	$	50,000.00
less administrative fee	$	150.00
less policy loan repayment	$	5,000.00
Benefits Payable	$	44,850.00

Immediately After Election is Made		
Face Amount	$	100,000.00
Lien*	$	50,000.00
Cash Surrender Value	$	30,000.00
Policy Loan	$	0.00
Death Benefit Payable	$	50,000.00
Cash Surrender Value available for loan	$	0.00

Face Amount	$	100,000.00
Lien**	$	53,000.00
Cash Surrender Value	$	30,000.00
Policy Loan	$	0.00
Death Benefit Payable	$	47,000.00
Cash Surrender Value available for loan	$	0.00

* *Equal to the Accelerated Death Benefit*

** *Equal to the Accelerated Death Benefit plus 12 months of interest. This illustration assumes a loan interest rate of 6%. The actual rate applicable is described in the Effect of an Accelerated Death Benefit section of this Summary.*

Premiums: There are no premiums for this benefit.

Acknowledgement: I acknowledge that I have received and read the Summary and Disclosure Statement for Accelerated Death Benefit which was furnished to me prior to signing the application.

Signature of Proposed Insured _____ Date _____

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

Signature of Agent _____ Date _____

For electronic use only - AGENT ONLY

I hereby certify that my electronic approval serves as my signature for legal and regulatory purposes for this application

Electronic Signature of _____ was
Broker or Agent

obtained _____ at _____.
Date *Time*

PLEASE RETAIN THIS COPY FOR YOUR RECORDS

Protective Life Insurance Company

"we, us, our"

SUMMARY DISCLOSURE STATEMENT for ACCELERATED DEATH BENEFIT

Benefit:

Subject to the terms of this Benefit, we will pay a portion of the death benefit upon receiving proof that the insured is terminally ill. An accelerated death benefit can only be paid one time.

Consequences of Receiving Accelerated Death Benefit:

The receipt of an accelerated death benefit may be considered a taxable event under the Internal Revenue Code. The receipt of an accelerated death benefit may also affect eligibility to receive, or continue to receive Medicaid benefits, or other state or federal government benefits and entitlements. Before you elect to receive any accelerated benefits, you should consult with your tax advisor.

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You may elect the amount of the accelerated death benefit to be paid. The limits are outlined in the Benefit but are generally limited to the lesser of 60% of the death benefit of the policy or $1,000,000. We will charge an administrative fee of not more than $250, deducted from any payment made.

When Eligible for Payment of Benefit:

You are entitled to receive the accelerated death benefit when we have determined that the insured is terminally ill and has a life expectancy of 6 months or less.

Notice and Proof of Qualifying Event:

We will require proof that the insured is terminally ill. The diagnosis must be made by a physician as defined in the Benefit. Any diagnosis must be the result of clinical, radiological, histological, or laboratory evidence of the terminal illness. We may require a second medical opinion by a physician of our choice at our expense. If there is a conflict of opinion, we reserve the right to make the final determination.

Effect of an Accelerated Death Benefit:

When you elect to receive an accelerated death benefit, it will be treated as a lien against your policy. We will charge you interest on the accelerated death benefit paid to you. The Accelerated Death Benefit does not have an effect on the Premium and/or Cost of Insurance Charges of the base policy.

The maximum interest rate we may charge you is the greater of:

1. The interest rate charged on policy loans; or

2. the current 90 day U.S. Treasury Bill rate in effect on the date that the accelerated death benefit is paid.

The maximum interest rate we will charge on the portion of the lien which is equal to the cash surrender value of the policy at the time the accelerated death benefit is requested will be no greater than the rate we charge on policy loans.

The accelerated death benefit will first be used to repay any outstanding policy loans and any unpaid accrued interest thereon. Your access to the cash surrender value of your policy, if any, will be limited to the excess of the cash surrender value over the lien. The death benefit will also be reduced by the amount of the lien. There will be no effect on any benefits not used to determine the accelerated death benefit.

Any irrevocable beneficiaries or assignees must send us a written consent to the accelerated death benefit payment. The written request must be in a form satisfactory to us.

Below is a **sample illustration** of the effect of an accelerated death benefit on a **UNIVERSAL LIFE** policy. This 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 Face Amount is $100,000; (2) a 50% accelerated death benefit is elected; (3) we are charging 6% on the lien; and (4) for **UNIVERSAL LIFE**, the cash surrender value does not change after the accelerated death benefit is elected.

UNIVERSAL LIFE

Before Election is Made		
Face Amount	$	100,000.00
Cash Surrender Value	$	30,000.00
Policy Loan	$	5,000.00
Death Benefit Payable	$	95,000.00
Net Cash Surrender Value	$	25,000.00

Accelerated Death Benefit Election		
Face Amount	$	100,000.00
50% Election	$	50,000.00
less administrative fee	$	150.00
less policy loan repayment	$	5,000.00
Benefits Payable	$	44,850.00

Immediately After Election is Made		
Face Amount	$	100,000.00
Lien*	$	50,000.00
Cash Surrender Value	$	30,000.00
Policy Loan	$	0.00
Death Benefit Payable	$	50,000.00
Cash Surrender Value available for loan	$	0.00

Face Amount	$	100,000.00
Lien**	$	53,000.00
Cash Surrender Value	$	30,000.00
Policy Loan	$	0.00
Death Benefit Payable	$	47,000.00
Cash Surrender Value available for loan	$	0.00

* *Equal to the Accelerated Death Benefit*

** *Equal to the Accelerated Death Benefit plus 12 months of interest. This illustration assumes a loan interest rate of 6%. The actual rate applicable is described in the Effect of an Accelerated Death Benefit section of this Summary.*

Premiums: There are no premiums for this benefit.

Acknowledgement: I acknowledge that I have received and read the Summary and Disclosure Statement for Accelerated Death Benefit which was furnished to me prior to signing the application.

_____ _____
Signature of Proposed Insured Date

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

_____ _____
Signature of Agent Date

For electronic use only - AGENT ONLY

I hereby certify that my electronic approval serves as my signature for legal and regulatory purposes for this application

Electronic Signature of _____ was
Broker or Agent

obtained _____ at _____.
Date *Time*

RETURN THIS SIGNED ACKNOWLEDGEMENT TO HOME OFFICE

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: The rider is intended to provide an accelerated death benefit which will qualify for favorable tax treatment under Section 101(g)(1)(B) of the Internal Revenue Code of 1986, as amended or its successor (the "Code"), except as provided in Section 101(g)(5) of the Code. Tax laws relating to acceleration of life insurance benefits are complex. As with all tax matters, you should consult a personal tax advisor to assess the impact of any benefit received under the rider.

Receipt of acceleration-of-life-insurance benefits may affect the recipient, the recipient's spouse or the recipient's family's eligibility for public assistance programs such as medical assistance (Medicaid), Aid to Families with Dependent Children (AFDC), supplementary social security income (SSI), and drug assistance programs. You are advised to consult with a qualified tax advisor and with social service agencies concerning how receipt of such a payment will affect the recipient, the recipient's spouse and recipient's family's eligibility for public assistance.

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 of at least 90 days due to the 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, provided at the Owner or Insured's expense, certifying that the Insured is Chronically Ill and as set forth in a Plan of Care in need of necessary diagnostic, preventative, therapeutic, curing, treating, mitigating and rehabilitative services and Maintenance or Personal Care Services, likely for the rest of the Insured's life.

Written Re-certification: Means Written Certification, at our expense, provided prior to the start of each benefit period after the first.

BENEFIT

The Monthly Benefit is subject to a maximum chosen by the Owner. 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 benefits under the rider when each of the following conditions are met: (1)We receive your written request for the Accelerated Death Benefit; (2) We receive Written Certification or Written Re-certification; (3) The Policy and the 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 Insured is Chronically Ill at the time a benefit payment is made.

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 accelerated death benefit payment will reduce the following values by a proportional amount equal to the monthly benefit payment, before reduction for repayment of Policy Debt, divided by the death benefit immediately before the payment: (1) Policy Value; (2) Face amount; (3) Surrender charges, if any; (4) Lapse Protection Account Value, if any, (5) Minimum premium requirements for lapse protection, if any; (6 Cumulative minimum premium requirements for lapse protection, if any; (7) Cumulative premiums paid to date; and (8) Policy Debt, if any. An amount equal to Policy Debt reduction will be applied to repay the Policy debt, and thus will reduce the net amount of proceeds distributable as an accelerated death benefit.

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 $250,000;
3. A $5000 monthly benefit payment is required following the 19th policy anniversary;
4. A single loan of $500 has been taken at the beginning of Policy Year 19, no withdrawals have been taken, and the Monthly Benefit payments are assumed to begin at the beginning of Policy year 20; 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 19)

Face Amount ……	$	250,000.00	Minimum Lapse Protection Premium: ……	$	0
Policy Value: ……	$	9,324.82	Cumulative Premiums for Lapse Protection:	$	0
Surrender Charges: ……	$	0	Cumulative Premiums Paid to Date: ……	$	37,111.56
Lapse Protection Account Value……	$	24,328.05	Policy Debt: ……	$	522.87

Immediately After Election is Made (at the beginning of Policy Year 20)

Face Amount: ……	$	245,000	Minimum Lapse Protection Premium: ……	$	0
Policy Value: ……	$	9,138.33	Cumulative Premiums for Lapse Protection:	$	0
Surrender Charges: ……	$	0	Cumulative Premiums Paid to Date: ……	$	36,369.33
Lapse Protection Account Value……	$	23,920.10	Policy Debt: ……	$	512.41

Policy Loan Repayment: …… $10.46
Net Monthly Benefit: …… $4,989.54

12 Months after Election is Made (at the beginning of Policy Year 21)

Face Amount: ……	$	190,000.00	Minimum Lapse Protection Premium:……	$	0
Policy Value: ……	$	5,782.93	Cumulative Premiums for Lapse Protection:	$	0
Surrender Charges: ……	$	0	Cumulative Premiums Paid to Date: ……	$	28,204.79
Lapse Protection Account Value……	$	18,500.21	Policy Debt: ……	$	417.25

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

PLEASE RETAIN THIS COPY FOR YOUR RECORDS

PROPOSED INSURED/OWNER COPY

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: The rider is intended to provide an accelerated death benefit which will qualify for favorable tax treatment under Section 101(g)(1)(B) of the Internal Revenue Code of 1986, as amended or its successor (the "Code"), except as provided in Section 101(g)(5) of the Code. Tax laws relating to acceleration of life insurance benefits are complex. As with all tax matters, you should consult a personal tax advisor to assess the impact of any benefit received under the rider.

Receipt of acceleration-of-life-insurance benefits may affect the recipient, the recipient's spouse or the recipient's family's eligibility for public assistance programs such as medical assistance (Medicaid), Aid to Families with Dependent Children (AFDC), supplementary social security income (SSI), and drug assistance programs. You are advised to consult with a qualified tax advisor and with social service agencies concerning how receipt of such a payment will affect the recipient, the recipient's spouse and recipient's family's eligibility for public assistance.

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 of at least 90 days due to the 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, provided at the Owner or Insured's expense, certifying that the Insured is Chronically Ill and as set forth in a Plan of Care in need of necessary diagnostic, preventative, therapeutic, curing, treating, mitigating and rehabilitative services and Maintenance or Personal Care Services, likely for the rest of the Insured's life.

Written Re-certification: Means Written Certification, at our expense, provided prior to the start of each benefit period after the first.

BENEFIT

The Monthly Benefit is subject to a maximum chosen by the Owner. 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 benefits under the rider when each of the following conditions are met: (1)We receive your written request for the Accelerated Death Benefit; (2) We receive Written Certification or Written Re-certification; (3) The Policy and the 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 Insured is Chronically Ill at the time a benefit payment is made.

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 accelerated death benefit payment will reduce the following values by a proportional amount equal to the monthly benefit payment, before reduction for repayment of Policy Debt, divided by the death benefit immediately before the payment: (1) Policy Value; (2) Face amount; (3) Surrender charges, if any; (4) Lapse Protection Account Value, if any, (5) Minimum premium requirements for lapse protection, if any; (6 Cumulative minimum premium requirements for lapse protection, if any; (7) Cumulative premiums paid to date; and (8) Policy Debt, if any. An amount equal to Policy Debt reduction will be applied to repay the Policy debt, and thus will reduce the net amount of proceeds distributable as an accelerated death benefit.

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 $250,000;
3. A $5000 monthly benefit payment is required following the 19th policy anniversary;
4. A single loan of $500 has been taken at the beginning of Policy Year 19, no withdrawals have been taken, and the Monthly Benefit payments are assumed to begin at the beginning of Policy year 20; 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 19)

Face Amount ……	$	250,000.00	Minimum Lapse Protection Premium: ……	$	0
Policy Value: ……	$	9,324.82	Cumulative Premiums for Lapse Protection:	$	0
Surrender Charges: ……	$	0	Cumulative Premiums Paid to Date: ……	$	37,111.56
Lapse Protection Account Value……	$	24,328.05	Policy Debt: ……	$	522.87

Immediately After Election is Made (at the beginning of Policy Year 20)

Face Amount: ……	$	245,000	Minimum Lapse Protection Premium: ……	$	0
Policy Value: ……	$	9,138.33	Cumulative Premiums for Lapse Protection:	$	0
Surrender Charges: ……	$	0	Cumulative Premiums Paid to Date: ……	$	36,369.33
Lapse Protection Account Value……	$	23,920.10	Policy Debt: ……	$	512.41

Policy Loan Repayment: …… $10.46
Net Monthly Benefit: …… $4,989.54

12 Months after Election is Made (at the beginning of Policy Year 21)

Face Amount: ……	$	190,000.00	Minimum Lapse Protection Premium:……	$	0
Policy Value: ……	$	5,782.93	Cumulative Premiums for Lapse Protection:	$	0
Surrender Charges: ……	$	0	Cumulative Premiums Paid to Date: ……	$	28,204.79
Lapse Protection Account Value……	$	18,500.21	Policy Debt: ……	$	417.25

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

RETURN THIS COPY TO HOME OFFICE

HOME OFFICE COPY

PROTECTIVE LIFE INSURANCE COMPANY

P.O. BOX 830619 • BIRMINGHAM, ALABAMA 35283-0619

DISCLOSURE FORM FOR CHRONIC ILLNESS ACCELERATED DEATH BENEFIT RIDER

NOTICE: The rider is intended to provide an accelerated death benefit which will qualify for favorable tax treatment under Section 101 (g)(1)(B) of the Internal Revenue Code, as amended, or its successor, except as provided in Section 101(g)(5) of the Internal Revenue Code, as amended, or its successor. As with all tax matters, the Owner should consult a personal tax advisor to assess the impact of any benefit received under the rider. Any benefit received under the rider may impact the recipient's eligibility for Medicaid or other government benefits.

PURPOSE OF DISCLOSURE FORM

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

GENERAL DESCRIPTION

The rider provides for accelerated death benefit payments each Benefit Period (subject to a lifetime maximum benefit), during the lifetime of the Insured and while the rider is in force, if the Insured is first diagnosed as being a Chronically Ill Individual by a Licensed Health Care Practitioner after the Effective Date and all of the terms and conditions of the rider are met. The accelerated death benefit amount the Company will pay each Benefit Period is called the Maximum Monthly Benefit.

DEFINITIONS

Benefit Period: The initial Benefit Period is the 12 month period beginning on the 1st monthly anniversary after approval of a request for accelerated benefits. Each subsequent benefit period is the 12 month period beginning on the 1st monthly anniversary after the most recent Benefit Period and satisfaction of the eligibility for benefits requirements.

Maximum Monthly Benefit: Means the maximum amount that can be accelerated in any single month during each Benefit Period (may be taken as a lump sum equal to the sum of the present value of the Maximum Monthly Benefit, before adjustments for Policy Debt, for each month of the Benefit Period).

Chronically Ill: Means that the Insured has been certified, within the preceding 12 months, by a Licensed Health Care Practitioner as:

1. Being unable to perform, without Substantial Assistance from another individual, at least two Activities of Daily Living for a period of at least 90 days due to a loss of functional capacity; or,
2. Requiring Substantial Supervision to protect the Insured from threats to health and safety due to Severe Cognitive Impairment.

ELIGIBILITY FOR BENEFITS

The Insured will become eligible, each Benefit Period, for Accelerated Death Benefit payments during the life of the Insured when each of the following conditions are met:

1. We receive Your written request for the Accelerated Death Benefit;
2. We receive Written Certification or Written Re-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 Waiting Period has expired; and
6. The Insured is Chronically Ill at the time a benefit payment is made.

IMPACT ON THE POLICY

Proportional Reductions: 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. Minimum premium requirements for lapse protection, if any;
5. Cumulative minimum premium requirements for lapse protection, if any;
6. Cumulative premiums paid to date; and
7. 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

Waiver of Costs: During any Benefit Period, the Monthly Deduction will cease until such time as the benefit payments are discontinued. This Waiver of Costs is in place of any benefit providing a waiver/credit of premium under any other rider or endorsement attached to the policy.

I acknowledge receipt of the Disclosure Form for Chronic Illness Accelerated Death Benefit Rider.

City & State: _____ Date: _____

Agent (Print Name): _____ Agent Signature: _____

Applicant / Owner (Print Name): _____ Applicant / Owner (Sign Full Name): _____

RETURN THIS SIGNED ACKNOWLEDGMENT TO HOME OFFICE

ORIGINAL – HOME OFFICE

PROTECTIVE LIFE INSURANCE COMPANY

P.O. BOX 830619 • BIRMINGHAM, ALABAMA 35283-0619

DISCLOSURE FORM FOR CHRONIC ILLNESS ACCELERATED DEATH BENEFIT RIDER

NOTICE: The rider is intended to provide an accelerated death benefit which will qualify for favorable tax treatment under Section 101 (g)(1)(B) of the Internal Revenue Code, as amended, or its successor, except as provided in Section 101(g)(5) of the Internal Revenue Code, as amended, or its successor. As with all tax matters, the Owner should consult a personal tax advisor to assess the impact of any benefit received under the rider. Any benefit received under the rider may impact the recipient's eligibility for Medicaid or other government benefits.

PURPOSE OF DISCLOSURE FORM

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

GENERAL DESCRIPTION

The rider provides for accelerated death benefit payments each Benefit Period (subject to a lifetime maximum benefit), during the lifetime of the Insured and while the rider is in force, if the Insured is first diagnosed as being a Chronically Ill Individual by a Licensed Health Care Practitioner after the Effective Date and all of the terms and conditions of the rider are met. The accelerated death benefit amount the Company will pay each Benefit Period is called the Maximum Monthly Benefit.

DEFINITIONS

Benefit Period: The initial Benefit Period is the 12 month period beginning on the 1st monthly anniversary after approval of a request for accelerated benefits. Each subsequent benefit period is the 12 month period beginning on the 1st monthly anniversary after the most recent Benefit Period and satisfaction of the eligibility for benefits requirements.

Maximum Monthly Benefit: Means the maximum amount that can be accelerated in any single month during each Benefit Period (may be taken as a lump sum equal to the sum of the present value of the Maximum Monthly Benefit, before adjustments for Policy Debt, for each month of the Benefit Period).

Chronically Ill: Means that the Insured has been certified, within the preceding 12 months, by a Licensed Health Care Practitioner as:

1. Being unable to perform, without Substantial Assistance from another individual, at least two Activities of Daily Living for a period of at least 90 days due to a loss of functional capacity; or,
2. Requiring Substantial Supervision to protect the Insured from threats to health and safety due to Severe Cognitive Impairment.

ELIGIBILITY FOR BENEFITS

The Insured will become eligible, each Benefit Period, for Accelerated Death Benefit payments during the life of the Insured when each of the following conditions are met:

1. We receive Your written request for the Accelerated Death Benefit;
2. We receive Written Certification or Written Re-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 Waiting Period has expired; and
6. The Insured is Chronically Ill at the time a benefit payment is made.

IMPACT ON THE POLICY

Proportional Reductions: 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. Minimum premium requirements for lapse protection, if any;
5. Cumulative minimum premium requirements for lapse protection, if any;
6. Cumulative premiums paid to date; and
7. 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

Waiver of Costs: During any Benefit Period, the Monthly Deduction will cease until such time as the benefit payments are discontinued. This Waiver of Costs is in place of any benefit providing a waiver/credit of premium under any other rider or endorsement attached to the policy.

I acknowledge receipt of the Disclosure Form for Chronic Illness Accelerated Death Benefit Rider.

City & State: _____ Date: _____

Agent (Print Name): _____ Agent Signature: _____

Applicant / Owner (Print Name): _____ Applicant / Owner (Sign Full Name): _____

PLEASE RETAIN THIS COPY FOR YOUR RECORDS

COPY – OWNER

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)

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

IMPORTANT NOTICE: REPLACEMENT OF LIFE INSURANCE OR ANNUITIES

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

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

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

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

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

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

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing life insurance policy or annuity contract? ☐ Yes ☐ No

2. Are you considering using funds from your existing policies or annuity contracts to pay premiums due on the new life insurance policy or annuity contract? ☐ Yes ☐ No

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

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

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

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

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

_____ | _____ _____
Applicant’s Signature Printed Name Date

_____ | _____ _____
Insurance Producer’s/Agent Signature Printed Name Date

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

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

PREMIUMS:

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

POLICY VALUES:

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

INSURABILITY:

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

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

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

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

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

OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:

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

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

IMPORTANT NOTICE ABOUT THE POLICY OF INSURANCE FOR WHICH YOU HAVE APPLIED

THIS DOCUMENT AFFECTS YOUR LEGAL RIGHTS

READ THE FOLLOWING INFORMATION CAREFULLY.

1. The policy for which you have applied includes a binding arbitration agreement.

2. The arbitration agreement requires that any disagreement related to this policy must be resolved by arbitration and not in a court of law.

3. The results of the arbitration are final and binding on you and the insurance company.

4. In an arbitration, an arbitrator, who is an independent, neutral party, gives a decision after hearing the positions of the parties.

5. When you accept this insurance policy you agree to resolve any disagreement related to the policy by binding arbitration instead of a trial in court, including a trial by jury.

6. Arbitration takes the place of resolving disputes by a judge and jury and the decision of the arbitrator cannot be reviewed in court by a judge and jury.

ACKNOWLEDGMENT OF ARBITRATION AGREEMENT

I have read this statement. I understand that I am voluntarily surrendering my right to have any disagreement between the insurance company and myself resolved in court. This means I am waiving my right to a trial by jury.

I understand that upon receipt of the policy, I should read the arbitration clause contained in the policy and that I have the right to reject this policy within thirty (30) days of the date of delivery if I do not want to accept the requirement for arbitration.

I understand that this same type of insurance may be available through an insurance company that does not require that policy related disagreement be resolved by binding arbitration.

_____ _____

Applicant/Owner Date

_____ _____

Broker/Representative Date

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)