

SERFF Tracking Number: PRTA-127295696 State: Arkansas
 Filing Company: Protective Life Insurance Company State Tracking Number: 49155
 Company Tracking Number: VICKIE APPS07/11
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
 Product Name: PL-226 (07/11), et al
 Project Name/Number: PL-226 (07/11), et al/PL-226 (07/11), et al

Filing at a Glance

Company: Protective Life Insurance Company

Product Name: PL-226 (07/11), et al

TOI: L08 Life - Other

Sub-TOI: L08.000 Life - Other

Filing Type: Form

SERFF Tr Num: PRTA-127295696 State: Arkansas

SERFF Status: Closed-Approved-
Closed State Tr Num: 49155

Co Tr Num: VICKIE – APPS07/11

State Status: Approved-Closed

Reviewer(s): Linda Bird

Author: Vickie Jerkins

Disposition Date: 06/30/2011

Date Submitted: 06/28/2011

Disposition Status: Approved-
Closed

Implementation Date Requested: 08/01/2011

Implementation Date:

State Filing Description:

General Information

Project Name: PL-226 (07/11), et al

Project Number: PL-226 (07/11), et al

Requested Filing Mode: Review & Approval

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments: This filing has been submitted to our domiciliary state of Tennessee, concurrently.

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Market Type: Individual

Individual Market Type:

Filing Status Changed: 06/30/2011

State Status Changed: 06/30/2011

Deemer Date:

Submitted By: Vickie Jerkins

Filing Description:

FORM NUMBER.....FORM TITLE

PL-226 (07/11).....Supplemental Underwriting Application

F-LAD-437 (07/11).....Supplemental Application – Child Rider Non-Medical Declarations

Created By: Vickie Jerkins

Corresponding Filing Tracking Number:

The intended implementation date for this filing is August 01, 2111 or upon approval by your Department. The above referenced Individual Life Application Filing is being submitted for filing acknowledgement or prior approval, as appropriate. This filing does not contain any unusual or possibly controversial items that vary from normal company or industry standards. The forms submitted in this filing are new and will not replace any forms currently in use. This filing

SERFF Tracking Number: PRTA-127295696 State: Arkansas
Filing Company: Protective Life Insurance Company State Tracking Number: 49155
Company Tracking Number: VICKIE APPS07/11
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: PL-226 (07/11), et al
Project Name/Number: PL-226 (07/11), et al/PL-226 (07/11), et al

has been submitted to our domiciliary state of Tennessee, concurrently.

These stand-alone supplemental application forms will be used to gather information to assist in underwriting the insurance applied for on existing applications. In most situations, these forms will be programmed electronically and populated during a phone interview process. The completed application will then be printed and provided to the Proposed Insured/Applicant for their review and hand-signed / wet ink on paper signature prior to underwriting decisions being made.

While the Company currently has no intention of implementing electronic or voice signatures with these forms, changing technology and business processes may result in their future use. In those cases where a signature is collected electronically, the Company will comply with applicable electronic signature guidelines described in the state's adopted version of the United Electronic Transactions Act and as stipulated in separate Company filings to your Department.

Due to the complexity of these forms, we are providing a clean final print generated form under the SERFF Form Schedule Tab along with a John Doe SAMPLE version under the SERFF Supporting Documentation Tab in conjunction with a Statement of Variables. The drill down / detail questions which are asked in follow-up are not variable. The John Doe examples of affirmative/negative answers are displayed in RED for your convenience in reviewing only (these answers do not appear in red on the Applicant's printed copy).

While these forms have been generated in final print format, 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 Company also wishes to reserve the right to use different fonts, margins and layouts, due to rapidly changing technology and the availability of software. The Company certifies that printed versions of these forms will be in a minimum of 10 point font.

These Supplemental Applications will be used with the various base (full application) packets in the Companies portfolio, which are based on distribution channel. Currently, our previously approved application packets include:

PL-110-AR (04/10) Approved 09/01/2010 – Under SERFF Tracking No. PRTA-126765485

PLB-300-AR 2/11 Approved 03/15/2011 – Under SERFF Tracking No. PRTA-127061881

Additionally, the Child Rider Non-Medical Declarations form will currently be used with previously approved Children's Term Life Insurance Rider L502V2 8-08 Approved 08/01/2008 – Under SERFF Tracking No. PRTA-125749887.

These forms have achieved FLESCH Ease of Reading Test Scores of 60.8 and 50.9.

SERFF Tracking Number: PRTA-127295696 State: Arkansas
 Filing Company: Protective Life Insurance Company State Tracking Number: 49155
 Company Tracking Number: VICKIE APPS07/11
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
 Product Name: PL-226 (07/11), et al
 Project Name/Number: PL-226 (07/11), et al/PL-226 (07/11), et al

If you need further information to complete the review of this filing, I can be contacted via SERFF Notes, email at Vickie.Jerkins@protective.com or tollfree at 1-800-866-3555 ext. 5514.

Company and Contact

Filing Contact Information

Vickie Jerkins, Policy Contract Filing Specialist vickie.jerkins@protective.com
 2801 Highway 280 South 800-866-3555 [Phone] 5514 [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: \$100.00
 Retaliatory? No
 Fee Explanation: \$50.00 PER FORM X 2
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Protective Life Insurance Company	\$100.00	06/28/2011	49188130

SERFF Tracking Number: PRTA-127295696 State: Arkansas
Filing Company: Protective Life Insurance Company State Tracking Number: 49155
Company Tracking Number: VICKIE APPS07/11
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: PL-226 (07/11), et al
Project Name/Number: PL-226 (07/11), et al/PL-226 (07/11), et al

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	06/30/2011	06/30/2011

SERFF Tracking Number: PRTA-127295696 State: Arkansas
Filing Company: Protective Life Insurance Company State Tracking Number: 49155
Company Tracking Number: VICKIE APPS07/11
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: PL-226 (07/11), et al
Project Name/Number: PL-226 (07/11), et al/PL-226 (07/11), et al

Disposition

Disposition Date: 06/30/2011

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: PRTA-127295696 State: Arkansas
 Filing Company: Protective Life Insurance Company State Tracking Number: 49155
 Company Tracking Number: VICKIE APPS07/11
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
 Product Name: PL-226 (07/11), et al
 Project Name/Number: PL-226 (07/11), et al/PL-226 (07/11), et al

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Statement of Variables With John Doe Example		Yes
Form	Supplemental Underwriting Application		Yes
Form	Supplemental Application – Child Rider		Yes
	Non-Medical Declarations		

SERFF Tracking Number: PRTA-127295696 State: Arkansas
 Filing Company: Protective Life Insurance Company State Tracking Number: 49155
 Company Tracking Number: VICKIE APPS07/11
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
 Product Name: PL-226 (07/11), et al
 Project Name/Number: PL-226 (07/11), et al/PL-226 (07/11), et al

Form Schedule

Lead Form Number: PL-226 (07/11)

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	PL-226 (07/11)	Application/ Supplemental Enrollment Underwriting Form Application	Initial		60.800	PL-226 (07_11).pdf
	F-LAD-437 (07/11)	Application/ Supplemental Enrollment Application – Child Rider Non-Medical Declarations Form	Initial		50.900	F-LAD-437 (07_11).pdf

SUPPLEMENTAL UNDERWRITING APPLICATION

Proposed Insured _____ Date of Birth _____
 First Name M.I. Last Name

IMPORTANT! For ALL QUESTIONS ANSWERED "YES", please provide details including: Name of physician, date diagnosed medications, and current condition. If additional space is needed, please use the Continuation of Information form.

<p>1. Has the Proposed Insured been diagnosed with or been treated within the past 10 years for:</p> <p>a) Alzheimer's disease or dementia, memory loss, Mild Cognitive Impairment (MCI), or organic brain syndrome? [DETAILS: _____] Yes No</p> <p>b) Connective Tissue, Lupus or other auto-immune disorder? [DETAILS: _____] <input type="checkbox"/> <input type="checkbox"/></p> <p>c) Nervous disorders such as seizures, fainting spells, Parkinson's disease, tremor, ALS, Multiple Sclerosis Aphasia or other disorders of the brain or nervous system? [DETAILS: _____] <input type="checkbox"/> <input type="checkbox"/></p> <p>d) Any history of fractures or falls? [DETAILS: _____] <input type="checkbox"/> <input type="checkbox"/></p>
--

<p>2. Has the Proposed Insured been:</p> <p>a) Declined, refused, rated or turned down for life insurance, long-term care insurance, medical or disability insurance? [DETAILS: _____] <input type="checkbox"/> <input type="checkbox"/></p> <p>b) Required to have home care, nursing home care, or adult care for any reason within the past 12 months? [DETAILS: _____] <input type="checkbox"/> <input type="checkbox"/></p> <p>c) Advised to enter, planning to reside in, or currently residing in a nursing home, assisted care living facility, or other custodial facility, or attending adult day care? [DETAILS: _____] <input type="checkbox"/> <input type="checkbox"/></p>

<p>3. Does the Proposed Insured:</p> <p>a) Use one of the following medical devices: walker; wheelchair; hospital bed; quad cane; oxygen; stair lift; or dialysis? (If "Yes", provide type of device and date usage began) [DETAILS: _____] <input type="checkbox"/> <input type="checkbox"/></p> <p>b) Participate in any type of exercise program? (If "Yes", provide type and frequency) [DETAILS: _____] <input type="checkbox"/> <input type="checkbox"/></p> <p>c) Drive a motor vehicle? (If "Yes", provide the number of miles driven in the past 12 months. If "No", what date did you last drive and why did you stop driving?) [DETAILS: _____] <input type="checkbox"/> <input type="checkbox"/></p> <p>d) Manage finances, including paying bills, writing checks and balancing the check book? (If "No", identify what activities require assistance, who provides it and why it is needed.) [DETAILS: _____] <input type="checkbox"/> <input type="checkbox"/></p> <p>e) Perform regular household tasks including cooking, cleaning, laundry, shopping, yard work? (If "No", identify what activities require assistance, who provides it and why it is needed.) [DETAILS: _____] <input type="checkbox"/> <input type="checkbox"/></p> <p>f) Live alone? (If "No", who do you live with?) [DETAILS: _____] <input type="checkbox"/> <input type="checkbox"/></p>
--

<p>4. Does ANYONE help the Proposed Insured with getting around inside the home, getting into and out of bed or a chair, bathing, dressing, toileting or eating? (If "Yes", identify the helper and give details of help required) [DETAILS: _____] <input type="checkbox"/> <input type="checkbox"/></p>
--

<p>5. Is the Proposed Insured's activity limited by shortness of breath or pain? (If "Yes", explain) [DETAILS: _____] <input type="checkbox"/> <input type="checkbox"/></p>
--

<p>6. How far can the Proposed Insured walk without needing to stop and rest on level ground? (If "Yes" how long would it typically take to walk this distance in seconds?)</p> <p>a) 50 feet or 1/2 block. [DETAILS: _____] <input type="checkbox"/> <input type="checkbox"/></p> <p>b) 100 feet or one block. [DETAILS: _____] <input type="checkbox"/> <input type="checkbox"/></p> <p>c) 400 feet or four blocks. [DETAILS: _____] <input type="checkbox"/> <input type="checkbox"/></p>
--

<p>7. Additional details or comments:</p>
--

The above statements and answers are true and complete to the best of my knowledge and belief.

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

 Witness Proposed Insured

SUPPLEMENTAL APPLICATION - CHILD RIDER NON-MEDICAL DECLARATIONS

Child (Print name) _____ Date of Birth _____ Height _____ Weight _____

**Please complete a separate form if you are applying for the Children's Term Rider on additional children.
For all questions, mark "Yes" or "No" AND give details for each condition to which "Yes" answer applies.**

1. Answer the following medical information for child of any age:

Has the child ever been treated or diagnosed by a physician as having:	Yes	No
(a) Disorder of brain or spinal cord, paralysis, mental disorder, epilepsy, convulsions, chronic headache? DETAILS: _____	<input type="checkbox"/>	<input type="checkbox"/>
(b) Asthma, bronchitis, tuberculosis or other disorder of the lungs or respiratory system? DETAILS: _____	<input type="checkbox"/>	<input type="checkbox"/>
(c) High Blood Pressure, heart murmur, chest pain or other disorder of the heart or blood vessels? DETAILS: _____	<input type="checkbox"/>	<input type="checkbox"/>
(d) Any disorder of the esophagus, stomach, intestines, liver or pancreas? DETAILS: _____	<input type="checkbox"/>	<input type="checkbox"/>
(e) Sugar or blood in the urine, chronic inflammation or other disorder of the kidneys? DETAILS: _____	<input type="checkbox"/>	<input type="checkbox"/>
(f) Cancer or tumor? DETAILS: _____	<input type="checkbox"/>	<input type="checkbox"/>
(g) Arthritis, disorder of the muscles, skin or bones including joints or spine? DETAILS: _____	<input type="checkbox"/>	<input type="checkbox"/>
(h) Diabetes, recurrent infections, enlarged lymph glands, anemia, excess fatigue or other disorders of the glandular or blood systems? DETAILS: _____	<input type="checkbox"/>	<input type="checkbox"/>
(i) Acquired Immune Deficiency Syndrome (AIDS) or "AIDS" related complex (ARC)? DETAILS: _____	<input type="checkbox"/>	<input type="checkbox"/>
(j) Been on or advised by a physician to be on any medication or prescribed diet? DETAILS: _____	<input type="checkbox"/>	<input type="checkbox"/>
(k) Other than previously stated, had examination, treatment or consultation with a physician? DETAILS: _____	<input type="checkbox"/>	<input type="checkbox"/>

2. Answer the following questions if the child is age 15 through 18:

Has the child ever:	Yes	No
(a) Used narcotics, sedatives, depressants, stimulants or hallucinogens, other than under a doctor's prescription and directions? DETAILS: _____	<input type="checkbox"/>	<input type="checkbox"/>
(b) Used marijuana, cocaine, or any illegal drug? DETAILS: _____	<input type="checkbox"/>	<input type="checkbox"/>
(c) Sought or been advised to seek advice or treatment for the use of drugs or alcohol? DETAILS: _____	<input type="checkbox"/>	<input type="checkbox"/>
(d) Been arrested for the use of drugs or alcohol? DETAILS: _____	<input type="checkbox"/>	<input type="checkbox"/>
(e) Been or is currently a member of any alcohol or drug rehabilitation program? DETAILS: _____	<input type="checkbox"/>	<input type="checkbox"/>
(f) Attempted suicide? DETAILS: _____	<input type="checkbox"/>	<input type="checkbox"/>

3. Provide the following information for child of any age:

- (a) Specific date of last medical consultation _____
- (b) Name of Personal Physician _____
Address of Personal Physician _____
Phone Number of Personal Physician _____

Please use the Continuation of Information form if additional space is needed for the details listed above.

The above statements and answers are true and complete to the best of my knowledge and belief. I agree that such statements and answers shall be part of the application and shall be considered the basis of any insurance issued.

Witness _____ Date _____ Signature of Parent or Guardian _____ Date _____

SERFF Tracking Number: PRTA-127295696 State: Arkansas
 Filing Company: Protective Life Insurance Company State Tracking Number: 49155
 Company Tracking Number: VICKIE APPS07/11
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
 Product Name: PL-226 (07/11), et al
 Project Name/Number: PL-226 (07/11), et al/PL-226 (07/11), et al

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification		
Comments:		
Attachments:		
AR Certification.pdf		
Readability Certification.pdf		

	Item Status:	Status Date:
Bypassed - Item: Application		
Bypass Reason: Not Applicable to this NEW LIFE APPLICATION filing.		
Comments:		

	Item Status:	Status Date:
Satisfied - Item: Statement of Variables With John Doe Example		
Comments:		
Due to the complexity of these forms, we are providing a John Doe SAMPLE version under the SERFF Supporting Documentation Tab in conjunction with a Statement of Variables.		
The drill down / detail questions which are asked in follow-up are not variable. The John Doe examples of affirmative/negative answers are displayed in RED for your convenience in reviewing only (these answers do not appear in red on the Applicant's printed copy).		
Attachments:		
Statement of Variables.pdf		
PL-226 JohnDoeDrillDown.pdf		
F-LAD-437 JohnDoeDrillDown.pdf		

PROTECTIVE LIFE INSURANCE COMPANY BIRMINGHAM, ALABAMA

CERTIFICATION OF COMPLIANCE

Arkansas

FORM(S): PL-226 (07/11) and F-LAD-437 (07/11)

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

June 23, 2011

Protective Life Insurance Company
Post Office Box 2606
Birmingham, Alabama 35282-9887

NAIC 458-68136
FEIN 63-0169720

READABILITY CERTIFICATION

Regarding:	Form Number	Form Title
	PL-226 (07/11)	Supplemental Underwriting Application
	F-LAD-437 (07/11)	Supplemental Application – Child Rider Non-Medical Declarations

This is to certify that the enclosed forms (and the corresponding state specific variations) have been created using fonts of 10 point or greater and have achieved compliance with the requirements for the FLESCH Ease of Reading Test, with scores as outlined in the following table.

	PL-226 (07/11)	F-LAD-437 (07/11)
Words:	500	387
Sentences:	30	22
Syllables:	763	632
FLESCH Score:	60.8	50.9



Keith Kirkley, J.D., MBA
Assistant Vice President
Protective Life Insurance Company
LAD Product Development
Contract Drafting & Filing Team

June 23, 2011

Protective Life Insurance Company
Birmingham, Alabama 35282-9887
NAIC 458-68136 / FEIN 63-0169720

Statement of Variability (Including state variations)

General Variables

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

"John Doe" Information – Denoted by RED Comments in the John Doe SAMPLE will vary by applicant. Size of open narrative sections (for requests to provide details) will vary based on information supplied by the applicant.

Specific Variables

PL-226 (07/11) PART II – Supplemental Questionnaire Application

Detail lines will expand for drill down/follow-up questions based on affirmative or negative answers.

F-LAD-437 (07/11) Supplemental Application – Child Rider Non-Medical Declarations

Detail lines will expand for drill down/follow-up questions based on affirmative or negative answers.

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, JD, MBA
AVP – Product Development
Protective Life Insurance Company
June 24, 2011

SUPPLEMENTAL UNDERWRITING APPLICATION

Proposed Insured **JOHN** **Q.** **DOE** Date of Birth **07/14/1938**
 First Name M.I. Last Name

IMPORTANT! For ALL QUESTIONS ANSWERED "YES", please provide details including: Name of physician, date diagnosed medications, and current condition. If additional space is needed, please use the Continuation of Information form.

	Yes	No
<p>1. Has the Proposed Insured been diagnosed with or been treated within the past 10 years for:</p> <p>a) Alzheimer's disease or dementia, memory loss, Mild Cognitive Impairment (MCI), or organic brain syndrome? DETAILS: [Yes] <input type="checkbox"/> Which diagnosis: [Alzheimer's Disease] <input type="checkbox"/> Date of Diagnosis: [05/05/2010] <input type="checkbox"/> Type of Treatment: [Medication and Supervision]</p> <p>b) Connective Tissue, Lupus or other auto-immune disorder? DETAILS: [Yes] <input type="checkbox"/> Which diagnosis: [Lupus] <input type="checkbox"/> Date of Diagnosis: [05/05/2010] <input type="checkbox"/> Type of Treatment: [Medication and Medical Supervision]</p> <p>c) Nervous disorders such as seizures, fainting spells, Parkinson's disease, tremor, ALS, Multiple Sclerosis Aphasia or other disorders of the brain or nervous system? DETAILS: [Yes] <input type="checkbox"/> Which diagnosis: [Fainting Spells] <input type="checkbox"/> Date of Diagnosis: [05/05/2010] <input type="checkbox"/> Type of Treatment: [Medical Supervision]</p> <p>d) Any history of fractures or falls? DETAILS: [Yes] <input type="checkbox"/> Which diagnosis: [Falls] <input type="checkbox"/> Number of Falls: [1] <input type="checkbox"/> Date of Fall: [01/05/2010] <input type="checkbox"/> Reason for Fall: [Spilled on Ice]</p>	<p><input checked="" type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input checked="" type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input checked="" type="checkbox"/></p> <p><input type="checkbox"/></p>	<p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p>
<p>2. Has the Proposed Insured been:</p> <p>a) Declined, refused, rated or turned down for life insurance, long-term care insurance, medical or disability insurance? DETAILS: [Yes] <input type="checkbox"/> Status: [Declined] <input type="checkbox"/> Date: [01/05/2010] <input type="checkbox"/> Company: [ABC Insurance] <input type="checkbox"/> Reason: [Medical History]</p> <p>b) Required to have home care, nursing home care, or adult care for any reason within the past 12 months? DETAILS: [Yes] <input type="checkbox"/> Which Facility: [Nursing Home Care] <input type="checkbox"/> Date: [01/05/2010 – 02/05/2010] <input type="checkbox"/> Reason/Frequency: [Recovery from fall]</p> <p>c) Advised to enter, planning to reside in, or currently residing in a nursing home, assisted care living facility, or other custodial facility, or attending adult day care? DETAILS: [Yes] <input type="checkbox"/> Which Facility: [Adult Day Care] <input type="checkbox"/> Date: [01/05/2010] <input type="checkbox"/> Reason/Frequency: [Recovery from fall]</p>	<p><input checked="" type="checkbox"/></p> <p><input checked="" type="checkbox"/></p> <p><input checked="" type="checkbox"/></p>	<p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p>
<p>3. Does the Proposed Insured:</p> <p>a) Use one of the following medical devices: walker; wheelchair; hospital bed; quad cane; oxygen; stair lift; or dialysis? (If "Yes", provide type of device and date usage began) DETAILS: [Yes] <input type="checkbox"/> Which device do you use: [Walker] <input type="checkbox"/> How long have you used [a walker]: [2 years] <input type="checkbox"/> Reason for use: [Assistance and recovery from fall]</p> <p>b) Participate in any type of exercise program? (If "Yes", provide type and frequency) DETAILS: [Yes] <input type="checkbox"/> Type of exercise: [Walking] <input type="checkbox"/> How often do you [walk]: [Daily] <input type="checkbox"/> What distance / How long do you [walk]: [1 mile / 30 minutes]</p> <p>c) Drive a motor vehicle? (If "Yes", provide the number of miles driven in the past 12 months. If "No", what date did you last drive and why did you stop driving?) DETAILS: [No] <input type="checkbox"/> When did you last drive: [01/05/2010]</p>	<p><input checked="" type="checkbox"/></p> <p><input checked="" type="checkbox"/></p> <p><input type="checkbox"/></p>	<p><input type="checkbox"/></p> <p><input checked="" type="checkbox"/></p>

<p>d) Manage finances, including paying bills, writing checks and balancing the check book? (If "No", identify what activities require assistance, who provides it and why it is needed.) <input type="checkbox"/> <input checked="" type="checkbox"/></p> <p>DETAILS: [No]</p> <p><input type="checkbox"/> What activities require assistance: [Paying Bills]</p> <p><input type="checkbox"/> Why do you need assistance with [Paying Bills]: [Forgetful and to avoid late payments]</p> <p>e) Perform regular household tasks including cooking, cleaning, laundry, shopping, yard work? (If "No", identify what activities require assistance, who provides it and why it is needed.) <input type="checkbox"/> <input checked="" type="checkbox"/></p> <p>DETAILS: [No]</p> <p><input type="checkbox"/> What activities require assistance: [Yard Work]</p> <p><input type="checkbox"/> Why do you need assistance with [Yard Work]: [To avoid falls]</p> <p>f) Live alone? (If "No", who do you live with?) <input type="checkbox"/> <input checked="" type="checkbox"/></p> <p>DETAILS: [No]</p> <p><input type="checkbox"/> Who do you live with (Name and Relationship): [Don Doe / Son]</p>	
<p>4. Does ANYONE help the Proposed Insured with getting around inside the home, getting into and out of bed or a chair, bathing, dressing, toileting or eating? (If "Yes", identify the helper and give details of help required) <input checked="" type="checkbox"/> <input type="checkbox"/></p> <p>DETAILS: [Yes]</p> <p><input type="checkbox"/> Which are you unable to do on your own: [Get out of bed, but only occasionally]</p> <p><input type="checkbox"/> Who helps you: [Son or Daughter-in-Law]</p>	
<p>5. Is the Proposed Insured's activity limited by shortness of breath or pain? (If "Yes", explain) <input checked="" type="checkbox"/> <input type="checkbox"/></p> <p>DETAILS: [Yes]</p> <p><input type="checkbox"/> Which activity is limited: [Walking and lifting]</p>	
<p>6. How far can the Proposed Insured walk without needing to stop and rest on level ground? (If "Yes" how long would it typically take to walk this distance in seconds?)</p> <p>a) 50 feet or 1/2 block. DETAILS: _____] <input type="checkbox"/> <input type="checkbox"/></p> <p>b) 100 feet or one block. DETAILS: _____] <input type="checkbox"/> <input type="checkbox"/></p> <p>c) 400 feet or four blocks. DETAILS: [Yes] <input type="checkbox"/> How long: [About 15 minutes] <input checked="" type="checkbox"/> <input type="checkbox"/></p>	
<p>7. Additional details or comments: [No additional details or comments provided]</p>	
<p>The above statements and answers are true and complete to the best of my knowledge and belief.</p>	
<p>Signed at: <u>Townville</u> (City) <u>AA</u> (State) Date: <u>10/10/2011</u></p>	
<p><i>Be A. Witness</i> < Note: Wet Ink Signature Obtained</p> <p>Witness</p>	<p><i>John Z. Doe</i> < Note: Wet Ink Signature Obtained</p> <p>Proposed Insured</p>

SUPPLEMENTAL APPLICATION - CHILD RIDER NON-MEDICAL DECLARATIONS

David D. Doe	07/18/1995	5'10	165
Child (Print name)	Date of Birth	Height	Weight

**Please complete a separate form if you are applying for the Children's Term Rider on additional children.
For all questions, mark "Yes" or "No" AND give details for each condition to which "Yes" answer applies.**

1. Answer the following medical information for child of any age:		Yes	No
Has the child ever been treated or diagnosed by a physician as having			
(a) Disorder of brain or spinal cord, paralysis, mental disorder, epilepsy, convulsions, chronic headache?		<input checked="" type="checkbox"/>	<input type="checkbox"/>
DETAILS: [YES]			
<input type="checkbox"/> Which diagnosis: [Chronic Headache]			
<input type="checkbox"/> Date of Diagnosis: [05/05/2010]			
<input type="checkbox"/> Type of Treatment: [Medication, limited activities and Physician Supervision]			
(b) Asthma, bronchitis, tuberculosis or other disorder of the lungs or respiratory system?		<input checked="" type="checkbox"/>	<input type="checkbox"/>
DETAILS: [YES]			
<input type="checkbox"/> Which diagnosis: [Asthma]			
<input type="checkbox"/> Date of Diagnosis: [05/05/2010]			
<input type="checkbox"/> Type of Treatment: [Medication, limited outdoor activities and Physician Supervision]			
(c) High Blood Pressure, heart murmur, chest pain or other disorder of the heart or blood vessels?		<input checked="" type="checkbox"/>	<input type="checkbox"/>
DETAILS: [YES]			
<input type="checkbox"/> Which diagnosis: [Heart Murmur]			
<input type="checkbox"/> Date of Diagnosis: [07/18/1999 – Detected at birth]			
<input type="checkbox"/> Type of Treatment: [Physician Supervision]			
(d) Any disorder of the esophagus, stomach, intestines, liver or pancreas?		<input checked="" type="checkbox"/>	<input type="checkbox"/>
DETAILS: [YES]			
<input type="checkbox"/> Which diagnosis: [Stomach]			
<input type="checkbox"/> Date of Diagnosis: [05/05/2010]			
<input type="checkbox"/> Type of Treatment: [Medication, Physician Supervision]			
(e) Sugar or blood in the urine, chronic inflammation or other disorder of the kidneys?		<input checked="" type="checkbox"/>	<input type="checkbox"/>
DETAILS: [YES]			
<input type="checkbox"/> Which diagnosis: [Disorder of the kidneys / kidney stones]			
<input type="checkbox"/> Date of Diagnosis: [05/05/2010]			
<input type="checkbox"/> Type of Treatment: [Stones passed; no further physician supervision]			
(f) Cancer or tumor?		<input checked="" type="checkbox"/>	<input type="checkbox"/>
DETAILS: [YES]			
<input type="checkbox"/> Which diagnosis: [Cancer / Skin]			
<input type="checkbox"/> Date of Diagnosis: [05/05/2010]			
<input type="checkbox"/> Type of Treatment: [Surgery to remove area; radiation; annual physician follow-up]			
(g) Arthritis, disorder of the muscles, skin or bones including joints or spine?		<input checked="" type="checkbox"/>	<input type="checkbox"/>
DETAILS: [YES]			
<input type="checkbox"/> Which diagnosis: [Bones / Broken Arm]			
<input type="checkbox"/> Date of Diagnosis: [05/05/2010]			
<input type="checkbox"/> Type of Treatment: [surgery to set bone and apply cast. No physician follow-up at six weeks]			
(h) Diabetes, recurrent infections, enlarged lymph glands, anemia, excess fatigue or other disorders of the glandular or blood systems?		<input checked="" type="checkbox"/>	<input type="checkbox"/>
DETAILS: [YES]			
<input type="checkbox"/> Which diagnosis: [Childhood diabetes]			
<input type="checkbox"/> Date of Diagnosis: [05/05/2010]			
<input type="checkbox"/> Type of Treatment: [Medication, modified diet and exercise program with Physician Supervision]			
(i) Acquired Immune Deficiency Syndrome (AIDS) or "AIDS" related complex (ARC)?		<input checked="" type="checkbox"/>	<input type="checkbox"/>
DETAILS: [YES]			
<input type="checkbox"/> Which diagnosis: [Acquired Immune Deficiency Syndrome (AIDS)]			
<input type="checkbox"/> Date of Diagnosis: [07/18/1999 – Detected at birth]			
<input type="checkbox"/> Type of Treatment: [Medication and Physician Supervision]			
(j) Been on or advised by a physician to be on any medication or prescribed diet?		<input checked="" type="checkbox"/>	<input type="checkbox"/>
DETAILS: [YES]			
<input type="checkbox"/> Which diagnosis: [Prescribed diet]			
<input type="checkbox"/> Date of Diagnosis: [05/05/2010]			
<input type="checkbox"/> Type of Treatment/Purpose: [to control Childhood diabetes as described under question 1(h)]			
(k) Other than previously stated, had examination, treatment or consultation with a physician?		<input checked="" type="checkbox"/>	<input type="checkbox"/>
DETAILS: [YES]			
<input type="checkbox"/> Which selection: [Examination]			
<input type="checkbox"/> Date: [05/05/2010]			
<input type="checkbox"/> Type of Examination, Treatment or consultation: [Grade School Sports]			
<input type="checkbox"/> Type of Diagnosis or report: [Acceptable to play]			
2. Answer the following questions if the child is age 15 through 18:			
Has the child ever			
(a) Used narcotics, sedatives, depressants, stimulants or hallucinogens, other than under a doctor's prescription and directions?		<input checked="" type="checkbox"/>	<input type="checkbox"/>
DETAILS: [YES]			
<input type="checkbox"/> Which substance: [Stimulants]			
<input type="checkbox"/> Date of Last use: [05/05/2010]			
<input type="checkbox"/> Type of Treatment: [Physician Supervision, Family Punishment, School Detention]			

<p>(b) Used marijuana, cocaine, or any illegal drug? <input checked="" type="checkbox"/> <input type="checkbox"/></p> <p>DETAILS: [YES]</p> <p><input type="checkbox"/> Which substance: [Marijuana]</p> <p><input type="checkbox"/> Date of Last use: [05/05/2010]</p> <p><input type="checkbox"/> Type of Treatment: [Physician Supervision, Family Punishment, School Detention]</p>	<input checked="" type="checkbox"/> <input type="checkbox"/>
<p>(c) Sought or been advised to seek advice or treatment for the use of drugs or alcohol? <input checked="" type="checkbox"/> <input type="checkbox"/></p> <p>DETAILS: [YES]</p> <p><input type="checkbox"/> Which substance: [Drugs / Marijuana]</p> <p><input type="checkbox"/> Date of Last use: [05/05/2010]</p> <p><input type="checkbox"/> Type of Treatment: [Physician Supervision, Family Punishment, School Detention]</p>	<input checked="" type="checkbox"/> <input type="checkbox"/>
<p>(d) Been arrested for the use of drugs or alcohol? <input checked="" type="checkbox"/> <input type="checkbox"/></p> <p>DETAILS: [YES]</p> <p><input type="checkbox"/> Which substance: [Drugs / Marijuana]</p> <p><input type="checkbox"/> Date of Arrest: [05/05/2010]</p> <p><input type="checkbox"/> Status/Outcome: [Probation, Teen Challenge Rehabilitation Program, Expelled from standard School]</p>	<input checked="" type="checkbox"/> <input type="checkbox"/>
<p>(e) Been or is currently a member of any alcohol or drug rehabilitation program? <input checked="" type="checkbox"/> <input type="checkbox"/></p> <p>DETAILS: [YES]</p> <p><input type="checkbox"/> Date Enrolled: [05/05/2010]</p> <p><input type="checkbox"/> Status: [Graduated [11/11/2010]]</p> <p><input type="checkbox"/> Program: [Teen Challenge Rehabilitation Program]</p>	<input checked="" type="checkbox"/> <input type="checkbox"/>
<p>(f) Attempted suicide? <input checked="" type="checkbox"/> <input type="checkbox"/></p> <p>DETAILS: [YES]</p> <p><input type="checkbox"/> Date: [05/05/2010]</p> <p><input type="checkbox"/> Why: [Drug Addiction]</p> <p><input type="checkbox"/> Type of Treatment: [Physician Supervision, Enrollment in Teen Challenge Rehabilitation Program]</p>	<input checked="" type="checkbox"/> <input type="checkbox"/>
<p>3. Provide the following information for child of any age:</p>	
<p>(a) Specific date of last medical consultation <u>05/05/2010</u></p>	
<p>(b) Name of Personal Physician <u>Dr. John Wallace</u></p>	
<p>Address of Personal Physician <u>555 Medical Drive / Anytown, AA 55555</u></p>	
<p>Phone Number of Personal Physician <u>(555) 555-5555</u></p>	

Please use the Continuation of Information form if additional space is needed for the details listed above.

The above statements and answers are true and complete to the best of my knowledge and belief. I agree that such statements and answers shall be part of the application and shall be considered the basis of any insurance issued.

<i>Be A. Witness</i>	10/10/2011	<i>John Z. Doe</i>	10/10/2011
Witness	Date	Signature of Parent or Guardian	Date
** Note: Wet Ink Signature Obtained **		** Note: Wet Ink Signature Obtained **	