



# DON BOOZER & ASSOCIATES

P: 800-543-0886 F: 940-315-8434

Email: [NewBusiness@DonBoozer.com](mailto:NewBusiness@DonBoozer.com)

TeleLife® Application Transmittal

## Agent Information

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Agent Name:

Appointment #:

Agent Phone:

Email:

## Required Forms

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- 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

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- 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

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- ◆ 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

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## Applicant's Checklist

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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 hospital(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



TeleLife®  
FAX # 1-888-543-0886

<b>APPLICATION FOR INDIVIDUAL LIFE INSURANCE</b>				Owner, if other than proposed insured	Owner's Address																				
Proposed Primary Insured <input type="checkbox"/> Proposed Other Insured <input type="checkbox"/>				Relationship to Proposed Insured																					
Name Last First MI <input type="checkbox"/> Male <input type="checkbox"/> Female				Social Security or Tax ID #																					
Street				Primary Beneficiary (name, relationship and percentage)																					
City State Zip				Contingent Beneficiary (name, relationship and percentage)																					
Social Security Number Occupation				Will this policy replace or change any existing life insurance or annuity in force? <input type="checkbox"/> Yes <input type="checkbox"/> No																					
Birthplace Birthdate Driver's License #				Does the applicant have existing life insurance policies or annuity contracts other than group insurance in force? <input type="checkbox"/> Yes <input type="checkbox"/> No																					
Home Phone ( ) Cell Phone ( ) Business Phone ( )				If yes, list below:																					
Where do you wish to be reached for additional information? <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell Best times: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.				<table style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left; border-bottom: 1px solid black;">Company Names</th> <th style="text-align: left; border-bottom: 1px solid black;">Face Amount</th> <th style="text-align: left; border-bottom: 1px solid black;">Year Issued</th> <th style="text-align: left; border-bottom: 1px solid black;">To Be Replaced?</th> </tr> </thead> <tbody> <tr> <td> </td> <td> </td> <td> </td> <td style="text-align: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td> </td> <td> </td> <td> </td> <td style="text-align: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td> </td> <td> </td> <td> </td> <td style="text-align: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td> </td> <td> </td> <td> </td> <td style="text-align: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> </tbody> </table>		Company Names	Face Amount	Year Issued	To Be Replaced?				<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Yes <input type="checkbox"/> No
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			<input type="checkbox"/> Yes <input type="checkbox"/> No																						
			<input type="checkbox"/> Yes <input type="checkbox"/> No																						
Annual Income Net Worth				Do you have an application pending in another company? <input type="checkbox"/> Yes <input type="checkbox"/> No																					
Initial Death Benefit \$				Have you ever had any life or health insurance declined, postponed or offered other than as applied for? <input type="checkbox"/> Yes <input type="checkbox"/> No																					
Plan of Insurance:				Is Proposed Insured a U.S. Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No																					
Riders: <input type="checkbox"/> WP <input type="checkbox"/> ADB <input type="checkbox"/> CTR <input type="checkbox"/> Other: _____ Indicate Amount for Riders: \$ _____				Has Proposed Insured used tobacco in any form in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No 36 months? <input type="checkbox"/> Yes <input type="checkbox"/> No 60 months? <input type="checkbox"/> Yes <input type="checkbox"/> No																					
Mode of Premium Payment: <input type="checkbox"/> Annual <input type="checkbox"/> SA <input type="checkbox"/> Qtrly <input type="checkbox"/> PAC				Special Request:																					
Rate Class Quoted: _____ Premium Quoted: _____																									
Amount remitted with this application, in exchange for this Company receipt: \$				<p><b>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.</b></p> <p><b>Authorization To Obtain And Disclose Information: I (we) hereby authorize:</b> 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. <b>I (we)</b> 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. <b>I (we)</b> 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.</p>																					
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)? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "Yes," complete any required replacement forms.)				<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> 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. 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?																									
Print Agent's Name/Social Security Number or Agent Code				Agent's Signature																					
Agent's Telephone Number				Date																					
Agent's Email Address				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:

- (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?
(2) Will any portion of the initial or future premiums be borrowed, loaned or otherwise financed?
(3) Will a trust, including family trust, own this policy?
(4) Is the Proposed Insured age 65 or older AND total coverage applied for across all Protective companies \$1,000,000 or more?

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. 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 \_\_\_\_\_, this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.

Signature(s) of Proposed Insured(s): X \_\_\_\_\_ SIGN HERE
Signature(s) of Owner(s)/Trustee(s): 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 plus 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 and 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.**

## **THE CIVIL UNION AND EQUALITY ACT OF 2011 DELAWARE**

Protective Life Insurance Company complies with The Civil Union and Equality Act of 2011 ("the Act").

The Act provides that parties to a civil union (as defined in the Act) are entitled to the same legal obligations, responsibilities, protections, and benefits that are afforded or recognized by the laws of the State of Delaware to spouses. For the purposes of interpreting this policy or contract under the Act, a party to a civil union will be included in any definition or use of the terms "spouse", "family", "immediate family", "dependent", "next of kin", "stepparent", "tenants by the entirety" and any other terms, whether or not gender-specific, that describe a spousal relationship.

Please note that the laws of the State of Delaware have no effect on the status of this policy or contract under the laws of the United States, which may affect the federal tax status of the owner and any beneficiary.

This notice is required by the State of Delaware.

# 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 \$300, 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.

<b>Acknowledgement:</b> 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

<b>For electronic use only - AGENT ONLY</b>	
I hereby certify that my electronic approval serves as my signature for legal and regulatory purposes for this application	
Electronic Signature of _____	_____ was
<i>Broker or Agent</i>	
obtained _____ at _____	
<i>Date</i>	<i>Time</i>

**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.

### **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 \$300, 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.

<b>Acknowledgement:</b> 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**



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.

**PROTECTIVE LIFE INSURANCE COMPANY  
HOME OFFICE - BIRMINGHAM ALABAMA**

**NOTICE TO APPLICANT REGARDING  
REPLACEMENT OF LIFE INSURANCE**

It is in your best interest to get all the facts before making a decision. Make sure you fully understand both the proposed new policy and your existing insurance. New policies may contain provisions which limit benefits during the initial period of the contract, in particular, the suicide and incontestable clauses.

To assist you in evaluating the proposed and the existing insurance, Delaware Insurance Regulation 30 requires that the insurer advising or recommending replacement:

Provide the consumer with a concise summary of the policy it proposes to issue;

Allow a twenty day period following the delivery of the policy during which time the consumer may surrender the new policy for a full refund;

Advise the present insurance company(s) of the pending replacement.

This same regulation requires your present insurer to provide, on your request, a similar summary describing your present insurance. This information will be provided if you request it using the form below.

**INFORMATION OF PRESENT POLICIES**

<b>Company Name</b>	<b>Policy Number</b>	<b>Name of Insured</b>	<b>Summary Requested mark yes or no</b>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

(continue on reverse as required)

**IT IS SELDOM WISE TO TERMINATE YOUR EXISTING POLICY UNTIL YOUR NEW POLICY HAS BEEN ISSUED AND YOU HAVE EXAMINED IT AND FOUND IT TO BE ACCEPTABLE.**

I have read this notice and received a copy of it.

\_\_\_\_\_  
Applicant's signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Agent's signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Agent's name and address (printed)

\_\_\_\_\_  
Company Name

ORIGINAL - HOME OFFICE    COPY - APPLICANT

# 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](http://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.

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

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Email Address for Proposed Insured

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