

SERFF Tracking Number: PRTA-126765485 State: Arkansas
Filing Company: Protective Life Insurance Company State Tracking Number: 46497
Company Tracking Number: LAURA-PL110
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: PL-110 et al
Project Name/Number: PL-110 et al/PL-110 et al

Filing at a Glance

Company: Protective Life Insurance Company

Product Name: PL-110 et al

TOI: L08 Life - Other

Sub-TOI: L08.000 Life - Other

Filing Type: Form

SERFF Tr Num: PRTA-126765485 State: Arkansas

SERFF Status: Closed-Approved-
Closed State Tr Num: 46497

Co Tr Num: LAURA-PL110

State Status: Approved-Closed

Author: Laura Jackson

Reviewer(s): Linda Bird

Date Submitted: 08/13/2010

Disposition Date: 09/01/2010

Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: PL-110 et al

Project Number: PL-110 et al

Requested Filing Mode: Review & Approval

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments: The forms are
being filed concurrently in our domiciliary state
of Tennessee.

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 09/01/2010

Explanation for Other Group Market Type:

State Status Changed: 08/17/2010

Deemer Date:

Created By: Laura Jackson

Submitted By: Laura Jackson

Corresponding Filing Tracking Number: PRTA-
126765569

Filing Description:

RE:

Form Number /// Form Title

PL-110-MAR (04/10) /// Life Insurance Application (Part I)

PL-109-AR (04/10) /// Supplemental Application - Part II

PL-359 (06/10) /// Authorization to Obtain and Disclose Information

SERFF Tracking Number: PRTA-126765485 State: Arkansas
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Please note that an identical filing (except for corporate and form number references) is being made for Protective Life's affiliate West Coast Life Insurance Company. The corresponding SERFF Tracking Number is on the General Information tab.

The captioned forms are being submitted for review and approval. They are new forms that will not replace any forms currently in use by the company. This filing does not contain any unusual or possibly controversial items that vary from normal company or industry standards.

The 109 and 110 forms are currently intended for use together, with the 109 questionnaire form used to gather information to assist in underwriting the insurance applied for on the 110 form. The 359 form is a general-use, HIPAA-compliant authorization form giving the Company permission to obtain and disclose applicant health and medical information for use in the underwriting process.

The 109 and 110 forms are currently intended to be completed electronically, with an electronic agent/broker signature, and then printed out for the applicant's "wet" signature. In addition to the 359 form's traditional paper format, in some cases it may be completed electronically and then printed out for the applicant's "wet" signature.

For the 109 form's question numbers 1-4, 7, and 13, the submitted form displays additional "drill down" questions that will be triggered for completion only if the answers to the cited questions are in the affirmative. Accordingly, these drill-down questions are bracketed as variable to indicate that they may, or may not, appear on the completed form. If they do appear, they will appear as shown on the submitted form (i.e., the drill-down question text displayed within the brackets is not variable). See the submitted Statement of Variability for details. The submitted John Doe specimen shows what the form looks like if the drill-down questions (except for Q2) are NOT triggered.

These forms have been generated in final print format. However, due to rapidly changing technology, we wish to reserve the right to use a different font (always at least 10 point). In addition, when the application and information are input to the computer system it may result in non-material formatting changes due to the amount of information received; i.e. the size of open narrative sections will vary based on the information supplied by the applicant. The Company will ensure that the formatting of these forms will not allow a disclosure or fraud warning to be split from the signature section. While the formatting of these forms may vary slightly by applicant, the material and content will remain the same.

The forms are being filed concurrently in our domiciliary state of Tennessee.

If you have any questions or need further information, please do not hesitate to contact Laura Jackson via SERFF, toll-free phone (800) 866-3555 x7288, or e-mail laura.jackson@protective.com.

Company and Contact

SERFF Tracking Number: PRTA-126765485 State: Arkansas
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Filing Contact Information

Laura Jackson, Policy Contract Filing Specialist laura.jackson@protective.com
 2801 Highway 280 South 800-866-3555 [Phone] 7288 [Ext]
 Birmingham, AL 35223 205-268-3401 [FAX]

Filing Company Information

Protective Life Insurance Company CoCode: 68136 State of Domicile: Tennessee
 2801 Highway 280 Group Code: 458 Company Type:
 Birmingham, AL 35223 Group Name: State ID Number:
 (800) 866-3555 ext. [Phone] FEIN Number: 63-0169720

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? No
 Fee Explanation: \$50 per filing
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Protective Life Insurance Company	\$50.00	08/13/2010	38764809
Protective Life Insurance Company	\$100.00	08/16/2010	38798244

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TOI: L08 Life - Other

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Product Name: PL-110 et al

Project Name/Number: PL-110 et al/PL-110 et al

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	09/01/2010	09/01/2010
Approved-Closed	Linda Bird	08/17/2010	08/17/2010

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Linda Bird	08/16/2010	08/16/2010	Laura Jackson	08/16/2010	08/16/2010

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Form	Life Insurance Application (Part I)	Laura Jackson	08/30/2010	08/30/2010
Supporting Document	John Doe Specimen Forms	Laura Jackson	08/30/2010	08/30/2010

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Please Re-open Filing for Amendment	Note To Filer	Linda Bird	08/30/2010	08/30/2010
Please Reopen Filing for Amendment	Note To Reviewer	Laura Jackson	08/30/2010	08/30/2010

SERFF Tracking Number: PRTA-126765485 State: Arkansas
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Product Name: PL-110 et al
Project Name/Number: PL-110 et al/PL-110 et al

Disposition

Disposition Date: 09/01/2010

Implementation Date:

Status: Approved-Closed

Comment: Company has submitted an amendment on the approved version of form number PL-110-MAR (04/10).

Rate data does NOT apply to filing.

SERFF Tracking Number: PRTA-126765485 State: Arkansas
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 Product Name: PL-110 et al
 Project Name/Number: PL-110 et al/PL-110 et al

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Statement of Variability		Yes
Supporting Document (revised)	John Doe Specimen Forms		Yes
Supporting Document	John Doe Specimen Forms	Replaced	Yes
Form (revised)	Life Insurance Application (Part I)		Yes
Form	Life Insurance Application (Part I)	Replaced	Yes
Form	Supplemental Application - Part II		Yes
Form	Authorization to Obtain and Disclose Information		Yes

SERFF Tracking Number: *PRTA-126765485* *State:* *Arkansas*
Filing Company: *Protective Life Insurance Company* *State Tracking Number:* *46497*
Company Tracking Number: *LAURA-PL110*
TOI: *L08 Life - Other* *Sub-TOI:* *L08.000 Life - Other*
Product Name: *PL-110 et al*
Project Name/Number: *PL-110 et al/PL-110 et al*

Disposition

Disposition Date: 08/17/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Statement of Variability		Yes
Supporting Document (revised)	John Doe Specimen Forms		Yes
Supporting Document	John Doe Specimen Forms	Replaced	Yes
Form (revised)	Life Insurance Application (Part I)		Yes
Form	Life Insurance Application (Part I)	Replaced	Yes
Form	Supplemental Application - Part II		Yes
Form	Authorization to Obtain and Disclose Information		Yes

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Project Name/Number: PL-110 et al/PL-110 et al

Objection Letter

Objection Letter Status Pending Industry Response
Objection Letter Date 08/16/2010
Submitted Date 08/16/2010
Respond By Date 09/16/2010

Dear Laura Jackson,

This will acknowledge receipt of the captioned filing.

Objection 1

No Objections

Comment: Regulation 57 was revised effective January 2010, the filing fee is now \$50.00 per form. We will hold your filing in a pending status until the additional \$100.00 is received.

Please feel free to contact me if you have questions.

Sincerely,

Linda Bird

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Product Name: PL-110 et al
Project Name/Number: PL-110 et al/PL-110 et al

Response Letter

Response Letter Status Submitted to State
Response Letter Date 08/16/2010
Submitted Date 08/16/2010

Dear Linda Bird,

Comments:

Thank you for your time in the initial processing of this filing.

Response 1

Comments: We have remitted the additional \$100 in fees via EFT. Please accept our apologies for the inconvenience.

Related Objection 1

Comment:

Regulation 57 was revised effective January 2010, the filing fee is now \$50.00 per form. We will hold your filing in a pending status until the additional \$100.00 is received.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

If you have any questions or need additional information as you continue your review, please do not hesitate to contact me.

Sincerely,
Laura Jackson

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 Project Name/Number: PL-110 et al/PL-110 et al

Amendment Letter

Submitted Date: 08/30/2010

Comments:

Amendment to Change Form Number

Dear Ms. Bird -

Thank you for your willingness to reopen this filing so that we may change the form number of the 110 form (which has not yet been implemented) so that the variation code is "-AR" instead of "-MAR".

We also took this opportunity to correct two typos in the 110 form's Declarations section at the top of page 3: In item (c), we added "paid" to the second sentence so it reads "...premium is paid as set forth...." In item (e), we replaced "of" with "and" so the sentence reads "...terms and conditions...."

The revised form, which is attached as a revised Form Schedule item (and as a revised John Doe specimen under the Supporting Documentation tab), is otherwise identical to the originally-submitted version.

If you have any questions or need additional information regarding this amendment, please contact me via SERFF, toll-free phone 1-800-866-3555 x7288, or email laura.jackson@protective.com.

Sincerely,

Laura Jackson

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
PL-110-AR (04/10)	Application/ELife nrollment Form	Insurance Application (Part I)	Initial				50.200	PL-110-AR 04.10 Life Ins App Part I .pdf

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Project Name/Number: PL-110 et al/PL-110 et al

Supporting Document Schedule Item Changes:

User Added -Name: John Doe Specimen Forms

Comment:

PL-359 06.10 Auth to Obtain Disclose Info John Doe.pdf

PL-109-AR 04.10 Supp App Part II John Doe .pdf

PL-110-AR 04.10 Life Ins App Part I John Doe.pdf

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Product Name: PL-110 et al
Project Name/Number: PL-110 et al/PL-110 et al

Note To Filer

Created By:

Linda Bird on 08/30/2010 10:43 AM

Last Edited By:

Linda Bird

Submitted On:

08/30/2010 10:43 AM

Subject:

Please Re-open Filing for Amendment

Comments:

Filing has been re-opened.

SERFF Tracking Number: PRTA-126765485 *State:* Arkansas
Filing Company: Protective Life Insurance Company *State Tracking Number:* 46497
Company Tracking Number: LAURA-PL110
TOI: L08 Life - Other *Sub-TOI:* L08.000 Life - Other
Product Name: PL-110 et al
Project Name/Number: PL-110 et al/PL-110 et al

Note To Reviewer

Created By:

Laura Jackson on 08/30/2010 09:38 AM

Last Edited By:

Laura Jackson

Submitted On:

08/30/2010 10:04 AM

Subject:

Please Reopen Filing for Amendment

Comments:

Dear Ms. Bird -

Thank you for your time on the phone this morning. Per our discussion, please reopen this filing so that we may submit an amendment to (1) change the form number on the PL-110-MAR (04/10) form to PL-110-AR (04/10), and (2) correct two typos on the last page of that form (adding "paid" to the second sentence in item (c) so it reads "...premium is paid as set forth...", and replacing "of" with "and" in item (e) so it reads "...terms and conditions..."). The form has not been implemented, and will be otherwise unchanged from the approved version.

Sincerely,

Laura Jackson

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Form Schedule

Lead Form Number: PL-110-MAR (04/10) et al

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	PL-110-AR (04/10)	Application/ Enrollment Form	Life Insurance Application (Part I)	Initial		50.200	PL-110-AR 04.10 Life Ins App Part I .pdf
	PL-109-AR (04/10)	Application/ Enrollment Form	Supplemental Application - Part II	Initial		57.300	PL-109-AR 04.10 Supp App Part II .pdf
	PL-359 (06/10)	Application/ Enrollment Form	Authorization to Obtain and Disclose Information	Initial		51.900	PL-359 06.10 Auth to Obtain Disclose Info .pdf

Policy Number _____

LIFE INSURANCE APPLICATION (PART I)

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

State of Domicile: [Tennessee]

1. Proposed Insured

_____	_____	_____	_____	_____	_____	_____	_____
Name	<i>First</i>	<i>M.I.</i>	<i>Last</i>	Birthdate	Birthplace	Marital Status	Gender
_____				_____		_____	
Street Address				Day Phone Number		Night Phone Number	
_____				_____		_____	
_____				Tax ID/Social Security Number		Annual Income	
_____				_____		_____	
City				State	Zip	U.S. Residency	Occupation

2. Owner (If other than Proposed Insured)

_____	_____	_____	_____	_____
Name	<i>First</i>	<i>M.I.</i>	<i>Last</i>	Trust Date
_____				_____
Street Address				Tax ID / Social Security Number
_____				_____
_____				Relationship to Proposed Insured
_____				_____
City				State Zip

3. Primary Beneficiary (Name, Relationship, Percent)

Contingent Beneficiary (Name, Relationship, Percent)

4. Plan Information

Plan Name: _____ Amount of Coverage: _____

Risk Class: _____ Tobacco Use: ___ Issue Best Underwriting Class: _____

Initial Payment Amount: _____ Planned Periodic Payment Amount: _____

Payment Frequency: _____

(Optional - Term Plan Only) Multi-Year Mode for _____ Number of Years

(Universal Life Plans Only) Death Benefit Option: _____

Policy Number _____

5. 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 NOT.

Company Name	Issue Date	Amount	REPLACEMENT YES NO	
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>

6. TO AVOID DELAY IN PROCESSING -- THIS QUESTION MUST BE ANSWERED.

Is there any 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? Yes No
 If "yes", please explain under "Remarks".

7. Regarding the Proposed Insured

	YES	NO
a. Do you have an application pending in another company?.....	<input type="checkbox"/>	<input type="checkbox"/>
b. Have you ever had any life or health insurance declined, postponed or offered other than as applied for?.....	<input type="checkbox"/>	<input type="checkbox"/>
c. Will this policy replace or change any existing life insurance or annuity in force?.....	<input type="checkbox"/>	<input type="checkbox"/>

Remarks:

Home Office Endorsement (Home Office Use Only)

[Racing Information

1. What type of racing vehicle do you use? (examples include: automobile, snowmobile, motorcycle, boat, other – please specify) [XXXXX]
2. What is the maximum speed attained? [XXXXX]
3. What is your engine size? [XXXXX]
4. What specific types of competition do you engage in? (examples include Midget, Sports Car, Drag, Sprint, Cross Country, etc.) [XXXXX]
5. What type of fuel is used? [XXXXX]
6. Are you an Amateur or Professional racer? [XXXXX]
7. Are you a member of a Racing Association? (examples include NASCAR, IMSA, SCCA, etc.) [XXXXX]

[Hang Gliding Information

1. How many years have you been hang-gliding? [XXXXX]
2. Are you a member of a hang-gliding and/or paragliding association or affiliated club? [XXXXX]
3. Do you hold a pilot rating for cross country or higher? If YES, provide details. [XXXXX]
4. Are you an instructor? [XXXXX]
5. Please give details of flying completed to date. (Include: total number of hours flown to date, altitude of flights and number of flights made to date.) [XXXXX]
6. Please give details of intended flying in the future. (Include: number of hours you intend to do per year, altitude of flights and number of flights you intend to make per year.) [XXXXX]
7. Where do you hang-glide? [XXXXX]
8. Which method of launching do you use? [XXXXX]
9. Do you expect to participate in any form of competition flying or record attempts, or to carry out any prototype testing? If YES, give full details. [XXXXX]
10. Have you been involved in any accident causing injury to yourself or significant damage to your hang-glider? If YES, please give full details. [XXXXX]

[Scuba Diving Information

1. Do you plan to dive in the next 24 months? If YES, when? [XXXXX]
2. How many dives do you plan to take in the next 12 months? [XXXXX]
3. Do you dive for pleasure or commercial purposes? [XXXXX]

4. Describe your diving history for the past 24 months including the number dives completed, depth of dives and average time.

Number of dives to depths of less than 50 feet: [XXXXX]

Number of dives to depths between 50 and 75 feet: [XXXXX]

Number of dives to depths between 76 and 100 feet: [XXXXX]

Number of dives to depths between 101 and 130 feet: [XXXXX]

Number of dives to depths between 131 and 150 feet: [XXXXX]

5. When was the date of your last dive? [XXXXX]

6. Do you engage in ice, cave or night diving? [XXXXX]

Search or rescue work? [XXXXX]

Salvage? [XXXXX]

7. What are the locations of your diving activities? (examples include: Lakes, Rivers, Pools, Ocean Beaches, Deep Sea, Other – specify) [XXXXX]

8. How long have you been diving? [XXXXX]

9. Will you use mixed gas equipment? (examples include: Nitrox, Trimix, Heliox, etc.)
If YES, how often? [XXXXX]

10. Do you dive alone? If YES, how often? [XXXXX]

11. Are you a certified diver? If YES, level of certification? Date of last certification?

Level of Certification: [XXXXX]

Date of last certification: [XXXXX]

12. Are you a member of an organized club? If YES, give details [XXXXX]

Club Details: [XXXXX]

13. Have you ever been treated for decompression sickness or arterial gas embolism?

Details: [XXXXX]

[Mountain Climbing Information

1. How many years have you been climbing regularly? [XXXXX]

2. How often do you climb? [XXXXX]

3. Are you a member of a climbing club? [XXXXX]

[Climbing club Details: [XXXXX]]

4. Where do you climb?

North America (Mt McKinley, other – please specify)

Specific Climbing Locations: [XXXXX]

Europe (Alps, other – please specify)

Specific Climbing Locations: [XXXXX]

Asia (Himalayas / Karakoram, other – please specify)

Specific Climbing Locations: [XXXXX]

Africa (please specify)

Specific Climbing Locations: [XXXXX]

Other (please specify)

Specific Climbing Locations: [XXXXX]

5. Please give details of the nature of climbing including

a. Type of terrain, i.e. rock, snow/ice, artificial climbing walls

[XXXXX]

b. Degree of difficulty, i.e. easy, moderate, difficult, severe

[XXXXX]

c. Maximum height climbed: [XXXXX]

d. Season(s) of year when you climb [XXXXX]

6. What proportion of your climbing is on routes protected by fixed or placed devices?

(Such as bolts, hangars, pitons, etc.) [XXXXX]

7. Do you ever climb without a rope?

If YES, please state how often, location and degree of difficulty. [XXXXX]

8. Do you plan to go on any overseas expeditions in the next 2 years?

If YES, please give full details, including area, length of expedition, and frequency of trips.

[XXXXX]

[Sky Diving Information

1. Do you belong to a club?

[Club or Association details: [XXXXX]]

2. What is the number of jumps you have made in the past 12 months? What do you anticipate for the next 12 months?

Past 12 months details: [XXXXX]

Next 12 months details: [XXXXX]

3. Are you an Amateur or Professional sky diver? If professional, do you participate in aerobatic stunts, instructing or training? Details?

Sky diver level: [XXXXX]

[Participation in aerobic stunts, instructing or training: [XXXXX]

Details: [XXXXX]

4. Do you participate in base jumping or delayed jumps?

Details: [XXXXX]

[Other Activities (Please describe the type of activity, frequency and future plans.)

[XXXXX]

YES NO

4. Have you piloted or been a crew member aboard an aircraft in the past 2 years or do you have any intention of becoming a pilot?
[I am a: [XXXX]

Aviation Information

1. What is the purpose of present and future flying? (Pleasure, commercial, military, business, student instruction, charters, test flying, racing, aerobatic flight, stunt flying, crop dusting (if crop dusting – Ag plane or Other – please specify))
[XXXXX]

2. Type of license currently held (student, private, commercial, ATR, IFR, Other)
[XXXXX]

3. Type of aircraft (i.e. jet, single engine, glider, ultralight, home built, etc.)
[XXXXX]

4. Total number of solo hours? [XXXXX]

5. Total number of hours flown per year? [XXXXX]

6. Have you ever had an aviation accident or violation?
If YES, provide details. [XXXXX]

7. Do you have any flights planned over inaccessible or remote areas?
If YES, provide details. [XXXXX]

8. Do you fly exclusively in the U.S. and Canada?
If YES, provide details. [XXXXX]

9. If aviation requires an extra premium or exclusion rider, which would you prefer?
Extra Premium or Exclusion Rider? [XXXXX]

5a. What is the name and address of your primary physician? (If none, indicate "None")
[XXXXX]

5b. When did you last consult a physician and why? [XXXXX]

5c. What treatment was given or medication prescribed? [XXXXX]

6a. What is your current height and weight? [XXXXX]

6b. Has your weight changed by more than 10 pounds in the past year?
If YES, provide details. [XXXXX]

7. When was your last use of any nicotine or tobacco product? (Never, Within 1 year, 2-3 years, 4+ years) If any answer other than "Never" - provide details. [XXXXX]

[7a. What types of nicotine or tobacco products have you used? (Note: Examples of nicotine or tobacco products include: cigarettes, cigars, chewing tobacco or snuff, pipe, nicotine gum, nicotine patch, other – please describe) [XXXXX]

7b. When was the date last used? [XXXXX]

YES NO

8. Have you ever had, been told you had, or been treated by a physician or medical professional for:

- | | | |
|--|--------------------------|--------------------------|
| 8a. Chest pain, pulse irregularity, high blood pressure, elevated cholesterol, rheumatic fever, heart murmur, heart attack, stroke, or other disorder of the heart or circulatory system?
[XXXXX] | <input type="checkbox"/> | <input type="checkbox"/> |
| 8b. Cancer, tumor, or disorders of the lymph glands? [XXXXX] | <input type="checkbox"/> | <input type="checkbox"/> |
| 8c. Diabetes, thyroid or other endocrine disorder? [XXXXX] | <input type="checkbox"/> | <input type="checkbox"/> |
| 8d. Sugar, protein or blood in urine; venereal disease, stone or other disorder of kidney, bladder, prostate, reproductive organs or breasts? [XXXXX] | <input type="checkbox"/> | <input type="checkbox"/> |
| 8e. Jaundice, hepatitis, intestinal bleeding, ulcer, chronic diarrhea, colitis, diverticulitis, or other disorder of the stomach, intestines, liver or gall bladder? [XXXXX] | <input type="checkbox"/> | <input type="checkbox"/> |
| 8f. Sleep Apnea, asthma, emphysema, bronchitis, tuberculosis, or chronic respiratory disorder? [XXXXX] | <input type="checkbox"/> | <input type="checkbox"/> |
| 8g. Convulsions, seizures, epilepsy, paralysis, mental or nervous disorder, anxiety or depression? [XXXXX] | <input type="checkbox"/> | <input type="checkbox"/> |
| 8h. AIDS (Acquired Immune Deficiency Syndrome)? [XXXXX] | <input type="checkbox"/> | <input type="checkbox"/> |
| 8i. Anemia, or disorder of the blood, or immune system or had transfusion or been refused as a donor? [XXXXX] | <input type="checkbox"/> | <input type="checkbox"/> |
| 8j. Fibromyalgia, arthritis, gout, lupus or disorder of the muscles, bones or joints, including the spine? [XXXXX] | <input type="checkbox"/> | <input type="checkbox"/> |
| 8k. Amputation or deformity? [XXXXX] | <input type="checkbox"/> | <input type="checkbox"/> |

If YES answer for any question above, please provide details.

9. Other than as previously stated, have you, within the past 5 years:

- | | | |
|---|--------------------------|--------------------------|
| 9a. Had a checkup, consultation, illness, injury or surgery? [XXXXX] | <input type="checkbox"/> | <input type="checkbox"/> |
| 9b. Had any mental or physical disorder? [XXXXX] | <input type="checkbox"/> | <input type="checkbox"/> |
| 9c. Been a patient in a hospital, clinic, sanatorium or other medical facility? [XXXXX] | <input type="checkbox"/> | <input type="checkbox"/> |
| 9d. Had electrocardiogram, x-ray, other diagnostic test? [XXXXX] | <input type="checkbox"/> | <input type="checkbox"/> |
| 9e. Been advised by a physician or medical professional to have surgery, medical treatment, biopsy or, diagnostic testing excluding HIV testing, that has not been completed? [XXXXX] | <input type="checkbox"/> | <input type="checkbox"/> |

If YES answer for any question above, please provide details.

- | | YES | NO |
|--|--------------------------|--------------------------|
| 10a. Are you taking any medications or treatments not previously mentioned? [XXXXX] | <input type="checkbox"/> | <input type="checkbox"/> |
| 10b. Are you planning to seek medical advice or treatment for any reason? [XXXXX] | <input type="checkbox"/> | <input type="checkbox"/> |
| If YES answer for any question above, please provide details. | | |
| 11. Have you ever requested or received a pension, or payment because of an injury, sickness or disability? If YES, please provide details. [XXXXX] | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Do you know if any parent, brother or sister has had Heart Disease, Cancer, Diabetes or Stroke? If YES, provide relationship and age at onset. If deceased, please provide age at death. [XXXXX] | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Have you ever: | | |
| 13a. Used amphetamines, marijuana, cocaine, hallucinogens, heroin or other drugs except as prescribed by a physician? [XXXXX] | <input type="checkbox"/> | <input type="checkbox"/> |
| 13b. Been addicted to prescription medication or been advised by a physician to discontinue using habit forming drugs? If YES, provide dates of use, type and frequency. [XXXXX] | <input type="checkbox"/> | <input type="checkbox"/> |
| 13c. Been treated or counseled for alcohol or drug use? [XXXXX] | <input type="checkbox"/> | <input type="checkbox"/> |
| 13d. Been advised to reduce your consumption of alcohol or drugs? [XXXXX] | <input type="checkbox"/> | <input type="checkbox"/> |

[Alcohol Usage Information

- | | | |
|---|--------------------------|--------------------------|
| 1. Do you presently use alcoholic beverages?
If YES, what type (beer, wine, liquor?); how frequently (daily, weekly?) and what quantity?
[XXXXX] | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Did you ever drink substantially more than at present?
If YES, provide timeframe (from ____ to ____) and details on the type of alcohol (beer, wine or liquor), how often it was consumed and the quantity involved. [XXXXX] | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Why did you change your drinking habits? [XXXXX] | | |
| 4. Have you ever consulted a physician or received treatment or advice or been hospitalized because of your alcohol use? If YES, provide dates, hospitals, treatment centers and physician's names and addresses. [XXXXX] | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever been arrested or convicted of driving while under the influence of alcohol? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Are you now a member of AA? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you joined and then left AA?
If so, what was the reason? [XXXXX] | <input type="checkbox"/> | <input type="checkbox"/> |

YES NO

- 8. How long have you totally abstained from alcohol usage? [XXXXX]
- 9. Please add any additional information which you feel is important concerning your use of alcohol before and/or after treatment: [XXXXX]]

[Drug Usage Information

- 1. Do you presently use mind or mood altering drugs? YES NO
If YES, give details concerning the name of the drug, how often it is used and the quantity involved. [XXXXX]
- 2. Did you ever use substantially more than you use currently? YES NO
If YES, what dates? From _____ to _____. Also, give details including the type of drug, quantity and frequency of use. [XXXXX]
- 3. Why did you change your drug use habits? [XXXXX]
- 4. Have you ever consulted a doctor or received treatment because of your drug use? YES NO
If YES, indicate name and address of any doctor, hospital or treatment center. [XXXXX]
- 5. Have you ever been arrested or convicted for using or possession of drugs? YES NO
If YES, give details. [XXXXX]
- 6. Please add any additional information which you feel is important concerning your use of drugs before and/or after treatment. [XXXXX]]
- 14. Have you ever been convicted or are you awaiting trial for a felony, misdemeanor or infraction other than a traffic violation? If YES, provide details. [XXXXX] YES NO
- 15a. Have you had more than 2 moving violations or had any suspensions or revocations in the past 3 years? If YES, provide details. [XXXXX] YES NO
- 15b. Have you been arrested or convicted for reckless driving or driving under the influence of alcohol or drugs within the past 7 years? If YES, provide details. [XXXXX] YES NO

I represent that all statements and answers made in all parts of the application are full, complete and true to the best of my knowledge and belief and I have not withheld any material information that may influence the assessment or acceptance of this application. I agree to inform Protective Life Insurance Company of any material changes before the insurance goes into effect.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Proposed Insured Signature _____

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

Parent Signature if Proposed Insured is under age 15: _____

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 that exempt the minimum necessary rules as they apply to life insurance. I (we) authorize Protective Life Insurance Company (Protective Life) and its reinsurers to obtain directly through designated third parties 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 to include all dates of service, including but not limited to information about chart notes, EKG's, 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 or life partner may be used to evaluate an application for insurance on either me or my spouse or 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, directly through designated third parties 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 including all satellite facilities 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 7 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 or 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. I (we) authorize Protective Life to release and disclose the information described in paragraphs 1 and 3 to other duly licensed life insurers if I (we) have applied or apply to the other insurers for insurance.
5. I (we) authorize Protective Life to release and disclose the information described in paragraphs 1 and 3 to the Agent and their Representative representing me to duly licensed specific life insurers for the purpose of applying for life insurance if my (our) application with Protective Life is declined or if Protective Life is unable to offer coverage at an acceptable rate.
6. I (we) authorize Protective Life to 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.
7. **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. I (we) hereby authorize Protective Life to obtain and use the results of any HIV tests that I (we) separately authorize, and if permitted by law, to disclose the results of those tests to its reinsurers and **MIB**.

8. This authorization shall be valid for 12 months from the Date of Authorization shown below or, in the event of a claim for benefits, for the duration of such claim.
9. 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 7 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.
10. I understand I do not have to sign this authorization in order to obtain **health care benefits (treatment, payment or enrollment)**.
11. 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.
12. *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 Protective Life's ability to process this application.*
13. 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 if you wish to be interviewed.)*
 If performed, I (we) would like copies of my (our) blood profile test results.

THIS AUTHORIZATION MUST BE SIGNED WITHOUT MODIFICATION AND RETURNED WITH THE APPLICATION BEFORE PROCESSING.

Proposed Insured 1 (Signature)	Date of Birth	Date of Authorization: _____ When applicable, print name(s) of minor(s) below:
Print Name	Social Security #	
Proposed Insured 2 (Signature)	Date of Birth	
Print Name	Social Security #	Health Care Provider
Parent or Legal Guardian (Signature)		Physician Name
		Physician Name

SERFF Tracking Number: PRTA-126765485

State: Arkansas

Filing Company: Protective Life Insurance Company

State Tracking Number: 46497

Company Tracking Number: LAURA-PL110

TOI: L08 Life - Other

Sub-TOI: L08.000 Life - Other

Product Name: PL-110 et al

Project Name/Number: PL-110 et al/PL-110 et al

Supporting Document Schedules

Item Status:

Status

Date:

Satisfied - Item: Flesch Certification

Comments:

Attachments:

PL Readability Certification - 110 109 359 SIGNED.pdf

PL AR Compliance Cert SIGNED.pdf

Item Status:

Status

Date:

Satisfied - Item: Statement of Variability

Comments:

Attachment:

PL Statement of Variability - 110 109 359 SIGNED.pdf

Item Status:

Status

Date:

Satisfied - Item: John Doe Specimen Forms

Comments:

Attachments:

PL-359 06.10 Auth to Obtain Disclose Info John Doe.pdf

PL-109-AR 04.10 Supp App Part II John Doe .pdf

PL-110-AR 04.10 Life Ins App Part I John Doe.pdf

PROTECTIVE LIFE INSURANCE COMPANY
Birmingham, Alabama

READABILITY CERTIFICATION

This is to certify that the listed forms, and state variations thereof, have achieved the stated Flesch Reading Ease Test scores:

FORM	SCORE
PL-110 (04/10)	50.2
PL-109 (04/10)	57.3
PL-359 (06/10)	51.9

Signed for the Company by:



Keith Kirkley, J.D. MBA
Assistant Vice President
Protective Life Insurance Company

August 10, 2010

PROTECTIVE LIFE INSURANCE COMPANY BIRMINGHAM, ALABAMA

CERTIFICATION OF COMPLIANCE

Arkansas

FORM NUMBER.....FORM TITLE

PL-110-MAR (04/10)....Life Insurance Application (Part I)

PL-109-AR (04/10).....Supplemental Application - Part II

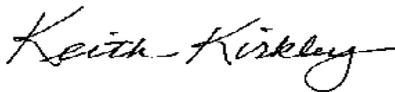
PL-359 (06/10).....Authorization to Obtain and Disclose Information

This is to certify that the Company is in compliance with Arkansas Insurance Department regarding:

Rule and Regulation 19 requirements of Unfair Sex Discrimination in the Sale of Insurance;

Rule and Regulation 49 requirements for Guaranty Association Notice;

Code Ann. 23-79-138 requirements for Consumer Notice.



Keith Kirkley, J.D., MBA
Assistant Vice President
Product Development
Contract Drafting & Filing Team

August 11, 2010

Statement of Variability

Life Insurance Application (Part I) Form PL-110 (04/10) Supplemental Application – Part II Form PL-109 (04/10) Authorization to Obtain and Disclose Information Form PL-359 (06/10) and State Variations Thereof

Variable material is denoted by [square brackets], except for underscores and boxed spaces for applicant ("John Doe") information to be filled in on the 110 and 359 forms.

Life Insurance Application (Part I) Form PL-110 (04/10)

Company Address – Will only be changed to accurately disclose the company's correct mailing address.

Company State of Domicile – Will only be changed to accurately disclose the company's state of domicile. This change would not be made until any required notifications or regulatory filings are completed.

"John Doe" Information – Denoted by underscores and boxed spaces to fill in information. Will vary by applicant.

Supplemental Application – Part II Form PL-109 (04/10)

Company Address – Will only be changed to accurately disclose the company's correct mailing address.

Company State of Domicile – Will only be changed to accurately disclose the company's state of domicile. This change would not be made until any required notifications or regulatory filings are completed.

"John Doe" Information – Denoted by "[XXXXX]". Will vary by applicant. Size of open narrative sections (for requests to provide details) will vary based on information supplied by the applicant.

Foreign Travel and Residence Information (following Q1) – This section will appear only if answer to Q1a is negative, or the answer to Q1b or Q1c is affirmative. If it appears, its text, except for "John Doe" fill-ins denoted by "[XXXXX]", is not variable.

Exercise Type and Frequency Details (following Q2) – This section will appear only if the answer to Q2 is affirmative. If it appears, its text, except for "John Doe" fill-ins denoted by "[XXXXX]", is not variable.

Racing Information, Hang Gliding Information, Scuba Diving Information, Mountain Climbing Information, Sky Diving Information, Other Activities Information (all following Q3) – Each of these sections will appear only if the answer to Q3 is affirmative for that activity. If they appear, their text, except for "John Doe" fill-ins denoted by "[XXXXX]", is not variable.

Aviation Information (following Q4) – This section will appear only if the answer to Q4 is affirmative. If it appears, its text, except for "John Doe" fill-ins denoted by "[XXXXX]", is not variable.

Nicotine/Tobacco Information (Q7a and Q7b following Q7) – This section will appear only if the answer to Q7 is other than "Never". If it appears, its text, except for "John Doe" fill-ins denoted by "[XXXXX]", is not variable.

Alcohol Usage Information (following Q13) – This section will appear if the answer to Q13c or Q13d is affirmative for alcohol. If it appears, its text, except for "John Doe" fill-ins denoted by "[XXXXX]", is not variable.

Drug Usage Information (following Q13) – This section will appear if the answer to Q13a or Q13b is affirmative, or if the answer to Q13c or Q13d is affirmative for drugs. If it appears, its text, except for "John Doe" fill-ins denoted by "[XXXXX]", is not variable.

Authorization to Obtain and Disclose Information Form PL-359 (06/10)

Company Address – Will only be changed to accurately disclose the company's correct mailing address.

"John Doe" Information – Denoted by underscores to fill in information. Will vary by applicant.

CERTIFICATION

I certify that the information contained in this Statement of Variability is true and correct to the best of my knowledge and belief, and that I am duly authorized by the company to make this certification.

Signed for the Company by:



Keith Kirkley, J.D. MBA
Assistant Vice President
Protective Life Insurance Company

August 10, 2010

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 that exempt the minimum necessary rules as they apply to life insurance. I (we) authorize Protective Life Insurance Company (Protective Life) and its reinsurers to obtain directly through designated third parties 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 to include all dates of service, including but not limited to information about chart notes, EKG's, 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 or life partner may be used to evaluate an application for insurance on either me or my spouse or 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, directly through designated third parties 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 including all satellite facilities 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 7 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 or 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. I (we) authorize Protective Life to release and disclose the information described in paragraphs 1 and 3 to other duly licensed life insurers if I (we) have applied or apply to the other insurers for insurance.
5. I (we) authorize Protective Life to release and disclose the information described in paragraphs 1 and 3 to the Agent and their Representative representing me to duly licensed specific life insurers for the purpose of applying for life insurance if my (our) application with Protective Life is declined or if Protective Life is unable to offer coverage at an acceptable rate.
6. I (we) authorize Protective Life to 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.
7. **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. I (we) hereby authorize Protective Life to obtain and use the results of any HIV tests that I (we) separately authorize, and if permitted by law, to disclose the results of those tests to its reinsurers and **MIB**.

8. This authorization shall be valid for 12 months from the Date of Authorization shown below or, in the event of a claim for benefits, for the duration of such claim.
9. 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 7 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.
10. I understand I do not have to sign this authorization in order to obtain **health care benefits (treatment, payment or enrollment)**.
11. 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.
12. *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 Protective Life's ability to process this application.*
13. 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 if you wish to be interviewed.)*
 If performed, I (we) would like copies of my (our) blood profile test results.

THIS AUTHORIZATION MUST BE SIGNED WITHOUT MODIFICATION AND RETURNED WITH THE APPLICATION BEFORE PROCESSING.

Proposed Insured 1 (Signature)	Date of Birth	Date of Authorization: _____ When applicable, print name(s) of minor(s) below:
Print Name	Social Security #	
Proposed Insured 2 (Signature)	Date of Birth	
Print Name	Social Security #	Health Care Provider
Parent or Legal Guardian (Signature)		Physician Name
		Physician Name

Supplemental Application – Part II

Protective Life Insurance Company
[P.O. Box 830619
Birmingham, ALABAMA 35283-0619]
State of Domicile: [Tennessee]

Proposed Insured Name John D. Doe

Policy Number 123456789

Birth Date January 1, 1990

Driver's License Number 1234567

DL State Alabama

- | | YES | NO |
|---|-------------------------------------|-------------------------------------|
| 1a. Are you a US Citizen? | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 1b. Do you plan to travel or reside outside the U.S., Puerto Rico or Canada in the next 12 months? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 1c. Have you traveled outside the U.S., Puerto Rico or Canada in the last 2 years? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 2. Do you participate in a regular, supervised exercise program or organized sport? If YES, provide details. | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| Exercise Type Details: <u>I visit the gym and run.</u>
Exercise Frequency Details: <u>gym – daily and run 5 miles a day.</u> | | |
| 3. In the past 2 years, have you participated in auto racing, hang gliding, scuba diving, mountain climbing, sky diving or other such activities? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 4. Have you piloted or been a crew member aboard an aircraft in the past 2 years or do you have any intention of becoming a pilot? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 5a. What is the name and address of your primary physician? (If none, indicate "None") | | |
| <u>Mr. Don Doc, 5617 Medical Center Avenue, Birmingham, AL 12345</u> | | |
| 5b. When did you last consult a physician and why? <u>July 1, 2010 for complete annual physical.</u> | | |
| 5c. What treatment was given or medication prescribed? <u>None</u> | | |
| 6a. What is your current height and weight? <u>6'2" and 160 lbs.</u> | | |
| 6b. Has your weight changed by more than 10 pounds in the past year?
If YES, provide details. | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 7. When was your last use of any nicotine or tobacco product? (Never, Within 1 year, 2-3 years, 4+ years) If any answer other than "Never" - provide details. <u>Never</u> | | |
| 8. Have you ever had, been told you had, or been treated by a physician or medical professional for: | | |
| 8a. Chest pain, pulse irregularity, high blood pressure, elevated cholesterol, rheumatic fever, heart murmur, heart attack, stroke, or other disorder of the heart or circulatory system? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 8b. Cancer, tumor, or disorders of the lymph glands? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 8c. Diabetes, thyroid or other endocrine disorder? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 8d. Sugar, protein or blood in urine; venereal disease, stone or other disorder of kidney, bladder, prostate, reproductive organs or breasts? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 8e. Jaundice, hepatitis, intestinal bleeding, ulcer, chronic diarrhea, colitis, diverticulitis, or other disorder of the stomach, intestines, liver or gall bladder? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

YES NO

8f. Sleep Apnea, asthma, emphysema, bronchitis, tuberculosis, or chronic respiratory disorder?

8g. Convulsions, seizures, epilepsy, paralysis, mental or nervous disorder, anxiety or depression?

8h. AIDS (Acquired Immune Deficiency Syndrome)?

8i. Anemia, or disorder of the blood, or immune system or had transfusion or been refused as a donor?

8j. Fibromyalgia, arthritis, gout, lupus or disorder of the muscles, bones or joints, including the spine?

8k. Amputation or deformity?

If YES answer for any question above, please provide details.

9. Other than as previously stated, have you, within the past 5 years:

9a. Had a checkup, consultation, illness, injury or surgery?

9b. Had any mental or physical disorder?

9c. Been a patient in a hospital, clinic, sanatorium or other medical facility?

9d. Had electrocardiogram, x-ray, other diagnostic test?

9e. Been advised by a physician or medical professional to have surgery, medical treatment, biopsy or, diagnostic testing excluding HIV testing, that has not been completed?

If YES answer for any question above, please provide details.

10a. Are you taking any medications or treatments not previously mentioned?

10b. Are you planning to seek medical advice or treatment for any reason?

If YES answer for any question above, please provide details.

11. Have you ever requested or received a pension, or payment because of an injury, sickness or disability? If YES, please provide details.

12. Do you know if any parent, brother or sister has had Heart Disease, Cancer, Diabetes or Stroke? If YES, provide relationship and age at onset. If deceased, please provide age at death.

13. Have you ever:

13a. Used amphetamines, marijuana, cocaine, hallucinogens, heroin or other drugs except as prescribed by a physician?

13b. Been addicted to prescription medication or been advised by a physician to discontinue using habit forming drugs? If YES, provide dates of use, type and frequency.

- | | YES | NO |
|--|--------------------------|-------------------------------------|
| 13c. Been treated or counseled for alcohol or drug use? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 13d. Been advised to reduce your consumption of alcohol or drugs? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 14. Have you ever been convicted or are you awaiting trial for a felony, misdemeanor or infraction other than a traffic violation? If YES, provide details. | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 15a. Have you had more than 2 moving violations or had any suspensions or revocations in the past 3 years? If YES, provide details. | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 15b. Have you been arrested or convicted for reckless driving or driving under the influence of alcohol or drugs within the past 7 years? If YES, provide details. | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

I represent that all statements and answers made in all parts of the application are full, complete and true to the best of my knowledge and belief and I have not withheld any material information that may influence the assessment or acceptance of this application. I agree to inform Protective Life Insurance Company of any material changes before the insurance goes into effect.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Proposed Insured Signature John D. Doe

Signed at Birmingham (City) Alabama (State) Date: July 15, 2010

Parent Signature if Proposed Insured is under age 15: _____

Policy Number _____

LIFE INSURANCE APPLICATION (PART I)

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

State of Domicile: [Tennessee]

1. Proposed Insured

_____	_____	_____	_____	_____	_____	_____	_____
Name	<i>First</i>	<i>M.I.</i>	<i>Last</i>	Birthdate	Birthplace	Marital Status	Gender
_____				_____	_____		
Street Address				Day Phone Number	Night Phone Number		
_____				_____		_____	
				Tax ID/Social Security Number	Annual Income		
_____				_____			
City				State	Zip	U.S. Residency	Occupation

2. Owner (If other than Proposed Insured)

_____	_____	_____	_____	_____	
Name	<i>First</i>	<i>M.I.</i>	<i>Last</i>	Trust Date	
_____				_____	
Street Address				Tax ID / Social Security Number	
_____				_____	
				Relationship to Proposed Insured	
_____				_____	
City				State	Zip

3. Primary Beneficiary (Name, Relationship, Percent)

Contingent Beneficiary (Name, Relationship, Percent)

4. Plan Information

Plan Name: _____ Amount of Coverage: _____

Risk Class: _____ Tobacco Use: ____ Issue Best Underwriting Class: ____

Initial Payment Amount: _____ Planned Periodic Payment Amount: _____

Payment Frequency: _____

(Optional - Term Plan Only) Multi-Year Mode for _____ Number of Years

(Universal Life Plans Only) Death Benefit Option: _____

Policy Number _____

5. 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 NOT.

Company Name	Issue Date	Amount	REPLACEMENT YES NO	
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>

6. TO AVOID DELAY IN PROCESSING -- THIS QUESTION MUST BE ANSWERED.

Is there any 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? Yes No
 If "yes", please explain under "Remarks".

7. Regarding the Proposed Insured

	YES	NO
a. Do you have an application pending in another company?.....	<input type="checkbox"/>	<input type="checkbox"/>
b. Have you ever had any life or health insurance declined, postponed or offered other than as applied for?.....	<input type="checkbox"/>	<input type="checkbox"/>
c. Will this policy replace or change any existing life insurance or annuity in force?.....	<input type="checkbox"/>	<input type="checkbox"/>

Remarks:

Home Office Endorsement (Home Office Use Only)

Policy Number _____

Declarations: I represent that all statements and answers made in all parts of the application are full, complete and true to the best of my knowledge and belief and I have not withheld any material information that may influence the assessment or acceptance of this application. I agree to inform Protective Life Insurance Company of any material changes before the insurance goes into effect. It is also agreed that:

- (a) All such statements and answers shall be the basis of any insurance issued.
- (b) No agent nor medical examiner can make, alter or discharge any contract, accept risks, or waive Protective Life's rights or requirements.
- (c) No insurance shall take effect unless: (1) a policy is delivered to the Owner; (2) the full first premium is paid while the Proposed Insured is alive; and (3) there has been no change in health and insurability from that described in this application. However, if the premium is paid as set forth in the attached Conditional Receipt Agreement and the Conditional Receipt Agreement is delivered to the Owner, the terms of the Conditional Receipt Agreement shall apply. No agent or medical examiner has any authority to waive or to alter these terms and conditions or to bind coverage under any other circumstances.
- (d) I have reviewed the attached Conditional Receipt Agreement and understand and agree that it provides a limited amount of life insurance for a limited period of time, and that such coverage is subject to the terms and conditions set forth in the Conditional Receipt Agreement.
- (e) The agent taking this application has made no statement or representation different from, contrary to or in addition to these Declarations and the terms and conditions of the attached Conditional Receipt Agreement.
- (f) Acceptance of a policy by the Owner shall constitute ratification of any changes made by the Company under "Home Office Endorsement". In those states where it is required, changes as to plan, amount, age at issue, classification or benefits will be made only with the Owner's written consent.

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 presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Signed At _____, _____ Date _____
City State Mo./Day/Yr.

Proposed Insured (Sign Name in Full)

Applicant /Owner (if other than the Proposed Insured)

Parent / Guardian

Have you advised the proposed policyowner or do you know of any advice that has been given to the 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? If yes, please explain in the Remarks section. Yes No

Will this policy replace or change any existing life insurance policy(ies) or annuity(ies)? Yes No

Agent / Broker Name Agent / Broker Number

I hereby certify that my electronic approval serves as my signature for legal and regulatory purposes for this application.

Electronic Signature of _____ was obtained

_____ at _____ Agent / Broker Phone Number _____
Date Time

Broker Dealer or Broker General Agent (if applicable)

SERFF Tracking Number: PRTA-126765485 State: Arkansas
 Filing Company: Protective Life Insurance Company State Tracking Number: 46497
 Company Tracking Number: LAURA-PL110
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
 Product Name: PL-110 et al
 Project Name/Number: PL-110 et al/PL-110 et al

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
08/12/2010	Form	Life Insurance Application (Part I)	08/30/2010	PL-110-MAR 04.10 Life Ins App Part I .pdf (Superseded)
08/12/2010	Supporting Document	John Doe Specimen Forms	08/30/2010	PL-359 06.10 Auth to Obtain Disclose Info John Doe.pdf PL-110-MAR 04.10 Life Ins App Part I John Doe.pdf (Superseded) PL-109-AR 04.10 Supp App Part II John Doe .pdf

Policy Number _____

LIFE INSURANCE APPLICATION (PART I)

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

State of Domicile: [Tennessee]

1. Proposed Insured

_____	_____	_____	_____	_____	_____	_____	_____
Name	<i>First</i>	<i>M.I.</i>	<i>Last</i>	Birthdate	Birthplace	Marital Status	Gender
_____				_____	_____		
Street Address				Day Phone Number	Night Phone Number		
_____				_____	_____		
_____				Tax ID/Social Security Number		Annual Income	
_____				_____	_____	_____	_____
City				State	Zip	U.S. Residency	Occupation

2. Owner (If other than Proposed Insured)

_____	_____	_____	_____	_____
Name	<i>First</i>	<i>M.I.</i>	<i>Last</i>	Trust Date
_____				_____
Street Address				Tax ID / Social Security Number
_____				_____
_____				Relationship to Proposed Insured
_____				_____
City				State Zip

3. Primary Beneficiary (Name, Relationship, Percent)

Contingent Beneficiary (Name, Relationship, Percent)

4. Plan Information

Plan Name: _____ Amount of Coverage: _____

Risk Class: _____ Tobacco Use: ___ Issue Best Underwriting Class: _____

Initial Payment Amount: _____ Planned Periodic Payment Amount: _____

Payment Frequency: _____

(Optional - Term Plan Only) Multi-Year Mode for _____ Number of Years

(Universal Life Plans Only) Death Benefit Option: _____

Policy Number _____

5. 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 NOT.

Company Name	Issue Date	Amount	REPLACEMENT YES NO	
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>

6. TO AVOID DELAY IN PROCESSING -- THIS QUESTION MUST BE ANSWERED.

Is there any 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? Yes No
 If "yes", please explain under "Remarks".

7. Regarding the Proposed Insured

	YES	NO
a. Do you have an application pending in another company?.....	<input type="checkbox"/>	<input type="checkbox"/>
b. Have you ever had any life or health insurance declined, postponed or offered other than as applied for?.....	<input type="checkbox"/>	<input type="checkbox"/>
c. Will this policy replace or change any existing life insurance or annuity in force?.....	<input type="checkbox"/>	<input type="checkbox"/>

Remarks:

Home Office Endorsement (Home Office Use Only)

Policy Number _____

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- (b) No agent nor medical examiner can make, alter or discharge any contract, accept risks, or waive Protective Life's rights or requirements.
- (c) No insurance shall take effect unless: (1) a policy is delivered to the Owner; (2) the full first premium is paid while the Proposed Insured is alive; and (3) there has been no change in health and insurability from that described in this application. However, if the premium is as set forth in the attached Conditional Receipt Agreement and the Conditional Receipt Agreement is delivered to the Owner, the terms of the Conditional Receipt Agreement shall apply. No agent or medical examiner has any authority to waive or to alter these terms and conditions or to bind coverage under any other circumstances.
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Signed At _____, _____ Date _____
City State Mo./Day/Yr.

Proposed Insured (Sign Name in Full)

Applicant /Owner (if other than the Proposed Insured)

Parent / Guardian

Have you advised the proposed policyowner or do you know of any advice that has been given to the 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? If yes, please explain in the Remarks section. Yes No

Will this policy replace or change any existing life insurance policy(ies) or annuity(ies)? Yes No

Agent / Broker Name *Agent / Broker Number*

I hereby certify that my electronic approval serves as my signature for legal and regulatory purposes for this application.

Electronic Signature of _____ was obtained

_____ at _____ Agent / Broker Phone Number _____
Date Time

Broker Dealer or Broker General Agent (if applicable)

Policy Number _____

LIFE INSURANCE APPLICATION (PART I)

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

State of Domicile: [Tennessee]

1. Proposed Insured

_____	_____	_____	_____	_____	_____	_____	_____
Name	<i>First</i>	<i>M.I.</i>	<i>Last</i>	Birthdate	Birthplace	Marital Status	Gender
_____				_____	_____		
Street Address				Day Phone Number	Night Phone Number		
_____				_____		_____	
				Tax ID/Social Security Number	Annual Income		
_____				_____			
City				State	Zip	U.S. Residency	Occupation

2. Owner (If other than Proposed Insured)

_____	_____	_____	_____	_____	
Name	<i>First</i>	<i>M.I.</i>	<i>Last</i>	Trust Date	
_____				_____	
Street Address				Tax ID / Social Security Number	
_____				_____	
				Relationship to Proposed Insured	
_____				_____	
City				State	Zip

3. Primary Beneficiary (Name, Relationship, Percent)

Contingent Beneficiary (Name, Relationship, Percent)

4. Plan Information

Plan Name: _____ Amount of Coverage: _____

Risk Class: _____ Tobacco Use: ___ Issue Best Underwriting Class: _____

Initial Payment Amount: _____ Planned Periodic Payment Amount: _____

Payment Frequency: _____

(Optional - Term Plan Only) Multi-Year Mode for _____ Number of Years

(Universal Life Plans Only) Death Benefit Option: _____

Policy Number _____

5. 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 NOT.

Company Name	Issue Date	Amount	REPLACEMENT YES NO	
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>

6. TO AVOID DELAY IN PROCESSING -- THIS QUESTION MUST BE ANSWERED.

Is there any 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? Yes No
 If "yes", please explain under "Remarks".

7. Regarding the Proposed Insured

	YES	NO
a. Do you have an application pending in another company?.....	<input type="checkbox"/>	<input type="checkbox"/>
b. Have you ever had any life or health insurance declined, postponed or offered other than as applied for?.....	<input type="checkbox"/>	<input type="checkbox"/>
c. Will this policy replace or change any existing life insurance or annuity in force?.....	<input type="checkbox"/>	<input type="checkbox"/>

Remarks:

Home Office Endorsement (Home Office Use Only)

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Signed At _____, _____ Date _____
City State Mo./Day/Yr.

Proposed Insured (Sign Name in Full)

Applicant /Owner (if other than the Proposed Insured)

Parent / Guardian

Have you advised the proposed policyowner or do you know of any advice that has been given to the 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? If yes, please explain in the Remarks section. Yes No

Will this policy replace or change any existing life insurance policy(ies) or annuity(ies)? Yes No

Agent / Broker Name *Agent / Broker Number*

I hereby certify that my electronic approval serves as my signature for legal and regulatory purposes for this application.

Electronic Signature of _____ was obtained

_____ at _____ Agent / Broker Phone Number _____
Date Time

Broker Dealer or Broker General Agent (if applicable)