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

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

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

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

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

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

Special Request:

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

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

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

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

Agent:

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

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

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

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

Agent's Telephone Number | Agent's Email Address

Protective

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

SUPPLEMENT TO LIFE INSURANCE APPLICATION — APPLICATION SUPPLEMENT – PART I

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

Print Name of Proposed Insured(s): _____

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

SIGNATURES

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

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

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

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

NOTIFICATION OF RIGHT TO NAME A SECONDARY ADDRESSEE

Under California law, you have the right to designate a secondary addressee to receive a notice concerning the potential lapse of your policy. The notice to the secondary addressee will be sent when the policy is in danger of lapsing.

If you wish to name a secondary addressee, please call us at 1-800-366-9378, or fax us at 1-205-268-5807, or write us at P.O. Box 830619, Birmingham, Alabama 35283-0619.

Please Print the Following Information:

_____
Policy Number (if known)

_____
Policy Owner's Name

_____
Insured's Name

Secondary Addressee:

_____
Name

_____
Street Address or P.O. Box

_____
City, State, Zip Code

TEMPORARY LIFE INSURANCE RECEIPT

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

Premium payment in the amount of $_____ is made for Life Insurance on each person proposed for insurance. **ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO THE INSURANCE COMPANY – DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.**

QUALIFYING SCREENING QUESTIONS

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

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

TERMS AND CONDITIONS

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

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

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

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

DATE COVERAGE BEGINS

Temporary Life Insurance under this Receipt will begin on the date this Receipt is executed and the application has been completed.

DATE COVERAGE TERMINATES

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

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

LIMITATIONS

This receipt does not provide benefits for disability. If Temporary Life Insurance is terminated in accordance with (a) above, Protective Life's liability under this Receipt is limited to a refund of the premium payment made. If any person proposed for insurance dies by suicide, Protective Life's liability under this Receipt is limited to a refund of the payment made. There is no coverage under this Receipt if the check submitted as payment is not honored by the bank on first presentation. No one is authorized to waive or modify any of the provisions of this Receipt. COVERAGE UNDER THIS RECEIPT SHALL BE VOID IF THERE IS FRAUD OR A MATERIAL MISREPRESENTATION IN THE APPLICATION FOR LIFE INSURANCE OR IN ANY ANSWER TO THE QUALIFYING SCREENING QUESTIONS OF THIS RECEIPT.

I (WE) HAVE RECEIVED A COPY OF AND HAVE READ THIS TEMPORARY LIFE INSURANCE RECEIPT AND DECLARE THAT THE ANSWERS ARE TRUE TO THE BEST OF MY (OUR) KNOWLEDGE AND BELIEF. I (WE) UNDERSTAND AND AGREE TO ALL ITS TERMS.

Signed At _____

Date _____

(X) _____
Witnessed by Agent

_____
Agent Name (Printed)

_____
Street Address

_____
City, State and Zip

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

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

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

(X) _____
*Applicant/Owner, if Other than Proposed Insured

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

NOTICE TO APPLICANT:

You should retain the copy of this Receipt. The original will be retained by Protective Life. If you do not hear from us regarding the insurance applied for within 100 days from the date of this Receipt, notify us at Protective Life Insurance Company, P.O. Box 830619, Birmingham, Alabama 35283-0619, Attention: Vice President, Underwriting Services.

ORIGINAL – HOME OFFICE **COPY – APPLICANT**

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: (205) 879-9230

NOTICE REGARDING REPLACEMENT

REPLACING YOUR LIFE INSURANCE POLICY OR ANNUITY?

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

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

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

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

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

_____ _____ _____

Applicant's Signature Date Agent's Signature

****

POLICY INFORMATION SHEET FOR EXISTING INSURANCE

Name of Applicant _____ D.O.B. _____

Address _____

Proposed Insured if other than Applicant _____

Application Number of Proposed Insurance _____

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

POLICY INFORMATION

Insurer _____

Policy Generic Name _____

Policy Number _____

POLICY INFORMATION

Insurer _____

Policy Generic Name _____

Policy Number _____

POLICY INFORMATION

Insurer _____

Policy Generic Name _____

Policy Number _____

POLICY INFORMATION

Insurer _____

Policy Generic Name _____

Policy Number _____

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)