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

Application for Critical Illness Insurance and/or Term Life Insurance with Critical Illness

❑ New Business ❑ Protective Policy Change from Policy_____ **Policy No.:** _____

APPLICATION PART 1

Proposed Insured (Please print full name)

Address	City	State	Zip Code

Sex	Social Security No.	Home Phone No.

Date of Birth	Birth Place (State or Country)	Age	Driver's License #

Occupation	Employer	Annual Income	Net Worth
		$	$

COVERAGE DETAILS

Plan Name	Benefit Amount
❑ Critical Illness	$
❑ Term with Critical Illness	$

Owner (if other than Proposed Insured)
Name: Relationship:
Address: Social Security No./Tax ID:

Optional Benefits/Riders
❑ Accidental Death Benefit $ ❑ Other_____
❑ Children's Term Rider _____# of units

Spouse Rider Only

Occupation	Annual Income	Benefit Amount
	$	$

Spouse/Child Riders

Full Name	Social Security No.	Date of Birth	Age	Sex	Relationship	Height	Weight

Beneficiary: If multiple beneficiaries named, shares will be divided equally among the surviving beneficiaries, unless otherwise speci-

Primary: Relationship:

Contingent: Relationship:

Premium

a) Initial Premium $_____ b) Premium Mode ❑ A ❑ S ❑ Q ❑ M- PAC ❑ Other_____
Actual Premium amount may be higher or lower based on underwriting. **DIRECT MONTHLY NOT AVAILABLE**

Regarding All Persons Proposed for Insurance:	INSURED	SPOUSE
Existing Insurance: Is the Policy applied for to replace or change any existing Life or Health insurance (i.e. critical illness, disability, long-term care or medical insurance) or annuities in this or any other Company? Indicate in chart below. (If "yes", check which policy and complete appropriate replacement form(s))	❑ YES ❑ NO	❑ YES ❑ NO
Is there an intention that any party other than the owner will obtain any right, title or interest in any policy issued on the life of the proposed insured as a result of this application? If "yes", please explain on page 5 in #5 under "Additional Remarks"	❑ YES ❑ NO	❑ YES ❑ NO

Regarding all persons proposed for insurance, list all insurance in force on each proposed insured's life. Include insurance whether owned by the Insured or

Person	Policy #	Company Name	Issue Date	Amount	Purpose (Business/Personal)	Type (Life/ADB/CI)	REPLACEMENT YES	REPLACEMENT NO
							❑	❑
							❑	❑
							❑	❑

(If there is additional insurance beyond those listed, please list on the Remarks page.)

PLEASE ANSWER ALL QUESTIONS TO THE BEST OF YOUR KNOWLEDGE AND BELIEF.

PLEASE PROVIDE DETAILS TO "YES" ANSWERS IN REMARKS SECTION

APPLICATION PART 2

	Insured		Spouse	
	YES	NO	YES	NO
1. a) Has Proposed Insured used any form of tobacco within the past 12 months? (including nicotine substitutes or nicotine products) . . . . . Quantity used _____	❑	❑	❑	❑
b) Has Spouse (if coverage applied for) used any form of tobacco within the past 12 months? (including nicotine substitutes or nicotine products) . . . . . Quantity used _____	❑	❑	❑	❑
2. Has **any** Proposed Insured within the past 5 years:				
a) been charged with driving while impaired (alcohol, drugs, other) violation, had a driver's license revoked or suspended or within the last 24 months received 3 or more citations for moving traffic violations?	❑	❑	❑	❑
b) had any application for insurance declined, rated, or postponed or is any other insurance pending now?	❑	❑	❑	❑
c) flown as a pilot, student pilot or crew member of any aircraft or have intentions to do so?	❑	❑	❑	❑
d) engaged in parachuting, scuba diving, mountain climbing, racing or other hazardous sport or intend to do so?	❑	❑	❑	❑
e) used intravenous drugs, cocaine, barbiturates, hallucinogens, marijuana, hashish, sought advice or treatment for alcohol or drug use or used illegal drugs or prescription drugs not prescribed by a doctor? . .	❑	❑	❑	❑
3. Has **any** of Proposed Insured's natural parents and/or siblings, either living or deceased, been diagnosed with or had heart disease, kidney disease, diabetes, cancer, stroke, or any other hereditary disease? (If "Yes", indicate family member, illness, age at onset of illness and, if applicable, age at death in Remarks.)	❑	❑	❑	❑
4. Does **any** Proposed Insured receive Medicare or Medicaid?	❑	❑	❑	❑
5. Are **all** Proposed Insureds US Citizens?	❑	❑	❑	❑

Non-Medical Declaration:

6. a) Proposed Insured Height _____ Weight _____ ❑ Gain ❑ Loss in past year? _____ lbs.
Name, Address, and Phone No. of usual medical advisor (and Doctor last consulted, if different)

_____

Date and reason of last visit? _____ Reason _____
What diagnosis and treatment was given or medication prescribed? _____
If None, then write None here: _____

b) Spouse Insured Height _____ Weight _____ ❑ Gain ❑ Loss in past year? _____ lbs.
Name, Address, and Phone No. of usual medical advisor (and Doctor last consulted, if different)

_____

Date and reason of last visit? _____ Reason _____
What diagnosis and treatment was given or medication prescribed? _____
If None, then write None here: _____

	Insured		Spouse	
	YES	NO	YES	NO
7. Has **any** Proposed Insured ever been diagnosed by a member of the medical profession or received treatment or advise for: breast cancer, breast disorders, including lumps, cysts, other physical changes, abnormal mammogram findings or biopsy? (If "Yes", the issued coverage shall be limited to a Maximum Benefit Amount of $10,000.).	❑	❑	❑	❑
8. Has **any** Proposed Insured ever been diagnosed by a member of the medical profession, or received treatment or advice for:				
a) abnormal blood pressure or elevated cholesterol?	❑	❑	❑	❑
b) chest pain, coronary heart disease, heart attack, heart murmur, abnormal ECG, stroke, transient ischemic attack (TIA), peripheral vascular disease or any other disorder of the heart, blood vessels or cerebrovascular system?	❑	❑	❑	❑
c) cancer, tumor, polyps, moles, basal or squamous cell carcinoma, melanoma, leukemia, lymphoma, or any other growth or malignancy?	❑	❑	❑	❑
d) diabetes, thyroid disorder, anemia, unusual bleeding, hepatitis, skin disorders, lupus, blood clots, or any other blood or glandular disorder, circulatory disorder, or acute or chronic Hepatitis B or C?	❑	❑	❑	❑
e) any disorder associated with the ears, hearing, speech, eyes, nose, throat, lungs or respiratory system, including but not limited to emphysema, pulmonary fibrosis, Chronic Obstructive Pulmonary Disease (COPD),, or other lung disorders?	❑	❑	❑	❑
f) any disorder of the stomach, intestines, rectum, liver, or pancreas, including but not limited to cirrhosis of the liver?	❑	❑	❑	❑
g) any injury to or disease of the bones, muscles, joints, eyes, or skin?	❑	❑	❑	❑
h) epilepsy, seizures, dizziness, paralysis, coma, multiple sclerosis, Motor Neuron disease (ALS), loss of speech, brain disorder, or any other disease or disorder of the nervous system?	❑	❑	❑	❑
i) anxiety, depression, or an emotional, behavioral, mental or nervous disorder?	❑	❑	❑	❑
j) any disease or disorder of the kidney, bladder, prostate, or reproductive organs?	❑	❑	❑	❑
9. Other than as stated above, has **any** Proposed Insured within the past 5 years:				
a) consulted, received treatment or advice from, been prescribed medication by any other medical advisor?	❑	❑	❑	❑
b) had any abnormal diagnostic tests (such as but not limited to lab work, PSA -Prostate Specific Antigen, PAP Smears, urinalysis)?	❑	❑	❑	❑
c) been aware of any conditions for which a medical advisor has not yet been consulted?	❑	❑	❑	❑
d) been advised by a member of the medical profession to have any diagnostic test, consultation, hospitalization or surgery that has not been completed?	❑	❑	❑	❑
10. Has **any** Proposed Insured ever tested positive for exposure to the HIV infection or been diagnosed by a member of the medical profession, as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection?.	❑	❑	❑	❑

REMARKS

REMARKS

Explain "Yes" answers to Questions 1-10.

Name of Person(s)	Illness	Date & Duration	Treatment & Results	Doctors & Hospitals

GENERAL REMARKS:

PROTECTIVE LIFE INSURANCE COMPANY

P. O. Box 830619 • Birmingham, AL 35283-0619

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

1. **This authorization to obtain and disclose information complies with HIPAA regulations as they relate to life insurance and/or specified disease insurance.** I (we) authorize Protective Life Insurance Company (Protective Life) and its reinsurers to obtain and use any information about or relating to me (us) that may affect my (our) insurability. Protective Life and its reinsurers may obtain and use health and medical information, including but not limited to information about drug use, alcohol use, nicotine use, physical and mental diseases and illness, and psychiatric disorders. Protective Life and its reinsurers may also obtain and use non-health and non-medical information, including but not limited to financial information, credit reports, consumer reports, driving record, criminal record, and information about avocations and aviation activity. All of this information may be used to evaluate an application for insurance, a claim for insurance benefits, or both. Information relating to communicable diseases and other risk factors relating to me or to my spouse and life partner may be used to evaluate an application for insurance on either me or my spouse and life partner. The Protective Life sales agent or regional sales office representing me on my (our) application for insurance may obtain the information described in this paragraph directly from any of the persons or organizations listed in paragraph 2 in order to expedite the delivery of the information to Protective Life.
2. I (we) authorize the following persons and organizations to release and disclose the information described in paragraph 1 to Protective Life or its agents acting on its behalf: (i) my (our) doctor(s); (ii) medical practitioners; (iii) pharmacists and Pharmacy Benefit Managers; (iv) medical and related facilities, including hospitals, clinics, facilities run by the Veteran's Administration, Kaiser Permanente, The Cleveland Clinic Foundation and The Mayo Clinic; (v) insurers; (vi) reinsurers; (vii) Medical Information Bureau, Inc. (**MIB**); (viii) my (our) current and previous employers; and (ix) commercial consumer reporting agencies (**CRA**). All of these persons and organizations other than **MIB** may release the information described above to a **CRA** acting for Protective Life. **MIB** may not release the information described in paragraph 1 to a **CRA**.
3. I (we) authorize Protective Life to draw and test my (our) blood, and/or oral fluids, and urine as may be necessary to obtain information to be used to underwrite my (our) application for insurance. These tests may include, but are not limited to, tests for cholesterol and related blood lipids, diabetes, liver or kidney disorders, immune disorders (other than HIV/AIDS; reference number 5 below), and the presence of drugs, nicotine, or their metabolites. This authorization does not include genetic testing. Unless otherwise required by law or regulation, Protective Life may, but is not obligated to, release any of these test results directly to me or to my spouse and life partner.
4. I (we) authorize Protective Life to release and disclose the information described in paragraphs 1 and 3 to its affiliates, its reinsurers, persons or organizations providing services relating to insurance underwriting for Protective Life, **MIB**, and as otherwise required by law with the following exception: Information pertaining to HIV and/or AIDS will not be disclosed to the **MIB**. Protective Life may release and disclose the information described in paragraphs 1 and 3 to other insurers if I (we) have applied or apply to the other insurers for insurance. Protective Life may release and disclose the information described in paragraphs 1 and 3 to the sales agent representing me on my (our) application for insurance if it is necessary to provide an explanation of the reasons for Protective Life's decision to impose special underwriting requirements, whenever my application cannot be approved as submitted, or in connection with a claim for benefits.This authorization does not include the release of HIV/AIDS test results to **MIB**.
5. **SPECIAL REQUIREMENT FOR HIV/AIDS TESTING**. If Protective Life intends to test for the presence of antibodies to the Human Immunodeficiency Virus (HIV), which is the virus that has been associated with Acquired Immune Deficiency Syndrome (AIDS), Protective Life may require me (us) to authorize that testing separately.
6. This authorization shall be valid for 24 months from the date shown below or, in the event of a claim for benefits, for the duration of such claim.
7. During the evaluation of my (our) insurance application, I (we) understand that I (we) have the right to revoke the authorizations in paragraphs 1 through 5 by writing to Protective Life at P. O. Box 830619 • Birmingham, AL 35283-0619. If this authorization is revoked, this would result in the file being closed and no coverage provided.
8. ❑ I (we) have been given a copy of this authorization form and Protective Life's Description of Information Practices.

   ❑ I (we) would like to be interviewed if an investigative consumer report will be made.
   (Please check the box if you wish to be interviewed if an investigative consumer report will be made.)

   ❑ If performed, I (we) would like copies of my (our) blood profile test results.
9. I (we) understand that information about me (us) may be disclosed under this authorization to persons or organizations that are not subject to the Health Insurance Portability and Accountability Act **(HIPAA)** and that the information would then no longer be protected by **HIPAA** and any related regulations.

   I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.Any modifications to this authorization may preclude our ability to process this application.
10. I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment).

_____ **Date of Authorization:** _____

Proposed Insured 1 (Signature)

When applicable, print name(s) of minor(s) below:

_____ _____

Print Name

_____ _____

Proposed Insured 2 (Signature)

_____

Print Name

_____

Parent or Legal Guardian (Signature)

THIS AUTHORIZATION MUST BE SIGNED WITHOUT MODIFICATION BEFORE THE APPLICATION CAN BE PROCESSED.
PLEASE RETURN THIS AUTHORIZATION WITH THE APPLICATION.

PROTECTIVE LIFE INSURANCE COMPANY

P. O. Box 830619 • Birmingham, AL 35283-0619

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2. I (we) authorize the following persons and organizations to release and disclose the information described in paragraph 1 to Protective Life or its agents acting on its behalf: (i) my (our) doctor(s); (ii) medical practitioners; (iii) pharmacists and Pharmacy Benefit Managers; (iv) medical and related facilities, including hospitals, clinics, facilities run by the Veteran's Administration, Kaiser Permanente, The Cleveland Clinic Foundation and The Mayo Clinic; (v) insurers; (vi) reinsurers; (vii) Medical Information Bureau, Inc. (**MIB**); (viii) my (our) current and previous employers; and (ix) commercial consumer reporting agencies (**CRA**). All of these persons and organizations other than **MIB** may release the information described above to a **CRA** acting for Protective Life. **MIB** may not release the information described in paragraph 1 to a **CRA**.
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6. This authorization shall be valid for 24 months from the date shown below or, in the event of a claim for benefits, for the duration of such claim.
7. During the evaluation of my (our) insurance application, I (we) understand that I (we) have the right to revoke the authorizations in paragraphs 1 through 5 by writing to Protective Life at P. O. Box 830619 • Birmingham, AL 35283-0619. If this authorization is revoked, this would result in the file being closed and no coverage provided.
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   I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.Any modifications to this authorization may preclude our ability to process this application.
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_____ **Date of Authorization:**_____

Proposed Insured 1 (Signature) When applicable, print name(s) of minor(s) below:

_____ _____

Print Name

_____ _____

Proposed Insured 2 (Signature)

_____

Print Name

_____

Parent or Legal Guardian (Signature)

THIS AUTHORIZATION MUST BE SIGNED WITHOUT MODIFICATION BEFORE THE APPLICATION CAN BE PROCESSED.

PLEASE RETURN THIS AUTHORIZATION WITH THE APPLICATION.

PROPOSED INSURED'S NAME IN FULL

AGREEMENT - AUTHORIZATION - ACKNOWLEDGMENT

I, the Proposed Insured and any Spouse or Owner signing below, by my signature set forth hereafter

AGREE to the following.

(a) All statements and answers in this application and any amendment(s), paramedical/medical exam and supplement(s) are complete and true to the best of my knowledge and belief.

(b) No insurance will take effect before the application is approved and the Proposed Insured(s) has/have completed all examinations and/or tests by the company, and unless the first full premium is paid and a policy is delivered while the health of any proposed insured continues to be as represented in this application.

(c) No agent has authority to waive any answer or otherwise modify this application or to bind Protective Life Insurance Company, hereinafter called "Company", in any way by making any promise or representation which is not set out in writing in this application.

AUTHORIZE any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsuring company, the Medical Information Bureau, Inc. ("MIB"), consumer reporting agency, or any other organization, institution or person to give to the Company or its reinsurer(s) all information it holds that pertains to medical consultations, treatments, surgeries, and hospital confinements which relate to the physical and mental condition of myself or my minor children. This authorization also includes information about drugs or alcoholism or any other non-health (non-medical) history information. I understand that such information will be used to determine eligibility for insurance, or for benefits under existing insurance. I further authorize the Company to release any information obtained only to reinsuring companies, MIB, or other persons or organizations performing business or legal services in connection with my application or claim, or as may be otherwise lawfully required or as I may further authorize, with the following exception: Information pertaining to HIV and/or AIDS will not be disclosed to the MIB. As to this authorization, I agree that a photographic copy will be as valid as the original and that it will be valid for 30 months from the date shown below. I know that I or my representative may request a copy of this authorization.

ACKNOWLEDGE receipt of the following notices:

(a) "Notice of Information Practices" required by Public Law 91-508 and other information practices statutes;

(b) MIB Pre-Notice;

(c) Consumer Privacy Notice; and

(d) Critical Illness Disclosure.

THIS IS NOT A MEDICARE SUPPLEMENT CONTRACT - If You are eligible for Medicare, please review the "Guide to Heath Insurance for People with Medicare," which is available from your local Social Security office.

Receipt of benefits under this Policy may affect your eligibility for Medicaid or other governmental benefits or entitlements. Please consult a legal advisor for additional information.

IMPORTANT INFORMATION ABOUT IDENTIFICATION INFORMATION

To help the government fight the funding of terrorism and money laundering activities, Federal Law requires all financial institutions to obtain, verify, and record information of its customers. We may ask for information or identifying documents that will allow us to verify the identity of our customers.

Any person who knowingly and with intent to injure, defraud or deceive any Insurer, files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Signed at _____ (City), _____ (State) _____ (Date)

X) _____
SIGNATURE OF PROPOSED INSURED (IF AGE 16 OR OVER) OR PARENT OR GUARDIAN (JUVENILE APPLICATIONS)

X) _____
WITNESS TO SIGNATURE(S) IF NOT WITNESSED BY AGENT

_____
SIGNATURE OF LICENSED AGENT

X) _____
SIGNATURE OF SPOUSE RELATIONSHIP (IF INCLUDED AS A PROPOSED INSURED)

X) _____
SIGNATURE OF OWNER RELATIONSHIP (IF OTHER THAN PROPOSED INSURED)

_____
AGENT PRINTED NAME

_____
AGENT NUMBER

_____
AGENT FLORIDA LICENSE NUMBER

APPLICATION PART 3

APPLICATION PART 4

AGENT'S REPORT

	YES	NO
1. Agent Checklist (Provide details in Additional Remarks Section below)		
A. Did you give the applicant a copy of the Privacy Notice and other disclosure information?	❑	❑
B. Are you related to the Proposed Insured?	❑	❑
C. Was this application taken in person?	❑	❑
D. Do you know anything not disclosed which might affect the underwriting of this risk?	❑	❑
E. Is there another application currently pending or being submitted to any other life insurance company?	❑	❑
F. Has any Proposed Insured applied elsewhere for any insurance coverage within the past 6 months?	❑	❑
G. Is replacement of existing insurance involved in this application? If yes, submit the appropriate replacement forms.	❑	❑
H. Have you advised the proposed policyowner or do you know of any advice that has been given to the proposed policyowner to transfer the ownership of the policy being applied for to a life settlement company or other entity associated with stranger owned or investment owned life insurance (commonly called SOLI or IOLI) or are you otherwise aware that the policyowner may be contemplating such a transfer?	❑	❑

2. Financial and Medical Requirement Information:

A. If exam required, give name of examiner, and date exam scheduled or completed _____

B. If required, have or ordered or obtained

❑ Exam
❑ Blood profile/DBS/Specimen
❑ EKG
❑ PHI number or Commercial Report
❑ Income verification type: _____
❑ Other _____

3. Information for Business Insurance (e.g., Buy/Sell, Key Person, etc.)

A. What is the value of the business? $_____

B. What percentage does the Proposed Insured own or control? _____%

C. Are other key individuals applying? If yes, indicate name of each person. If no, for what reason? (indicate below.) ❑ YES ❑ NO

4. Answer these questions only if this is a replacement:

A. Did you use any pre-printed Company approved sales materials? ❑ YES ❑ NO
If yes, list the name or form numbers of materials here: _____
_____

B. Did you use any Company-approved, electronically generated, individualized sales materials (such as illustrations or concept materials? If yes, you must provide a copy of these material(s) with the application. ❑ YES ❑ NO

5. Additional Remarks

I hereby certify that all statements and answers made in this Agent's Report are full, complete and true to the best of my knowledge and belief and that I know nothing affecting the insurability of the Proposed Insured(s) which is not fully set forth in these papers.

Signed at (City and State)_____ Date _____

Soliciting Agent's Printed Name _____ Agent's Number _____ Agent FL License Number _____

Address _____ Phone No. _____ Fax No. _____

Soliciting Agent's Signature _____ E-mail_____ Percentage _____

Soliciting Agent's Printed Name _____ Agent's Number _____ Agent FL License Number _____

Address _____ Phone No. _____ Fax No. _____

Soliciting Agent's Signature _____ E-mail_____ Percentage _____

❑ Critical Illness Policy
❑ Life Insurance with
Critical Illness Rider

Protective
Life Insurance Company

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 the Company can alter or waive any of the provisions of this Agreement. No insurance is provided under the terms of this document in the event of the death of the Insured by suicide. In the event of suicide, the Company's sole liability will be the return of any money received.

Received: ☐ Check in the amount of $_____,
☐ Pre-Authorized Funds Withdrawal Plan (PAW), as conditional payment of the first premium for an insurance policy on the Proposed Insured(s) _____.

An application for insurance on each person proposed for insurance is being made today to Protective Life Insurance 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.

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. CASH AND MONEY ORDERS WILL NOT BE ACCEPTED.

NOTE: Premium may not be collected where the face amount applied for on this application plus any in force Protective Life policies on this Insured exceeds $500,000 of Life coverage and $100,000 of Critical Illness Coverage or on Proposed Insureds under 15 days of age or over age 80 (Life) and over age 65 (Critical Illness).

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 printed underwriting rules for the plan, amount and premium rate class applied for;
(B) that the amount paid with the application and shown above is equal to the first full modal premium for the premium rate class applied for; and
(C) the Proposed Insured(s) has/have completed all examinations and/or tests requested by the Company.
(D) the company has secured all evidence necessary to complete the under writing process.

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 of the last of any medical examinations or tests required under the rules and practices of the Company.

AMOUNT OF COVERAGE - $500,000 (Life) and $100,000 (Critical Illness)

The total amount of insurance which may become effective prior to delivery of the policy to the Owner **shall not exceed $500,000 for Life coverage and shall not exceed $100,000 for Critical Illness coverage.** This amount includes other insurance and accidental death benefits then in force or applied for with this Company.

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 check, and it is not honored by the drawee bank upon presentation;
(2) by PAW, and the deduction is not honored by the drawee bank;

(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.

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.

Date:_____ Agent:_____

Date:_____ Applicant/Owner: _____

❑ Critical Illness Policy
❑ Life Insurance with Critical Illness Rider

Protective Life Insurance Company

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 the Company can alter or waive any of the provisions of this Agreement. No insurance is provided under the terms of this document in the event of the death of the Insured by suicide. In the event of suicide, the Company's sole liability will be the return of any money received.

Received: ☐ Check in the amount of $_____,
☐ Pre-Authorized Funds Withdrawal Plan (PAW), as conditional payment of the first premium for an insurance policy on the Proposed Insured(s) _____.

An application for insurance on each person proposed for insurance is being made today to Protective Life Insurance 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.

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. CASH AND MONEY ORDERS WILL NOT BE ACCEPTED.

NOTE: Premium may not be collected where the face amount applied for on this application plus any in force Protective Life policies on this Insured exceeds $500,000 of Life coverage and $100,000 of Critical Illness Coverage or on Proposed Insureds under 15 days of age or over age 80 (Life) and over age 65 (Critical Illness).

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 printed underwriting rules for the plan, amount and premium rate class applied for;
(B) that the amount paid with the application and shown above is equal to the first full modal premium for the premium rate class applied for; and
(C) the Proposed Insured(s) has/have completed all examinations and/or tests requested by the Company.
(D) the company has secured all evidence necessary to complete the under writing process.

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 of the last of any medical examinations or tests required under the rules and practices of the Company.

AMOUNT OF COVERAGE - $500,000 (Life) and $100,000 (Critical Illness)

The total amount of insurance which may become effective prior to delivery of the policy to the Owner **shall not exceed $500,000 for Life coverage and shall not exceed $100,000 for Critical Illness coverage.** This amount includes other insurance and accidental death benefits then in force or applied for with this Company.

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 check, and it is not honored by the drawee bank upon presentation;
  (2) by PAW, and the deduction is not honored by the drawee bank;

(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.

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.

Date:_____ Agent:_____

Date:_____ Applicant/Owner: _____

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

PRE-AUTHORIZED WITHDRAWAL AGREEMENT

FOR DRAFTING OF MONTHLY PREMIUM PAYMENTS

The person paying the premium on the life insurance policies listed below must sign this agreement.

I request and authorize Protective Life Insurance Company to draw against the account listed below to pay premiums on the following policies:

Policy No. (if known)	Name of Insured

Name of Bank: _____

Street Address or P.O. Box: _____

City: _____ **State:** _____ **Zip Code:** _____

Type of Account: _____ **Checking** _____ **Savings** _____ **Account Number:** _____

I request that the withdrawal be made on the _____ **day of the month.**
1st–28th

_____
Premium Payer – Depositor (Please Print)

_____ _____
Date **Signature**

PLEASE ATTACH A VOIDED CHECK HERE

PROTECTIVE LIFE INSURANCE COMPANY • P.O. Box 830619 • Birmingham, Alabama 35283-0619

DESCRIPTION OF INFORMATION PRACTICES

(Including Medical Information Bureau Notice and Fair Credit Reporting Act Notice)

In considering your application for insurance, information from various sources must be considered. These include the results of your physical examination, if required, and any reports Protective Life may receive from doctors and hospitals who have attended you.

Information regarding your insurability will be treated as confidential. Protective Life, or its reinsurers, may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such company, the Bureau upon request, will supply such company with the information it may have in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, their telephone number is 866-692-6901 (TTY 866-346-3642).

Protective Life, or its reinsurers, may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

Furthermore, as part of our procedures for processing your insurance application, an investigative consumer report may be prepared by one or more of the commercial agencies offering this service whereby information is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics and mode of living except as may be related directly or indirectly to your sexual orientation. You have the right to be personally interviewed if we order an investigative consumer report. You also have the right to receive a copy of the report, and by making a written request to Protective Life within a reasonable period of time to receive additional detailed information about the nature and scope of this investigation.

As a general practice, we will not disclose personal or privileged information about you to anyone else without your consent, unless a legitimate business need exists or disclosure is required or permitted by law. You are entitled, upon request, to receive a more detailed statement of our information practices. You also have the right to access the personal information about you that we have in our records. You may see and copy the information, or we will send it to you, whichever you prefer. You also have the right to request correction of personal information we may have about you which you think is wrong. To exercise these rights, please write to us at the address appearing at the end of this notice.

Ask our agent for assistance, or call or write us at Protective Life Insurance Company, Attention: Vice President-Underwriting, P.O. Box 830619, Birmingham, Alabama 35283-0619. Telephone (205) 879-9230

THIS NOTICE MUST BE GIVEN TO PROPOSED INSURED

DIP 1/05

Protective Life Insurance Company
Notice and Consent for AIDS-RELATED Testing

To evaluate your insurability, the Insurer named above (the insurer) has requested that you provide a bodily fluid sample for testing and analysis to determine the presence of human immunodeficiency virus (HIV) antibodies. By signing and dating this form you agree that this test may be done and that underwriting decisions will be based on the test result. A series of tests will be performed by a certified laboratory through a medically accepted procedure.

PRE-TESTING CONSIDERATIONS

Many public health organizations have recommended that before taking an AIDS-related test, a person seek counseling to become informed concerning the implications of such a test. You may wish to consider counseling, at your expense, prior to being tested.

MEANING OF POSITIVE TEST RESULT

The test is not a test for AIDS. It is a test for antibodies to the HIV virus, the causative agent for AIDS, and shows whether you have been exposed to the virus. A positive test result does not mean that you have AIDS but that you are at significantly increased risk of developing problems with your immune system. The test for HIV antibodies is very sensitive. Errors are rare, but they do occur. Your private physician, a public health clinic, or an AIDS information organization in your city might provide you with further information on the medical implications of a positive test.

Positive HIV antibody test results will adversely affect your application for insurance.

CONFIDENTIALITY OF TEST RESULTS

All test results are required to be treated confidentially. They will be reported by the laboratory to the Insurer. The test results may be disclosed as required by law or may be disclosed to employees of the Insurer who have the responsibility to make underwriting decisions on behalf of the Insurer or to outside legal counsel who needs such information to effectively represent the Insurer in regard to your application. The results may be disclosed to a reinsurer, if the reinsurer is involved in the underwriting process. The test may be released to an insurance medical information exchange under procedures that are designed to assure confidentiality, including the use of general codes that also cover results of tests for other diseases or conditions not related to AIDS, or for the preparation of Statistical reports that do not disclose the identity of any particular person.

NOTIFICATION OF TEST RESULT

A positive test result will be disclosed to a physician you designate. If you do not designate a physician, a positive test result will be disclosed to the Florida Department of Health, Chief, Bureau of STD Prevention and Control, Bin A-19, 4052 Bald Cypress Way, Tallahassee, Florida 32399-1716. Because a trained person should deliver that information so that you can understand clearly what the test result means, please list your private physician so that the Insurer can have him or her tell you the test result and explain its meaning.

Name of physician for reporting a positive test result: _____

Address: _____

CONSENT

I have read and I understand this Notice and Consent for AIDS-Related Testing. I voluntarily consent to the collection of bodily fluids from me, the testing of that sample, and the disclosure of the test results as described above.

I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

Name of Proposed Insured: _____

Address: _____

Signature of Proposed Insured
or Parent/Guardian: _____ Date Signed:_____

Protective
Protective Life Insurance Company

PROTECTIVE LIFE INSURANCE COMPANY / P. O. BOX 2606 / BIRMINGHAM, ALABAMA 35202
A STOCK COMPANY (205-268-1000)

CRITICAL ILLNESS DISCLOSURE
POLICY FORM CI-03-FL 4-05
RETAIN THIS FOR YOUR RECORDS

CRITICAL ILLNESS INSURANCE COVERAGE. This is a **Limited Benefit Health Coverage** Policy. Policies of this category are designed to provide limited or supplemental coverage, paying benefits ONLY upon the Occurrence and Diagnosis of a Covered Condition. This Policy does not provide benefits for any other disease, sickness or incapacity. This Policy does not provide for basic hospital, basic medical-surgical, or major medical expenses. Benefits provided are a supplement, and not a substitute for, medical coverage or disability insurance.

READ YOUR POLICY CAREFULLY. This outline of coverage provides a very brief description of the important features of the Policy. This is not the insurance contract and only the actual provisions of the Policy will control. The Policy itself sets forth in detail the rights and obligations of both the Owner and the Company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

IMPORTANT NOTICE. Please read the copy of your application attached to this policy. Carefully check the application and write to us, within ten days, if any information shown on it is not correct and complete, or if any past medical history has been left out of the application. This application is a part of the policy and the policy was issued on the basis that answers to all questions and the information shown on the application are correct and complete. Errors or omissions in the application may void the policy or cause an otherwise valid claim to be denied. Advise us at once if any information on the application is wrong or incomplete.

THIS IS NOT A MEDICARE SUPPLEMENT CONTRACT. If You are eligible for Medicare, please review the "Guide to Health Insurance for People with Medicare," which is available from your local Social Security office.

Receipt of benefits under this Policy may affect Your eligibility for Medicaid or other governmental benefits or entitlements. Please consult a legal advisor for additional information.

TERMS UNDER WHICH THE POLICY MAY BE RETURNED AND PREMIUM REFUNDED. The Policy may, at any time within thirty (30) days after receipt by the Owner, be returned to the Company's Home Office or to the agent who sold the Policy. If returned, the Policy will then be void from the effective date and any Premium paid will be refunded.

If you have any questions about your policy or need assistance in filing a claim, please call us tollfree at 1-800-866-9933.

COVERED CONDITIONS OF YOUR POLICY. The Initial Benefit Amount* is the amount of Critical Illness Insurance Coverage requested by the Insured, which the Company subsequently approves for an Insured.

100% of the Benefit Amount is payable for:
Heart Attack
Stroke
Invasive Cancer**
Major Organ Transplant
End-Stage Renal Failure
Advanced Alzheimer's Disease
Blindness
Deafness
Paralysis
Major Burns
Accidental Loss of Speech

25% of the Benefit Amount is payable for:
Cancer In Situ**
Coronary Bypass Surgery

10% of the Benefit Amount is payable for:
Angioplasty

*The Initial Benefit Amount reduces by 50% at Age 65 or 5 years after issue if later, with no reduction in Premium.

**If the Covered Condition is diagnosed as Invasive or In Situ Cancer, the Reduced Benefit Period shall be 90 days, beginning on the Policy Effective Date of this Policy. If such Covered Condition Occurs and is diagnosed during the first 90 days of coverage after the Policy Effective Date, there shall be a Benefit Payment of 10% for Invasive Cancer or 2.5% for Cancer In Situ, and the Policy will terminate.

CRITICAL ILLNESS BENEFITS

The Covered Conditions listed above are the only conditions, diseases or surgeries for which an Insured may receive benefits under the Policy. The Company, will subject to the terms and conditions of this Policy, pay the Benefit Amount shown in the Policy Schedule. If a Covered Condition First Occurs while You are insured under this Policy, a Physician diagnoses the Covered Condition, and We receive the required Proof of the Covered Condition, the Current Benefit Amount will be paid depending on the type of Covered Condition. The Benefit Payment(s) will be paid in a lump-sum to the Owner. Benefits payable will not exceed the Maximum Benefit Amount. The Policy will terminate upon payment of the Maximum Benefit Amount.

RETURN OF PREMIUM UPON DEATH

If the Insured dies while this Policy is in force, this benefit pays the Policy Owner, beneficiary, or the estate an amount equal to the total amount of Premiums paid to date, less any benefits paid, to the extent that the Premiums paid exceed the benefits paid or payable under this Policy. The Premiums to be returned will be calculated without interest. The combination of Premiums returned under this provision, benefits that have been paid and benefits that become available for Covered Conditions will never exceed the Current Benefit Amount that is in effect on the date of Your death. When determining the amount of Premiums to be returned, We will disregard any Premiums paid for spouse coverage or other riders.

MULTIPLE PAYMENT BENEFIT

Critical Illness Categories

Category 1	Category 2	Category 3
Heart Attack	Invasive Cancer	Major Organ Transplant - not covered in Category 1
Stroke	Cancer In Situ	End-Stage Renal Failure
Major Organ Transplant - Heart or combination transplant including Heart		Advanced Alzheimer's Disease
Coronary Bypass Surgery		Blindness
Angioplasty		Deafness
		Paralysis
		Major Burns
		Accidental Loss of Speech

Benefits

The Multiple Payment Benefit is a feature of the Policy, which allows for multiple payments from the three categories of Covered Conditions listed above. The payment of benefits under each category shall not exceed 100% of the Initial Benefit Amount for each category. You can receive a Benefit Payment on a second or third Covered Condition if that Covered Condition meets the terms and conditions of the Policy. The total of Benefit Payments can be up to three times the Initial Benefit Amount. After the Initial Benefit Payment under the Policy, You can choose to continue paying Premiums and possibly receive additional Benefit Payments, so You are not limited to the amount of Critical Illness Insurance issued with the Policy.

How this Benefit is Calculated:

a) Before Age 65 (or 5 years after issue, if Insured is Age 60 or older on Policy Effective Date):
   * The benefit available in a category equals the Initial Benefit Amount less the sum of any payments made to date for Covered Conditions in that category.
   * The Benefit Payment for a Covered Condition equals the appropriate percentage of the Initial Benefit Amount for that Covered Condition but no greater than the benefit remaining for that category.

b) After Age 65 (or 5 years after issue, if Insured is Age 60 or older on Policy Effective Date):
   * The Current Benefit Amount for a category equals 50% of the benefit remaining in that category on the day prior to the Policy Anniversary.
   * The benefit available in a category equals the Current Benefit Amount less the sum of any payments made since the Age 65 reduction for Covered Conditions in that category.
   * The Benefit Payment for a Covered Condition equals the appropriate percentage of the Current Benefit Amount for that Covered Condition, but no greater than the benefit remaining for that category.

Exceptions and Limitations

a) The payment of all benefits under the Policy shall not exceed three (3) times the Initial Benefit Amount stated in the Policy schedule.
b) The payment of benefits under each category shall not exceed 100% of the Initial Benefit Amount for each category.
c) There shall be only one Benefit Payment for each Covered Condition.
d) There shall be only one Benefit Payment per 180-day period across the three categories. However, the 180-day period does not apply to Benefit Payments within the same category.
e) If a First-Ever Diagnosis Occurs within the 180-day period after a Benefit Payment, it is not effectively considered a "First-Ever Diagnosis" under the Policy. Therefore, a Benefit Payment may be paid for a subsequent Occurrence and Diagnosis of that Covered Condition.
f) If more than one Covered Condition is diagnosed at the same time, the Benefit Payment shall be based on the larger Benefit Amount of those diagnosed. If the Benefit Amounts are the same, there shall be only one Benefit Payment per 180-day period.

BENEFIT REDUCTION DUE TO AGE

If the Insured is Age 60 or older on the Policy Effective Date, the Initial Benefit Amount will be reduced by 50 percent on the fifth anniversary of the Policy Effective Date. In all other cases, the Benefit Amount will be reduced by 50 percent when the Insured reaches Age 65. After this reduction occurs, the Current Benefit Amount for a category is 50 percent of the benefit remaining in that category on the day prior to the reduction.

DEFINITIONS

Age. The attained age as of the last birthday.

Application. The written form(s) provided by Us that You use to apply for this Policy, including any amendments and supplemental application(s) thereto, and any application(s) for a Policy change or reinstatement.

Benefit Payment. The percentage of the Current Benefit Amount applicable for that condition if the claim is payable.

Clinical Diagnosis. A Diagnosis of Invasive Cancer or Cancer In Situ based on the study of symptoms and diagnostic test results. We will accept a Clinical Diagnosis of Cancer only if the following conditions are met:

a) a Pathological Diagnosis cannot be made because it is medically inappropriate or life threatening;
b) there is medical evidence to support the Diagnosis; and
c) a Physician is treating the Insured for Invasive Cancer and/or Cancer In Situ.

Company. The term "Company" shall mean Protective Life Insurance Company.

Critical Illness. A Critical Illness is the First Occurrence, while this Policy is in force, of one of the following Covered Conditions, as defined below:

a) Accidental Loss of Speech
b) Advanced Alzheimer's Disease
c) Angioplasty
d) Blindness
e) Cancer In Situ
f) Coronary Bypass Surgery
g) Deafness
h) End-Stage Renal Failure
i) Heart Attack
j) Invasive Cancer
k) Major Burns
l) Major Organ Transplant
m) Paralysis
n) Stroke

a) **Accidental Loss of Speech.** The Diagnosis, by a Physician board-certified as medically appropriate for this condition, of the total, permanent and irreversible loss of your ability to speak as a result of an accidental injury.

b) **Advanced Alzheimer's Disease.** The Diagnosis, by a Physician board-certified as a Neurologist, of Advanced Alzheimer's Disease. The Insured must exhibit loss of intellectual capacity involving impairment of memory and judgment as measured by clinical evidence and standardized testing. It must result in significant reduction in mental and social functioning such that the Insured requires Substantial Assistance in performing at least three of the six Activities of Daily Living (as defined below). No other dementing brain disorders or psychiatric illnesses shall meet the definition of Alzheimer's Disease, nor will they be considered a Covered Condition.

a. **Activities of Daily Living (ADLs)** refer to certain basic daily tasks necessary to maintain a person's health and safety. In this Policy, ADLs refer to the activities described below:

i. Transfer and mobility - The ability to move into or out of a bed, chair or wheelchair or to move from place to place, either via walking, a wheelchair, cane, crutches, walker or other equipment.
ii. Continence - The ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).
iii. Dressing - Putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.
iv. Toileting - Getting to and from the toilet, transferring on and off the toilet and performing associated personal hygiene.
v. Eating - Feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously.
vi. Bathing - Washing oneself by sponge bath; or in either a tub or a shower, including the task of getting into or out of the tub or shower.

b. **Substantial Assistance** means hands-on assistance and stand-by assistance. For the purposes of this Policy "stand-by assistance" will be used to determine that substantial assistance by another person is required by You to perform the ADL.

i. "Hands-on Assistance" means the physical assistance of another person without which You would be unable to perform the ADL.

ii. "Stand-by Assistance" means the presence of another person within Your arm's reach, to prevent, by physical intervention, injury to You while You perform an ADL (such as being ready to catch You if You fall while getting into or out of the bathtub or shower as part of bathing, or being ready to remove food from Your throat if You choke while eating).

c) **Angioplasty**. The actual undergoing of a percutaneous transluminal angioplasty deemed medically necessary to correct a narrowing or blockage of one or more coronary arteries. A Physician board-certified as a Cardiologist must perform the Procedure. Other surgical or non-surgical techniques such as laser relief or any other intra-arterial procedures are excluded.

d) **Blindness**. The Diagnosis, by a Physician board-certified as an Ophthalmologist, of the permanent and uncorrectable loss of sight in each of Your eyes. Your corrected visual acuity must either be worse than 20/200 in both eyes or the field of vision must be less than 20 degrees in both eyes, for a continuous period of at least 30 days.

e) **Cancer In Situ**. A Diagnosis of cancer wherein the tumor cells still lie within the tissue of origin without having invaded neighboring tissue. Cancer In Situ includes:

a. early prostate cancer diagnosed as T1N0M0 or equivalent staging; and
b. melanoma not invading the dermis.

Cancer In Situ does NOT include:

a. other skin malignancies;
b. pre-malignant lesions (such as intraepithelial neoplasia); or
c. benign tumors or polyps.

f) **Coronary Bypass Surgery**. The actual undergoing of coronary artery bypass surgery using either a saphenous vein or internal mammary artery graft for the treatment of coronary heart disease deemed medically necessary to correct a narrowing or blockage of one or more coronary arteries. The procedure must be performed by a Physician board-certified as a Cardiologist. Other surgical or non-surgical techniques such as laser relief or any other intra-arterial procedures are excluded.

g) **Deafness.** The Diagnosis, by a Physician board-certified as an Otolaryngologist, of the permanent loss of hearing in both ears with an auditory threshold of more than 90 decibels in each ear, for a continuous period of at least 30 days.

h) **End-Stage Renal Failure.** The chronic and irreversible failure of both of Your kidneys which requires You to undergo periodic and ongoing dialysis. The Diagnosis must be made by a Physician board-certified in Nephrology.

i) **Heart Attack.** An Acute Myocardial Infarction resulting in the death of a portion of the heart muscle (myocardium) due to a blockage of one or more coronary arteries and resulting in the loss of the normal function of the heart. The Diagnosis must be made by a Physician board-certified as a Cardiologist and based on both:

a. new clinical presentation and electrocardiographic changes consistent with an evolving heart attack; and
b. serial measurement of cardiac biomarkers showing a pattern and to a level consistent with a Diagnosis of Heart Attack.

j) **Invasive Cancer.** A malignant neoplasm, which is characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue, and which is not specifically hereafter excluded. Leukemias and lymphomas are included. The following are NOT considered Invasive Cancer:

a. pre-malignant lesions (such as intraepithelial neoplasia);
b. benign tumors or polyps;
c. early prostate cancer diagnosed as T1N0M0 or equivalent staging;
d. Cancer In Situ; or
e. any skin cancer (other than invasive malignant melanoma in the dermis or deeper or skin malignancies that have become metastatic).

k) **Major Burns.** The Diagnosis, by a Physician board-certified as a Plastic Surgeon, that You have sustained third degree burns covering at least 20% of the surface area of Your body.

l) **Major Organ Transplant.** The clinical evidence of major organ(s) failure which requires the malfunctioning organ(s) or tissue of the Insured to be replaced with an organ(s) or tissue from a suitable human donor (excluding the Insured) under generally accepted medical procedures. The organs and tissues covered by this definition are limited to: liver, kidney, lung, entire heart, small intestine, pancreas, or bone marrow. In order for the Major Organ Transplant to be covered under this Policy, the Insured must be registered by the United Network of Organ Sharing (UNOS).

m) **Paralysis.** The complete and permanent loss of use of two or more limbs through neurological injury for a continuous period of at least 180 days, confirmed by a Physician board-certified as a Neurologist.

n) **Stroke.** Any acute cerebrovascular accident producing neurological impairment and resulting in paralysis or other measurable objective neurological deficit persisting for at least 96 hours and expected to be permanent. Cerebral symptoms due to migraine, cerebral injury due to trauma or hypoxia, vascular disease affecting the eye or optic nerve, ischemic disorders of the vestibular system, and transient ischemic attack (mini-stroke) are excluded. The Diagnosis must be made by a Physician board-certified as a Neurologist.

Current Benefit Amount. The amount of Critical Illness Insurance used to calculate benefits. At issue, equal to the Initial Benefit Amount. It is reduced for each category at Age 65 (or 5 years after issue, if Insured is Age 60 or older on Policy Effective date) to 50% of the Benefit Available for each Covered Condition.

Diagnosis. The definitive establishment of the Covered Condition through the use of clinical and/or laboratory findings, as supported by the Insured's medical records. The Diagnosis must be made by a Physician who is a board certified specialist where required under this Policy.

Family Member. The term "Family Member" shall mean the Insured's spouse and anyone who is related to the Insured or Insured's spouse by the following degree of blood, marriage, adoption or operation of law: parents, grandparents, brothers, sisters, children, grandchildren, aunts, uncles, nephews and nieces.

First Occur(s)/First-Ever Diagnosis or Procedure. This Occurrence, Diagnosis or Procedure is the first time ever in the Insured's lifetime that he or she has experienced such Covered Condition, been diagnosed with that specific condition included as a Covered Condition, or undergone that specific Procedure included as a Covered Condition.

Home Office. 2801 Highway 280 South, Birmingham, Alabama, 35223.

Initial Benefit Amount. The amount of Critical Illness Insurance coverage requested by the Insured, which the Company subsequently approves for the Insured.

Insured. The person(s) covered under this Policy.

Issue Age. The Insured's attained age at the Policy Effective Date.

Maximum Benefit Amount. The eligible total of Benefit Payments for all Covered Conditions as stated in the Policy, including all components of the Multiple Payment Benefit provision.

Occur(s)/Occurrence(s). An event or incident that: (1) occurs after the date coverage on an Insured becomes effective under this Policy; (2) occurs while the Policy is in force; and (3) is not precluded by any specific description or exclusion stated in this Policy.

Owner. The person(s) who own(s) this Policy. The Insured is the Owner of this Policy unless someone else is named as Owner in the Policy Schedule or an endorsement to the Policy.

Pathological Diagnosis. A Diagnosis of Invasive Cancer or Cancer In Situ based on a microscopic study of fixed tissue or preparations from the hemic (blood) system. This type of Diagnosis must be done by a Physician who is a board certified pathologist and whose Diagnosis of malignancy conforms to the standards set by the American College of Pathology.

Physician. A person other than the Insured or the Owner; a Family Member of the Insured or the Owner; a member of the same household; or a business partner or associate of the Insured, Owner or Family Member; who is duly licensed and practicing medicine in the United States, and who is legally qualified to diagnose and treat sickness and injuries. The Physician must be providing services within the scope of his or her license issued by the jurisdiction in which such person's services are rendered. Such jurisdiction must be within the United States of America. The Physician must be a board certified specialist where required under this Policy.

Policy. The written statement of this contract effecting Critical Illness Insurance, including all clauses, riders, endorsements, applications, or other attached papers. This insurance Policy is a binding contract, issued by the Company to the Insured, which promises to pay a Benefit Amount according to certain defined terms and conditions.

Policy Effective Date. The date that this Policy takes effect. The Policy Effective Date is shown in the Policy Schedule.

Premium. The dollar amount that must be paid to keep this Policy in force. Premium is shown in the Policy Schedule.

Premium Class. The Premium Class of the Insured as designated in the Policy Schedule.

Premium Payment Mode. The period of time for which one Premium payment will keep this Policy in force. The Premium Payment Mode is shown in the Policy Schedule.

Proof. Written evidence satisfactory to the Company that a claimant has satisfied the conditions and requirements for a benefit described in this Policy. Proof must include all of the information required under the terms of this Policy and be timely submitted as described in this Policy. When a claim is made for a benefit described in this Policy, Proof must establish:

a) the nature and extent of the Covered Condition;
b) the Company's obligation to pay the claim; and
c) the claimant's right to receive payment.

Except as provided in the "Physical Examinations, Autopsy" claim provision of this Policy, Proof must be provided at the claimant's expense.

Reduced Benefit Period. If the Covered Condition of Invasive or In Situ Cancer is diagnosed, the Reduced Benefit Period shall be 90 days, beginning on the Policy Effective Date of this Policy. If such Covered Condition Occurs and is diagnosed during the first 90 days of coverage after the effective date, there shall be a Benefit Payment of 10% for Invasive Cancer or 2.5% for Cancer In Situ, and the Policy will terminate.

We, Us, Our. Protective Life Insurance Company.

You, Your. Insured(s) named in the Policy Schedule.

EXCEPTIONS AND LIMITATIONS

Unless the Insured's Covered Condition First Occurs or is diagnosed during the coverage period of the Policy, no Benefit Amount will be payable.

Payment of any Benefit Amount under this Policy shall be subject to the following:

a) The payment of all benefits under the Policy shall not exceed three (3) times the Initial Benefit Amount stated in the Policy schedule.
b) The payment of benefits under each category shall not exceed 100% of the Current Benefit Amount for each category.
c) There shall be only one Benefit Payment for each Covered Condition.
d) There shall be only one Benefit Payment per 180-day period across the three categories. However, the 180-day period does not apply to Benefit Payments within the same category.
e) If a First-Ever Diagnosis Occurs within the 180-day period after a Benefit Payment, it is not effectively considered a "First-Ever Diagnosis" under the Policy. Therefore, a Benefit Payment may be paid for a subsequent Occurrence and Diagnosis of that Covered Condition.
f) If more than one Covered Condition is diagnosed at the same time, the Benefit Payment shall be based on the larger Benefit Amount of those diagnosed. If the Benefit Amounts are the same, there shall be only one Benefit Payment per 180-day period.

The Company will NOT pay the Benefit Amount for a Covered Condition if such Covered Condition is caused by, results from, or occurs during:

a) intentionally causing self-inflicted injuries;
b) suicide, or any attempt at suicide, while sane or insane;
c) serving in the armed forces or any auxiliary unit of the armed forces;
d) participation in the commission or attempted commission of a felony;
e) participation in a riot or insurrection;
f) alcoholism or drug addiction; or
g) being intoxicated or under the influence of alcohol, drugs, or any narcotic (including overdose) unless administered on the advice of a physician and taken according to the physician's instructions. The term "intoxicated" refers to that condition as defined by law and decisions of the jurisdiction in which the accident, cause of loss, or loss occurred.

The Company will NOT pay the Benefit Amount for a Covered Condition if:

a) such Covered Condition is not covered under this Policy;
b) such Covered Condition First Occurred while this Policy was not in force;
c) such Covered Condition was diagnosed by a person who is not a Physician;
d) such Covered Condition was diagnosed outside the U.S., unless the Diagnosis is confirmed in the U.S.;
e) such Covered Condition or surgical procedure was performed outside the U.S., unless on a U.S. military base or facility; or within another U.S. military or government building or facility; or
f) the Insured's date of birth, Age or sex was misstated on the Application and at the correct date of birth, Age or sex the Policy would not have become effective or would have terminated.

Any Benefit Amount payment under this Policy is subject to the adjustments provided in the Policy provisions; including, but not limited to, the Time Limit for Certain Defenses, Misstatement of Age or Sex, and Grace Period provisions.

TERMS UNDER WHICH THIS POLICY MAY BE CONTINUED IN EFFECT OR DISCONTINUED

This Policy, as long as it remains in force, is guaranteed renewable for life. The Owner may renew the Policy by paying each renewal Premium as it becomes due or during the Grace Period. The Company reserves the right to change Premium rates. Any change in Premium will be made on a class basis only, and will be based on the Insured's Issue Age and Premium Class on the Policy Effective Date of the Policy. If the Company changes the rates, We will notify the Owner in writing, at least 30 days before the change, at the Owner's address as listed in the Company's records.

OPTIONAL SPOUSE CRITICAL ILLNESS RIDER

An optional Spouse Critical Illness Rider covering the spouse of the Insured (Spouse Insured) may be available for an additional Premium. This is not the insurance contract for such Rider. The terms and conditions of such Rider are contained in the Rider.

OPTIONAL ACCIDENTAL DEATH BENEFIT RIDER

An optional Accidental Death Benefit Rider covering the Insured may be available for an additional Premium. The Accidental Death Benefit amount, not to exceed the Current Benefit Amount in force at the time of the accident, is paid to the Policy's beneficiary upon receipt of Proof that the Insured's death was accidental in accordance with the terms of the Rider. This is not the insurance contract for such Rider. The terms and conditions of such Rider are contained in the Rider.

Acknowledgement

This receipt must be signed and dated by the applicant and returned with the Application.

This Disclosure provides a brief summary of the Policy. It is not a contract. Only the actual Policy provisions will control. The Policy sets forth in detail the rights and obligations of both the Insured(s) and the Company. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**

Protective Life Insurance Company

The undersigned applicant acknowledges the receipt of this Disclosure. A copy of this document is to be sent in with the Application.

_____

Signature of Applicant

_____

Date

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

According to information you have furnished, you intend to lapse or otherwise terminate existing accident and sickness insurance, Policy No. _____ you have with _____ (Company) and replace it with a policy to be issued by Protective Life Insurance Company. For your own information and protection, you should be aware of and seriously consider certain factors, which may affect the insurance protection available to you under the new policy.

1. Health conditions which you may presently have, (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
3. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain that all questions on the application concerning your medical/health history are truthfully and completely answered. Failure to include all material medical information on an application may provide a basis for the Company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed it should be carefully reviewed before being signed to be certain that all information has been properly recorded.
4. New policies may be issued at an older age than that used for issuance of your present policy; therefore, the cost of the new policy, depending upon the benefits, may be higher than you are paying for your present policy.
5. The renewal provisions of the new policy should be reviewed so as to make sure of your rights to periodically renew the policy.

The above “Notice To Applicant” was delivered to me on:

_____
Date

Witness _____ _____
(Writing Agent) Applicant’s Signature

PROTECTIVE LIFE INSURANCE COMPANY
P.O. Box 830619
BIRMINGHAM, ALABAMA 352830619
(205) 879-9230

NOTICE TO APPLICANT REGARDING REPLACEMENT OF LIFE INSURANCE

A decision to buy a new policy and discontinue or change an existing policy may be a wise choice or a mistake.

Get all the facts. Make sure you fully understand both the proposed policy and your existing policy or policies. New policies may contain clauses which limit or exclude coverage of certain events in the initial period of the contract, such as the suicide and incontestable clauses which may have already been satisfied in your existing policy or policies.

Your best source for facts on the proposed policy is the proposed company and its agent. The best source on your existing policy is the existing company and its agent.

Hear from both before you make your decision. This way you can be sure your decision is in your best interest.

If you indicate that you intend to replace or change an existing policy, Florida regulations require notification of the company that issued the policy.

Florida regulations give you the right to receive a written Comparative Information Form which summarizes your policy values. Indicate whether or not you wish a Comparative Information Form from the proposed company and your existing insurer or insurers by placing your initials in the appropriate box below.

☐ Yes ☐ No

DO NOT TAKE ACTION TO TERMINATE YOUR EXISTING POLICY UNTIL YOUR NEW POLICY HAS BEEN ISSUED AND YOU HAVE EXAMINED IT AND FOUND IT ACCEPTABLE.

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

_____ _____
Applicant's Signature Date

_____ _____
Agent's Signature Date

_____
Agent's Name (Printed or Typed)

_____
Agents Address (Printed or Typed)

_____
Agent's Company (Printed or Typed)

Information on Policies which may be replaced:

Company Name	Policy Number	Name of Insured

ORIGINAL - HOME OFFICE COPY - APPLICANT

COMPARATIVE INFORMATION FORM FOR PROPOSED INSURANCE

PROTECTIVE LIFE INSURANCE COMPANY • P.O. BOX 2606 • BIRMINGHAM, ALABAMA 35202

_____
(Replacing Agent's Name)

APPLICANT INFORMATION

Name _____

Address _____

Telephone ( ) _____

Date of Birth _____ Age _____

POLICY INFORMATION

Policy Generic Name _____

Policy Number _____

Date of Issue _____ Issue Age _____

Contestable Period Expires _____

Suicide Period Expires _____

Policy Loan Rate _____

POLICY/RIDER DESCRIPTION

POLICY/ RIDER NAME	INITIAL/CONTINUING BENEFIT	(Age) BENEFIT FROM TO	INITIAL/RENEWAL ANNUAL PREMIUM	(Age) PAYABLE FROM TO

TOTAL INITIAL ANNUAL PREMIUM $_____ MODE OF PAYMENT _____ AMOUNT $_____

TOTAL RENEWAL ANNUAL PREMIUM $_____ AMOUNT $_____

COMPOSITE DISCLOSURE OF PROPOSED INSURANCE FOR PRIMARY INSURED

		GUARANTEES				PROJECTIONS*			
YR	AGE	ANNUAL PREMIUM	CUMLTV PREMIUM	CASH VALUE	DEATH BENEFIT	ANNUAL PREMIUM	CUMLTV PREMIUM	CASH VALUE	DEATH BENEFIT
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									
16									
17									
18									
19									
20									
55									
60									
65									
75									
85									
95									

*Projections include dividends and current interest rates which are not guaranteed.

IMPORTANT NOTICE:

The income tax treatment of the benefits illustrated above may significantly affect their magnitude. Competent tax advice should be secured to clarify income tax implications.

COMPARATIVE INFORMATION FORM FOR PROPOSED INSURANCE

PROTECTIVE LIFE INSURANCE COMPANY • P.O. BOX 2606 • BIRMINGHAM, ALABAMA 35202

_____ _____

(Existing Insurer) (Insurer's Address)

APPLICANT INFORMATION

Name _____

Address _____

Telephone ( ) _____

Date of Birth _____ Age _____

POLICY INFORMATION

Policy Generic Name _____

Policy Number _____

Date of Issue _____ Issue Age _____

Contestable Period Expires _____

Suicide Period Expires _____

Policy Loan Rate _____

POLICY/RIDER DESCRIPTION

POLICY/ RIDER NAME	INITIAL/CONTINUING BENEFIT	(Age) BENEFIT FROM TO	INITIAL/RENEWAL ANNUAL PREMIUM	(Age) PAYABLE FROM TO

TOTAL INITIAL ANNUAL PREMIUM $_____ MODE OF PAYMENT _____ AMOUNT $_____

TOTAL RENEWAL ANNUAL PREMIUM $_____ AMOUNT $_____

COMPOSITE DISCLOSURE OF PROPOSED INSURANCE FOR PRIMARY INSURED

	GUARANTEES				PROJECTIONS*			
YR AGE	ANNUAL PREMIUM	CUMLTV PREMIUM	CASH VALUE	DEATH BENEFIT	ANNUAL PREMIUM	CUMLTV PREMIUM	CASH VALUE	DEATH BENEFIT
CURRENT								
2nd								
3rd								
4th								
5th								
6th								
7th								
8th								
9th								
10th								
11th								
12th								
13th								
14th								
15th								
16th								
17th								
18th								
19th								
20th								
55								
60								
65								
75								
85								
95								

*Projections include dividends and current interest rates which are not guaranteed.

IMPORTANT NOTICE:

The income tax treatment of the benefits illustrated above may significantly affect their magnitude. Competent tax advice should be secured to clarify income tax implications.

INSTRUCTIONAL NOTES FOR COMPLETION OF COMPARATIVE INFORMATION FORM

1. Existing life insurance must be identified by name of insurer and the policy number. In the event that a policy number has not been assigned by the existing insurer, alternative identification information such as an application or receipt number must be shown.

2. If more than one existing life insurance policy is to be replaced, a separate Comparative Information Form is to be provided for each such policy.

3. In the disclosure of values premiums shall be shown only if they increase the cash value or death benefits for the primary insured.

4. Any benefits for secondary insureds shall be shown on a supplementary exhibit.

5. Values will be shown for each year in which either an initial change in face value or premium payment occurs.

6. Values will be shown in the disclosure for the maximum duration policy guarantees permit. If this benefit extension requires that guaranteed policy options be utilized, the option to be used will be that (those) automatically utilized by the issuing insurer. However, if the policy application provides for applicant election of an alternative option which is binding on the insurer and the applicant elects to make an alternative election, then the extension of benefits must be identified and briefly explained in the "Policy/Rider Description" section of the Comparative Information Form.

7. The dividend option elected by an insured or applicant must be identified and briefly explained in the "Policy/Rider Description" section of the Comparative Information Form. The dividend option elected by the insured or applicant must be employed in completing the disclosure of values.