



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



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 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

APPLICATION FOR INDIVIDUAL LIFE INSURANCE				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>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.</p> <p>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.</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 _____ 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:
(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 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):
Signature(s) of Owner(s)/Trustee(s):
Signature of Witness:

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 Producer Signature Producer Name (Print)

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 PROTECTIVE LIFE INSURANCE COMPANY.

DO NOT MAKE CHECKS 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?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 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?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. | within the past 5 years, been rated or declined for insurance?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. | Is any person proposed for insurance in this application under 15 days of age or over the age of 80 years (nearest birthday)?.. | <input type="checkbox"/> | <input type="checkbox"/> |

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. No one is authorized to accept a premium on Proposed Insureds under 15 days of age or over age 80.

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 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 life, or (ii) \$50,000.

In no event shall Protective Life's liability under this Receipt exceed \$1,000,000.

DATE COVERAGE BEGINS: Temporary Life Insurance under this Receipt will begin on the date the Application has been completed and the premium has been paid.

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 an adverse underwriting decision, as defined in **K.S.A. 40-2.111**, 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. In the event of an adverse underwriting decision, as defined in **K.S.A. 40-2.111**, 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. 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: _____ (City) _____ (State) Date: _____

(X) _____ (X) _____
 Witnessed by Agent Proposed Insured 1 (Sign Name in Full)

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

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

_____ (X) _____
 City, State, Zip *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 P.O. Box 830619, Birmingham, AL 35283-0619, Attention: Underwriting Services.



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
POST OFFICE BOX 830619
BIRMINGHAM, ALABAMA 35283-0619
TELEPHONE: (205) 879-9230

IMPORTANT NOTICE REGARDING REPLACEMENT OF LIFE INSURANCE

Our agent is recommending that you purchase a life insurance policy from us. In connection with this purchase, you have indicated either as a result of his recommendation or at your own initiative, that you may terminate or change your existing policy issued by our company or another insurance company or that you may obtain a loan against your existing policy to pay premiums on the proposed policy. Any of these actions is a replacement of life insurance. This notice must be given to you. Please read this notice carefully.

Whether it is to your advantage to replace your existing insurance coverage, only you can decide. It is in your best interest, however, to have adequate information before a decision to replace your present coverage becomes final so that you may understand the essential features of the proposed policy and of your existing insurance coverage.

To this end, we are required to give you a Policy Summary including complete information on the proposed policy no later than when the policy is delivered to you. In addition, we are required to notify the insurance company that issued your existing policy (if not issued by our company). That company may then furnish you with additional information concerning your existing policy. If applicable, you may want to contact that company or its agent for further information and advice or discuss your purchase with other advisors. The information you receive will be of value to you in reaching a final decision.

If either the proposed policy or the existing insurance you intend to replace is a participating policy, you should be aware that dividends may materially reduce the cost of insurance and are an important factor to consider. Dividends, however, are not guaranteed.

You should also recognize that a policy which has been in existence for a period of time may have certain advantages to you over a new policy. If the policy coverages are basically similar, the premiums for a new policy may be higher because rates increase as your age increases. Under your existing policy, the period of time during which the issuing company could contest the policy because of a material misstatement or omission on your application, or deny coverage for death caused by suicide, may have expired or may expire earlier than it will under the proposed policy. Your existing policy may have options which are not available under the policy being proposed to you or may not come into effect under the proposed policy until a later time during your life. Also, your proposed policy's cash values and dividends, if any, may grow slower initially because the company will incur the cost of issuing your new policy. On the other hand, the proposed policy may offer advantages which are more important to you.

If you are considering borrowing against your existing policy to pay the premiums on the proposed policy, you should understand that in the event of your death, the amount of any unpaid loan, including unpaid interest, will be deducted from the benefits of your existing policy thereby reducing your total insurance coverage.

After we have received your application and notified the other insurance company (if applicable), you will have twenty days from the date the proposed policy is delivered to you to cancel the policy issued on your application and receive back all payments you made to us.

CAUTION

If, after studying the information made available to you, you decide to replace the existing life insurance with our life insurance policy, you are urged not to take action to terminate or alter your existing life insurance coverage until after you have been issued the new policy, examined it and have found it to be acceptable to you. If you should terminate or otherwise materially alter your existing coverage and fail to qualify for the life insurance for which you have applied, you may find yourself unable to purchase other life insurance or able to purchase it only at substantially higher rates.

By _____
Agent or Employee*

I have received and read a copy of this Replacement Notice.

(Signed) _____ Date _____

*Agent's signature is always required in Montana and Ohio. Agent's signature is not required in Arizona or Kansas if application contains appropriate information.

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)