



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



TeleLife®
FAX # 1-888-543-0886

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		Contingent Beneficiary (name, relationship and percentage)	
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? <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell Best times: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.					
Annual Income			Net Worth		
Initial Death Benefit \$					
Plan of Insurance:					
Riders: <input type="checkbox"/> WP <input type="checkbox"/> ADB <input type="checkbox"/> CTR <input type="checkbox"/> Other: _____ Indicate Amount for Riders: \$ _____					
Mode of Premium Payment: <input type="checkbox"/> Annual <input type="checkbox"/> SA <input type="checkbox"/> Qtrly <input type="checkbox"/> PAC					
Rate Class Quoted: _____ Premium Quoted: _____					
Amount remitted with this application, in exchange for this Company receipt: \$					
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.					
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)? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "Yes," complete any required replacement forms.) Has the Owner been provided an illustration which conforms to this application? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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:

- (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 (Month) day of (Year)

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.



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.



P.O. Box 830619, Birmingham, Alabama 35283-0619 • (205) 879-9230

DISCLOSURE STATEMENT

THIS DISCLOSURE STATEMENT WITH ALL APPLICABLE BLANKS FILLED IN IS FOR YOUR PROTECTION. IT GIVES YOU BASIC INFORMATION ABOUT THE COST AND COVERAGE OF THE INSURANCE BEING SOLICITED. READ IT CAREFULLY BEFORE SIGNING ANY AGREEMENT TO BUY LIFE INSURANCE.

THIS DISCLOSURE STATEMENT SHALL NOT BE CONSIDERED AS AN OFFER TO CONTRACT OR AS ALTERING OR MODIFYING ANY POLICY OR RIDER THAT MAY BE ISSUED.

Name of Proposed Insured _____ Age _____ Sex _____

Name of Agent preparing disclosure _____

Agent home or agency address _____

Telephone number of Agent _____ Name of Insurer: Protective Life Insurance Company

Home office address of Insurer: P.O. Box 830619, Birmingham, Alabama 35283-0619

Direct all correspondence to above address.

	Descriptive Title of Coverage	Face Amount of Coverage (1) If Not Applicable, Description of Coverage	Annual Premium If Not Known, Premium For Mode Quoted (2)
*Policy			
*Rider(s)			
*Supplemental Benefit(s) (Built into policy)			The cost is included in the premium for the policy.

1. The face amount of coverage of the (policy, rider, supplemental benefit) changes as follows _____

2. Total Initial (annual, semi-annual, quarterly, & monthly) premium for the policy and riders, if any, will be _____.

*Guaranteed Cash Value. If you continuously pay your premiums on this policy as they come due, you will have the following guaranteed cash value for each \$1,000 (or face amount). *You may borrow against this cash value at any annual _____% loan interest charge.

Number of Years Policy Has Been In Force	5	10	20	Age 65
Total Accumulated Cash Value per \$1,000 (or Total Face Amount)	\$	\$	\$	\$

*A Surrender Comparison Index will be provided upon delivery of the policy or earlier if requested. This index provides one means of comparing the relative costs of two or more similar policies.

*The prospective insured has _____ has not _____ requested an earlier delivery of the Index.

Upon request either the company or agent will furnish you with additional information about the insurance described.

*If inapplicable to insurance being offered, section may be deleted entirely or clearly marked "Not Applicable."

**SURRENDER COMPARISON INDEX DISCLOSURE
PER \$1,000 OF FACE AMOUNT OF BASIC INSURANCE**

Name of Insured _____ Age _____ Sex _____

Face amount of Policy _____

Descriptive Title of Policy _____

Policy Number _____

*10 Year Surrender Index _____

*20 Year Surrender Index _____

The Surrender Comparison Index was designed to measure the relative cost of life insurance protection and may be useful for comparison of similar policies offered by other companies. Technically, the Index shows the relationship between the amounts paid by the insured and the amounts paid by the insurer (the cash value of the policy in the event of surrender over periods of 10 and 20 years all adjusted for compound interest at the rate of five percent per annum to reflect the timing of the payments).

When comparing similar policies, if all things are equal, the policy with the lower Index is generally the lower cost policy and the better buy in the event that the policy was surrendered at the end of the designated period. If death would occur during the designated period, the policy with the lower Index would not necessarily be the lower cost policy. The Index does not take into account, among other things: (1) the value of the services of an agent or company; (2) the relative strength and reputation of the company; and (3) small differences in policy provisions. The Index does assume that annual premiums are paid and that no additional benefit provisions are included.

* If inapplicable to insurance being offered, section may be deleted entirely or clearly marked "Not Applicable."

CERTIFICATION OF DISCLOSURE

I certify that the written disclosure statement required by Chapter 83 of the Pennsylvania Regulations was given to the proposed insured above on or before the date the application was completed.

Dated: _____ Signature of Agent: _____

PROTECTIVE LIFE INSURANCE COMPANY
P.O. BOX 830619
BIRMINGHAM, ALABAMA 35283-0619
TELEPHONE: 205-879-9230

NOTICE REGARDING REPLACEMENT OF LIFE INSURANCE AND ANNUITIES

You have indicated that you intend to replace existing life insurance or annuity coverage in connection with the purchase of our life insurance or annuity policy. As a result, we are required to send you this notice. Please read it carefully.

Whether it is to your advantage to replace your existing insurance or annuity 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 your existing insurance or annuity coverage.

You may want to contact your existing life insurance or annuity company or its agent for additional information and advice or discuss your purchase with other advisors. Your existing company will provide this information to you. The information you receive should be of value to you in reaching a final decision.

If either the proposed coverage or the existing coverage you intend to replace is participating, 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 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 misrepresentation or omission concerning the medical information requested in 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 issued your policy, you will have 20 days from the date the new policy is received by you to notify us you are cancelling the policy issued on your application and you will receive back all payments you made to us.

You are urged not to take action to terminate or alter your existing life insurance or annuity coverage until you have been issued the new policy, examined it and have found it acceptable to you.

Insurer
as it appears on the policy or contract

Insured
as it appears on the policy or contract

Policy or Contract Number

Insured Birthdate

Agent's Signature

Applicant's Signature

Date

Date

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)