

State: Arkansas **Filing Company:** Protective Life Insurance Company
TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other
Product Name: PL-400, et al
Project Name/Number: PL-400, et al/PL-400, et al

Filing at a Glance

Company: Protective Life Insurance Company
Product Name: PL-400, et al
State: Arkansas
TOI: L08 Life - Other
Sub-TOI: L08.000 Life - Other
Filing Type: Form
Date Submitted: 07/13/2012
SERFF Tr Num: PRTA-128570361
SERFF Status: Closed-Approved-Closed
State Tr Num:
State Status: Approved-Closed
Co Tr Num: VICKIE-400

Implementation: 09/17/2012
Date Requested:
Author(s): Vickie Jerkins
Reviewer(s): Linda Bird (primary)
Disposition Date: 07/19/2012
Disposition Status: Approved-Closed
Implementation Date:

State Filing Description:

State: Arkansas Filing Company: Protective Life Insurance Company

TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other

Product Name: PL-400, et al

Project Name/Number: PL-400, et al/PL-400, et al

General Information

Project Name: PL-400, et al Status of Filing in Domicile: Authorized
Project Number: PL-400, et al Date Approved in Domicile: 06/18/2012
Requested Filing Mode: Review & Approval Domicile Status Comments: Versions of these forms have been approved by our domicile state of Tennessee as an IIPRC/Compact Submission, effective June 18, 2012.

Explanation for Combination/Other: Market Type: Individual
Submission Type: New Submission Individual Market Type:
Overall Rate Impact: Filing Status Changed: 07/19/2012
State Status Changed: 07/19/2012
Deemer Date: Created By: Vickie Jerkins
Submitted By: Vickie Jerkins Corresponding Filing Tracking Number:

Filing Description:

- Form Number // Form Title
PL-400-AR // Individual Life Insurance Application
PL-401 // Authorization To Obtain And Disclose Information
PL-402 // Individual Life Insurance - Part 1A Supplemental Application - Medical Declarations
PL-403 // Individual Life Insurance - Rider Worksheet
PL-404 // Individual Life Insurance - Supplemental Application - Child Rider Medical Declarations
PL-405 // Individual Life Insurance - Confidential Financial Statement
PL-406 // Continuation of Information

The captioned forms are being submitted for review and approval. These are new forms that will replace 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. Versions of these forms have been approved by our domicile state of Tennessee as an IIPRC/Compact Submission, effective June 18, 2012.

The submitted applications will be used within our general market by brokerage life insurance agents. In addition to the traditional paper format, in some cases, the data gathered on the application will be transferred to the home office electronically. For electronic submissions, a signature pad will be used for the signature of both the applicant and the agent.

The submitted applications, when used collectively will create an application packet. However, in some cases, not all forms are required.

PL-400 Is the base Application used to collect information to apply for individual life insurance.

PL-401 Is the required Authorization to Obtain and Disclose Information which must be completed for all cases submitted. A copy of the signed form is left with the Proposed Insured at time of application.

PL-402 Is used to collect Medical Declarations in cases when the Proposed Insured is NOT being examined for underwriting purposes.

PL-403 Is an optional form used to apply for additional benefits or riders. Please note, sections 1-3 are [bracketed] to allow for the removal of rider selections upon discontinuation by the Company.

PL-404 Is an optional form used in conjunction with PL -403 when applying for Child Riders

SERFF Tracking #:	PRTA-128570361	State Tracking #:	Company Tracking #: VICKIE-400
State:	Arkansas	Filing Company:	Protective Life Insurance Company
TOI/Sub-TOI:	L08 Life - Other/L08.000 Life - Other		
Product Name:	PL-400, et al		
Project Name/Number:	PL-400, et al/PL-400, et al		

PL-405 Is required, under specific circumstances, for the purpose of establishing financial suitability and insurability for the Proposed Insured.

PL-406 is a general use form to capture overflow information and details from any/all other forms.

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 required Readability Certification has been provided.

The required Statement of Variability has been provided. Please note with the exception of form PL-403, the only [bracketed] information is the Company contact information (Top/Right corner of each Page 1) which will only be changed to accurately disclose the correct mailing address and phone number.

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, Senior Policy Contract Filing vickie.jerkins@protective.com

Analyst

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:	\$350.00
Retaliatory?	No
Fee Explanation:	\$50.00 per form x 7
Per Company:	No

Company	Amount	Date Processed	Transaction #
Protective Life Insurance Company	\$350.00	07/13/2012	60869184

SERFF Tracking #:	PRTA-128570361	State Tracking #:		Company Tracking #:	VICKIE-400
State:	Arkansas	Filing Company:	Protective Life Insurance Company		
TOI/Sub-TOI:	L08 Life - Other/L08.000 Life - Other				
Product Name:	PL-400, et al				
Project Name/Number:	PL-400, et al/PL-400, et al				

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	07/19/2012	07/19/2012

SERFF Tracking #:	PRTA-128570361	State Tracking #:	Company Tracking #:	VICKIE-400
State:	Arkansas	Filing Company:	Protective Life Insurance Company	
TOI/Sub-TOI:	L08 Life - Other/L08.000 Life - Other			
Product Name:	PL-400, et al			
Project Name/Number:	PL-400, et al/PL-400, et al			

Disposition

Disposition Date: 07/19/2012

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Statement of Variables		Yes
Form	Individual Life Insurance Application		Yes
Form	Individual Life Insurance - Authorization To Obtain And Disclose Information		Yes
Form	Individual Life Insurance - Part 1A Supplemental Application - Medical Declarations		Yes
Form	Individual Life Insurance - Rider Worksheet		Yes
Form	Individual Life Insurance - Supplemental Application - Child Rider Medical Declarations		Yes
Form	Individual Life Insurance - Confidential Financial Statement		Yes
Form	Continuation of Information		Yes

SERFF Tracking #:	PRTA-128570361	State Tracking #:		Company Tracking #:	VICKIE-400
State:	Arkansas	Filing Company:	Protective Life Insurance Company		
TOI/Sub-TOI:	L08 Life - Other/L08.000 Life - Other				
Product Name:	PL-400, et al				
Project Name/Number:	PL-400, et al/PL-400, et al				

Form Schedule

Lead Form Number: PL-400							
Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
1		PL-400-AR	AEF	Individual Life Insurance Application	Initial:	52.298	PL-400-AR.pdf
2		PL-401	AEF	Individual Life Insurance - Authorization To Obtain And Disclose Information	Initial:	51.966	PL-401.pdf
3		PL-402	AEF	Individual Life Insurance - Part 1A Supplemental Application - Medical Declarations	Initial:	54.872	PL-402.pdf
4		PL-403	AEF	Individual Life Insurance - Rider Worksheet	Initial:	52.281	PL-403.pdf
5		PL-404	AEF	Individual Life Insurance - Supplemental Application - Child Rider Medical Declarations	Initial:	50.845	PL-404.pdf
6		PL-405	AEF	Individual Life Insurance - Confidential Financial Statement	Initial:	50.422	PL-405.pdf
7		PL-406	AEF	Continuation of Information	Initial:	57.192	PL-406.pdf

Form Type Legend:

ADV	Advertising	AEF	Application/Enrollment Form
CER	Certificate	CERA	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	FND	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	NOC	Notice of Coverage
OTH	Other	OUT	Outline of Coverage
PJK	Policy Jacket	POL	Policy/Contract/Fraternal Certificate

SERFF Tracking #:	PRTA-128570361	State Tracking #:		Company Tracking #:	VICKIE-400
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State:	Arkansas	Filing Company:	Protective Life Insurance Company
TOI/Sub-TOI:	L08 Life - Other/L08.000 Life - Other		
Product Name:	PL-400, et al		
Project Name/Number:	PL-400, et al/PL-400, et al		

POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	SCH	Schedule Pages
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SECTION I: INSUREDS **INDIVIDUAL LIFE INSURANCE APPLICATION**

1. Proposed Insured 1

Name (First, Middle, Last)			
Gender	Birthdate	Birth State	Marital Status
Driver's License Number and State		Social Security Number	
Home Phone	Work Phone	Cell Phone	
Address (Street, City, State, Zip Code and Number of Years)			
Email Address			

Proposed Insured 2

Name (First, Middle, Last)			
Gender	Birthdate	Birth State	Marital Status
Driver's License Number and State		Social Security Number	
Home Phone	Work Phone	Cell Phone	
Address (Street, City, State, Zip Code and Number of Years)			
Relationship to Prop Ins 1		Email Address	

2. Employment Information

Proposed Insured 1

Employer's Name	
Employer's Address	
Annual Income	Net Worth
Occupation	Number of Years

Proposed Insured 2

Employer's Name	
Employer's Address	
Annual Income	Net Worth
Occupation	Number of Years

3. Owner (If other than Proposed Insured, must complete information below. If Trust, include Name and Date of Trust.)

Name	Date of Trust	Phone Number	Relationship to Prop Ins	SSN/Taxpayer ID No.
Street Address, City, State, Zip Code				Email Address

4. Send Premium Notices To (If other than Owner)

Name/Relationship	Street, Address, City, State, Zip Code
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SECTION II: PLAN OF INSURANCE

Plan of Insurance: (Name of Product)	Face Amount: (Proposed Insured 1)	(Proposed Insured 2)
	\$	\$
If Term or Alternative to Term: (Indicate Years)	Underwriting Class Quoted:	
<input type="checkbox"/> 10 Yrs <input type="checkbox"/> 15 Yrs <input type="checkbox"/> 20 Yrs <input type="checkbox"/> 25 Yrs <input type="checkbox"/> 30 Yrs	(Protective will issue best underwriting class.)	
If Universal Life: <input type="checkbox"/> Level Face Amount <input type="checkbox"/> Increasing Face Amount	Section 1035: <input type="checkbox"/> Yes <input type="checkbox"/> No	1035 Loan Transfer: <input type="checkbox"/> Yes <input type="checkbox"/> No
	CVAT: <input type="checkbox"/> (If not checked, the Guideline Premium Test will apply, subject to product availability.)	
Is Proposed Insured requesting Additional Benefits, Riders, or Child Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, must complete the Rider Worksheet.)	Premium Payment: <input type="checkbox"/> Annual <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-Annual	\$ \$ \$
	<input type="checkbox"/> Monthly (Pre-Authorized Withdrawal Only)	<input type="checkbox"/> Cash with Application
	\$	\$

SECTION III: BENEFICIARY DESIGNATIONS

If multiple beneficiaries are named, shares will be divided equally among the surviving beneficiaries, unless otherwise specified.

1.	Primary Beneficiary Name(s)	Social Security Number	Relationship	Percentage
2.	Contingent Beneficiary Name(s)	Social Security Number	Relationship	Percentage

SECTION IV: EXISTING COVERAGE/PENDING INSURANCE AND REPLACEMENT

(Must be answered completely on all cases.)

- Is the policy applied for to replace an existing insurance or annuity policy(ies) with this or any other company?..... Yes No
(If Yes, complete any State required replacement forms and comparison statements.)
- Regarding all persons proposed for insurance, list all life insurance in force on each proposed insured's life.** Please be sure to list insurance policy information, whether owned by any proposed insured or not. **If None, insert None.**

Name of Insured		Company		Policy Number	
Replace or Change?	Amount	Purpose: Business/Personal		Issue Date	
Name of Insured		Company		Policy Number	
Replace or Change?	Amount	Purpose: Business/Personal		Issue Date	
Name of Insured		Company		Policy Number	
Replace or Change?	Amount	Purpose: Business/Personal		Issue Date	

- Is there any application for any other life or health insurance on the life of any proposed insured now pending or being considered with this or any other company? (If Yes, complete information below.)..... Yes No

Company Name	Amount of Coverage	Total Amount to be Placed	Purpose of Coverage
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- Has any proposed insured had a request for life or health insurance declined, postponed, rated, canceled, or restricted in any way? If Yes, please explain Yes No
- In the next 3 years, will the ownership of the policy or interest in any trust owning the policy be transferred? If Yes, please explain Yes No
- Is someone other than any Proposed Insured responsible for paying premiums? If Yes, please explain..... Yes No
- Will anyone unrelated to any Proposed Insured receive any of the policy death benefit? If Yes, please explain..... Yes No
- Has a mortality analysis or life expectancy analysis been performed on any Proposed Insured?..... Yes No
- Has any Proposed Insured discussed transfer of the policy to be issued, or its death benefits, to a life settlement company, investor, offshore trust, investment trust, or entity associated with stranger owned or investment owned life insurance (commonly called SOLI or IOLI) or have you considered such a transfer? If Yes, please explain..... Yes No

Remarks and Explanations to any Yes answers in Section IV.

SECTION V: PURPOSE OF INSURANCE (TO BE ANSWERED BY PROPOSED OWNER)

1. What is the purpose of the insurance? (Personal - Family/Estate Protection, Asset Transfer or Business - Key Man, Buy-Sell, etc.) **If Business insurance, complete questions 2 - 6 below.**

<input type="checkbox"/> Personal
<input type="checkbox"/> Business
2. What percent of business does any Proposed Insured own or control?.....%
3. What is approximate net annual income of business?.....\$
4. What is approximate market value of the business?.....\$
5. What year was the business established?.....

6. Please complete the information below:

Name / Business Partner		Title
% of Business Owned	Insurance Company	Amount Now Carried or Applied For
Name / Business Partner		Title
% of Business Owned	Insurance Company	Amount Now Carried or Applied For
Name / Business Partner		Title
% of Business Owned	Insurance Company	Amount Now Carried or Applied For

SECTION VI: PERSONAL HISTORY

Provide details to any Yes answers under Section VII, Page 4.

HAS PROPOSED INSURED: (Must be answered for all Proposed Insureds.)

	Proposed Insured 1		Proposed Insured 2						
	Yes	No	Yes	No					
1. Used tobacco or nicotine of any kind over the last 5 years?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td>Type</td> <td>Frequency</td> <td>Date Last Used</td> </tr> </table>					Type	Frequency	Date Last Used		
Type	Frequency	Date Last Used							
2. Consulted a physician or had treatment for the use or possession of:									
A. Alcohol? (If Yes, complete the Alcohol Usage Questionnaire.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
B. Narcotics, stimulants, sedatives, hallucinogenic drugs? (If Yes, complete the Drug Use Questionnaire.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
3. In the past 5 years, been convicted of (i) two or more moving violations, (ii) driving under the influence of alcohol or other drugs, or (iii) had their driver's license suspended or revoked?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
4. Have any proposed insureds ever been convicted of, or pled guilty or no contest to a felony, or do they have any such charge pending against them?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
5. Flown as a pilot, student pilot or crew member, or intend to fly as such? (If Yes, complete the Aviation Questionnaire.).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
6. Been a member of, or applied to be a member of, or received a notice of required service in, the armed forces, reserves or National Guard? (If Yes, provide details below.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td>Branch of Service</td> <td>Rank</td> <td>Duties</td> <td>Mobilization Category</td> <td>Current Duty Station</td> </tr> </table>					Branch of Service	Rank	Duties	Mobilization Category	Current Duty Station
Branch of Service	Rank	Duties	Mobilization Category	Current Duty Station					
7. Engaged in any of the following activities in the past 2 years? (If Yes, complete the appropriate questionnaire.).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
<input type="checkbox"/> Racing <input type="checkbox"/> Scuba Diving <input type="checkbox"/> Hang Gliding <input type="checkbox"/> Mountain Climbing <input type="checkbox"/> Sky Diving <input type="checkbox"/> Parachuting									
8. Is Proposed Insured: (If Yes to any questions below, complete the Foreign Travel Questionnaire.)									
a. A citizen of any country other than the United States or Canada? (If Yes, provide details below.).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td>Country of Citizenship</td> <td>Visa Type</td> <td>Expiration Date</td> <td>Length of U.S. Residency</td> </tr> </table>					Country of Citizenship	Visa Type	Expiration Date	Length of U.S. Residency	
Country of Citizenship	Visa Type	Expiration Date	Length of U.S. Residency						
b. Have you traveled or resided outside of the United States in the past 2 years? (If Yes, provide details.).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td>Travel Details</td> </tr> </table>					Travel Details				
Travel Details									
c. Intending to travel or reside outside the United States or Canada within the next 12 months?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td>To Where</td> <td>Why</td> </tr> <tr> <td>When</td> <td>For How Long</td> </tr> </table>					To Where	Why	When	For How Long	
To Where	Why								
When	For How Long								

SECTION VII: SPECIAL REMARKS AND DETAILS TO ANY YES ANSWERS

(Must be answered if applicable.)

*For each Yes answer, provide Section Number, Question Number, Name of the Proposed Insured, Date, Details or Reason. **Include Any Attending Physician, Hospital or Medical Facility Name, Address and Phone Number.***

DECLARATIONS

I (We) have read or have had read to me (us) the completed Application before signing below. I (We) represent that all statements and answers made in all parts of this application are full, complete and true. It is agreed that:

1. All such statements and answers shall be the basis of any insurance issued, and my (our) answers are material to the decision as to whether the risk is accepted by Protective Life.
2. No representative or medical examiner can make, alter or discharge any contract, accept risks, or waive Protective Life's rights or requirements.
3. Acceptance of a policy by the Owner shall constitute ratification of any changes made by the Company. 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.
4. 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(s) is (are) 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 representative or medical examiner has any authority to waive or to alter these terms and conditions or to bind coverage under any other circumstances.
5. 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.
6. The representative 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.

IMPORTANT INFORMATION ABOUT IDENTIFICATION VERIFICATION

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 _____
(City and State)

Date _____

(X) _____
Signature of Proposed Insured 1

(X) _____
Signature of Proposed Insured 2

Signed At _____
(City and State)

Date _____

(X) _____
Signature of Owner, If Other than Proposed Insured

(X) _____
Signature of Representative



AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

1. This authorization to obtain and disclose information complies with HIPAA regulations as they relate 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) MIB, 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. I (we) authorize Protective Life Insurance Company, or its reinsurers, to make a brief report of my personal health information to **MIB**.
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 24 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.)*

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 (Proposed Insured 1)	Social Security #	_____
Proposed Insured 2 (Signature)	Date of Birth	_____
Print Name (Proposed Insured 2)	Social Security #	Health Care Provider
Parent or Legal Guardian (Signature)		Physician Name
		Physician Name



[P.O. Box 830619
Birmingham, AL 35283-0619]

INDIVIDUAL LIFE INSURANCE – PART 1A SUPPLEMENTAL APPLICATION – MEDICAL DECLARATIONS

SECTION 1

Proposed Insured 1		
Name (First, Middle, Last)		
Height	Weight	<input type="checkbox"/> Gain Pounds in past year? <input type="checkbox"/> Loss
Reason for Weight Gain or Loss		
Currently pregnant <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," anticipated delivery date		

Proposed Insured 2		
Name (First, Middle, Last)		
Height	Weight	<input type="checkbox"/> Gain Pounds in past year? <input type="checkbox"/> Loss
Reason for Weight Gain or Loss		
Currently pregnant <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," anticipated delivery date		

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

SECTION 2

Has any person proposed for insurance ever been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for a disease or disorder such as : (Circle conditions to which "Yes" answer applies and give details below)	Proposed Insured 1		Proposed Insured 2	
	Yes	No	Yes	No
(a) Any disorder or disease of the brain or nervous system (such as paralysis, epilepsy, stroke, convulsions, chronic headache).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b) Any disorder or disease of the heart, blood vessels, or circulatory system (such as high blood pressure, heart attack, heart murmur, chest pain).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(c) Any disorder or disease of the respiratory system (such as Asthma, bronchitis, emphysema, tuberculosis).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(d) Any disorder or disease of the stomach, liver, intestines, rectum, pancreas, or abdominal organs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(e) Any disorder or disease of the genitourinary organs (such as kidneys, urinary tract, blood or sugar in the urine, chronic inflammation).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(f) Any disorder or disease of the skeletal system (such as arthritis, osteoporosis, joints, bones, spine, muscles).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(g) Any disorder or disease of eyes, ears, nose or throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(h) Any disorder or disease of the blood, skin, thyroid, lymph or other glands (such as anemia, diabetes).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(i) Any psychiatric or mental health disorders or diseases (such as attempted suicide, Bipolar, Obsessive-compulsive).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(j) Any gynecological disorders or diseases (such as irregular Pap Smear, Toxic Shock Syndrome).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(k) Any cancer, tumor, cyst or nodule	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(l) Any sexually transmitted disorders or diseases.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(m) Any disorders or diseases of the immune system except those related to the <i>Human Immunodeficiency Virus (AIDS Virus)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please provide details for any/all "Yes" responses.

	Question Number	Date of Diagnosis	Diagnosis, Medication or Treatment Prescribed	Medical Professional or Facility
Proposed Insured 1				
Proposed Insured 2				

SECTION 3

Has any person proposed for insurance ever been diagnosed or treated by a member of the medical profession for specified symptoms such as: (Circle conditions to which "Yes" answer applies and give details below)				Proposed Insured 1 Yes No		Proposed Insured 2 Yes No	
(a) Immune deficiency, anemia, recurrent fever, fatigue or unexplained weight loss, malaise, loss of appetite, diarrhea, fever of unknown origin, severe night sweats; unexplained or unusual infections or skin lesions; unexplained swelling of the lymph glands; Kaposi's Sarcoma or Pneumocystis Carinii Pneumonia.....				<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>	
(b) Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS).....				<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>	
Please provide details for any/all "Yes" responses.							
	Question Number	Date of Diagnosis	Diagnosis, Medication or Treatment Prescribed	Medical Professional or Facility			
Proposed Insured 1							
Proposed Insured 2							

SECTION 4

Has any person proposed for insurance ever (Circle conditions to which "Yes" answer applies and give details below)				Proposed Insured 1 Yes No		Proposed Insured 2 Yes No	
(a) Used narcotics, barbiturates, amphetamines, hallucinogens, marijuana, heroin, cocaine, or other habit forming drugs, except as prescribed by a physician.....				<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>	
(b) Received medical treatment or counseling for, or been advised by a physician to discontinue, the use of alcohol or prescribed or non-prescribed drugs.....				<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>	
(c) Been a member of any self-help group such as Alcoholics Anonymous or Narcotics Anonymous.....				<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>	
Please provide details for any/all "Yes" responses.							
	Question Number	Date of Diagnosis	Diagnosis, Medication or Treatment Prescribed	Medical Professional or Facility			
Proposed Insured 1							
Proposed Insured 2							

SECTION 5

The following questions in Section 5 do not include answers related to the Human Immunodeficiency Virus (AIDS virus) or for minor viruses, injuries, common colds that prevented normal activities for a period of less than five (5) days.							
Within the past five (5) years, has any person proposed for insurance (Circle items or conditions to which "Yes" answer applies and give details below)				Proposed Insured 1 Yes No		Proposed Insured 2 Yes No	
(a) Been treated, examined or advised by a member of the medical profession for any condition other than stated above.....				<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>	
(b) Been advised by a member of the medical profession to get specified medical care which has not been completed, such as any hospitalization, surgery or diagnostic test.....				<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>	
(c) Been an inpatient or outpatient in a hospital, clinic, medical facility, or any similar entity.....				<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>	
(d) Had any diagnostic tests such as: an electrocardiogram (EKG), MRI, CT-Scan or X-ray.....				<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>	
(e) Been on, or advised to be on any prescribed, non-prescribed (over the counter) medication or prescribed diet.....				<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>	
(f) Been unable to work, attend school or perform normal activities of life age and gender or been confined at home.....				<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>	
(g) Has made a claim for or received benefits, compensation or pension for any injury, sickness, disability or impaired condition.....				<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>	
Please provide details for any/all "Yes" responses.							
	Question Number	Date of Diagnosis	Diagnosis, Medication or Treatment Prescribed	Medical Professional or Facility			
Proposed Insured 1							
Proposed Insured 2							

SECTION 6

For the following Family Medical History question, please provide in section number 8 below for each parent or sibling: diagnosis, age of diagnosis, date last treated, age – if still alive and if not alive, age, date, and cause of death.					Proposed Insured 1	Proposed Insured 2
					Yes No	Yes No
Has any person proposed for insurance had a parent or sibling diagnosed or treated by a member of the medical profession for certain conditions, such as heart or vascular disease, cancer, diabetes, high blood pressure, kidney disease, attempted suicide or mental illness.....					<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Please provide details for any/all "Yes" responses.						
	Family Member	Age of Diagnosis	Diagnosis	Date Last Treated	Age – if still alive and if not alive, age, date, and cause of death.	
Proposed Insured 1						
Proposed Insured 2						

SECTION 7

Name, Address and Phone Number of Personal Physician or Medical Facility that is consulted for routine health care or periodic check-ups.	
Proposed Insured 1	Name:
	Address:
	Phone Number:
	Date and Reason of last consult:
	Name:
	Address:
	Phone Number:
	Date and Reason of last consult:
Proposed Insured 2	Name:
	Address:
	Phone Number:
	Date and Reason of last consult:
	Name:
	Address:
	Phone Number:
	Date and Reason of last consult:

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

I have read or have had read to me the completed Supplemental Application before signing below. 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.

_____ Proposed Insured 1 (Sign Name in Full)	_____ Date	_____ Proposed Insured 2 (Sign Name in Full)	_____ Date
_____ Signature of Parent or Guardian	_____ Date	_____ Signature of Witness	_____ Date

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[P.O. Box 830619
Birmingham, AL 35283-0619]

INDIVIDUAL LIFE INSURANCE APPLICATION - RIDER WORKSHEET

Required if applying for additional benefits or riders.

New Business

Protective Policy Change from Policy: _____

Print Proposed/Primary Insured's Name

Proposed/Primary Insured's Social Security Number

*** If applying for Child Rider, Income Provider Option, ExtendCare Rider or Chronic Illness Accelerated Death Benefit, please complete the rider specific supplemental application(s) per Application Instructions.**

1. ADDITIONAL BENEFITS

- Accidental Death Benefit \$ _____
(Range \$10,000 - \$250,000)
- * Child Rider
- Death Benefit Plus Rider _____% (Optional Interest Rate)
- Disability Benefit (Universal Life Only)
Monthly Benefit Amount \$ _____
- Enhanced Cash Surrender Value Rider
- Estate Protection Endorsement (Survivorship Plans Only)
- * ExtendCare Rider or Chronic Illness Accelerated Death Benefit
Maximum Monthly Benefit Amount \$ _____
Elimination Period (Number of Days) _____
- * Income Provider Option
- Protected Insurability Rider \$ _____
- Return of Substandard Charges Option (ROSCO)
- Waiver of Premium (Non-Universal Life Only)
- Other _____

2. COVERED INSURED RIDER (Available on certain Universal Life Plans only)

Name/Relationship to Primary Proposed Insured	Gender	Date of Birth	Birth State	Height	Weight
-----------------------------------------------	--------	---------------	-------------	--------	--------

Amount	Beneficiary/Relationship/Social Security Number	Percentage
--------	-------------------------------------------------	------------

Name/Relationship to Primary Proposed Insured	Gender	Date of Birth	Birth State	Height	Weight
-----------------------------------------------	--------	---------------	-------------	--------	--------

Amount	Beneficiary/Relationship/Social Security Number	Percentage
--------	-------------------------------------------------	------------

Name/Relationship to Primary Proposed Insured	Gender	Date of Birth	Birth State	Height	Weight
-----------------------------------------------	--------	---------------	-------------	--------	--------

Amount	Beneficiary/Relationship/Social Security Number	Percentage
--------	-------------------------------------------------	------------

I have read or have had read to me the completed Supplemental Application before signing below. 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.

Signed at: _____
(City and State)

_____ Date

Owner Signature

Proposed/Primary Insured Signature

Signature of Parent or Guardian

Witness to All Signatures



INDIVIDUAL LIFE INSURANCE – SUPPLEMENTAL APPLICATION – CHILD RIDER MEDICAL DECLARATIONS

SECTION 1

Children's Term Rider _____ Units (1 Unit equals \$1,000 Death Benefit – 20 Units maximum)

Please complete a separate form if you are applying for the Children's Term Rider on more than three (3) children.

CHILD #1		CHILD #2		CHILD #3	
Name: (First, Middle, Last)		Name: (First, Middle, Last)		Name: (First, Middle, Last)	
Gender	Date of Birth	Gender	Date of Birth	Gender	Date of Birth
Height	Weight	Height	Weight	Height	Weight
Place of Birth		Place of Birth		Place of Birth	
Relationship to Insured		Relationship to Insured		Relationship to Insured	

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

SECTION 2

Answer the following medical information for all children being applied for:

Has any child proposed for insurance ever been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for a disease or disorder such as: (Circle conditions to which "Yes" answer applies and give details below.)	Child #1 Yes No	Child #2 Yes No	Child #3 Yes No
(a) Any disorder or disease of the brain or nervous system (such as paralysis, epilepsy, stroke, convulsions, chronic headache).....	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
(b) Any disorder or disease of the heart, blood vessels, or circulatory system (such as high blood pressure, heart attack, heart murmur, chest pain).....	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
(c) Any disorder or disease of the respiratory system (such as Asthma, bronchitis, emphysema, tuberculosis)..	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
(d) Any disorder or disease of the stomach, liver, intestines, rectum, pancreas, or abdominal organs	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
(e) Any disorder or disease of the genitourinary organs (such as kidneys, urinary tract, blood or sugar in the urine, chronic inflammation).....	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
(f) Any disorder or disease of the skeletal system (such as arthritis, osteoporosis, joints, bones, spine, muscles).....	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
(g) Any disorder or disease of the eyes, ears, nose or throat	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
(h) Any disorder or disease of the blood, skin, thyroid, lymph or other glands (such as anemia, diabetes).....	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
(i) Any psychiatric or mental health disorders or diseases (such as attempted suicide, Bipolar, Obsessive-compulsive).....	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
(j) Any cancer, tumor, cyst or nodule	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
(k) Any disorders or diseases of the immune system except those related to the Human Immunodeficiency Virus (AIDS Virus).....	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>

Please provide details for any/all "Yes" responses.

	Question Number	Date of Diagnosis	Diagnosis, Medication or Treatment Prescribed	Medical Professional or Facility
Child #1				
Child #2				
Child #3				

SECTION 3

Answer the following medical information for all children being applied for:

Has any child proposed for insurance ever been diagnosed or treated by a member of the medical profession for specified symptoms such as: (Circle conditions to which "Yes" answer applies and give details below.)	Child #1 Yes No	Child #2 Yes No	Child #3 Yes No
(a) Immune deficiency, anemia, recurrent fever, fatigue or unexplained weight loss, malaise, loss of appetite, diarrhea, fever of unknown origin, severe night sweats; unexplained or unusual infections or skin lesions; unexplained swelling of the lymph glands; Kaposi's Sarcoma or Pneumocystis Carinii Pneumonia.....	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
(b) Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS).....	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>

Please provide details for any/all "Yes" responses.

	Question Number	Date of Diagnosis	Diagnosis, Medication or Treatment Prescribed	Medical Professional or Facility
Child #1				
Child #2				
Child #3				

SECTION 4

Answer the following information for all children age 15 through 18 being applied for:

Has any child age 15 through 18 proposed for insurance ever (Circle conditions to which "Yes" answer applies and give details below.)	Child #1 Yes No	Child #2 Yes No	Child #3 Yes No
(a) Used narcotics, barbiturates, amphetamines, hallucinogens, marijuana, heroin, cocaine, or other habit forming drugs, except as prescribed by a physician.....	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
(b) Received medical treatment or counseling for, or been advised by a physician to discontinue, the use of alcohol or prescribed or non-prescribed drugs.....	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
(c) Been a member of any self-help group such as Alcoholics Anonymous or Narcotics Anonymous.....	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>

Please provide details for any/all "Yes" responses.

	Question Number	Date of Diagnosis	Diagnosis, Medication or Treatment Prescribed	Medical Professional or Facility
Child #1				
Child #2				
Child #3				

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[P.O. Box 830619
Birmingham, AL 35283-0619]
1-800-366-9378

INDIVIDUAL LIFE INSURANCE - CONFIDENTIAL FINANCIAL STATEMENT

Name of Proposed Insured:

The following financial disclosures are made for the purposes of establishing insurability in connection with pending Life Insurance Application on my life. They are furnished as a true and accurate statement of my financial condition on _____, 20 _____.

ASSETS

Cash in Banks: *(Include approximate balance)*

\$

Notes Receivable:

\$

Real Estate: *(Include name of the owner as titled for tax purposes, full address, and a description of the property such as personal residence, commercial property, rental property, farm, etc.)*

\$

Stocks, Bonds, Mutual funds, or Other Investments: *(Include the type of investment and the current value. Quarterly statements can be submitted.)*

\$

Business Interest: *(Provide the name of the business, address, estimated market value, your percentage of ownership, and corporate structure such as S Corporation, C Corporation, etc.)*

\$

Other: *(Personal property, collectibles, etc.)*

\$

TOTAL ASSETS: \$ _____

LIABILITIES	
Mortgage: <i>(Primary Residence)</i>	\$
Mortgage: <i>(2nd Home)</i>	\$
Home Equity Loans, Second Mortgage, Etc:	\$
Mortgages for Rental Properties:	\$
Mortgages or Liens on Real Estate:	\$
Notes Payable to Banks:	\$
Notes Payable to Others:	\$
Accounts Payable:	\$
Taxes Payable:	\$
Credit Card, Auto Loans, Other Personal Debt: <i>(Describe)</i>	\$
Pending Suits, Tax Liens or Other Liabilities: <i>(Describe)</i>	\$

TOTAL LIABILITIES: \$ _____

NET WORTH: \$ _____

(assets minus liabilities)

ANNUAL INCOME	LAST YEAR	PRIOR YEAR
Annual Salary: <i>(Salary paid to you as an employee or business owner)</i>	\$	\$
Social Security Income:	\$	\$
Bonuses:	\$	\$
Interest:	\$	\$
Income Derived from Investments, Dividends, Bonds, etc:	\$	\$
Retirement Income: <i>(Pension, 401K, Annuities, etc)</i>	\$	\$
Other Income: <i>(Give details)</i>	\$	\$
TOTAL:	\$ _____	\$ _____

There are no suits pending or judgements against me at this time **EXCEPT:**

Have you personally guaranteed a debt owed by another party? Yes No If "Yes", give details:

VERIFICATION OF INFORMATION

Please provide the name, address, and phone number for CPA, Tax Attorney, or other 3rd party financial professional that we can contact should 3rd party verification of information be required.

SIGNATURES

I have read or have had read to me the completed Supplemental Application before signing below. 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.

Signature of Proposed Insured
PL-405

Date
Page 2 of 2

Signature of Agent



[P.O. Box 830619
Birmingham, AL 35283-0619]

Continuation of Information

Proposed Insured 1: _____
First Name Middle Name Last Name

Proposed Insured 2: _____
First Name Middle Name Last Name

[Empty box for additional information]

I have read or have had read to me the completed Supplemental Application before signing below. 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.

Proposed Insured 1 (Sign Name in Full) Date Proposed Insured 2 (Sign Name in Full) Date

Signature of Parent or Guardian Date Signature of Witness Date

SERFF Tracking #:	PRTA-128570361	State Tracking #:		Company Tracking #:	VICKIE-400
State:	Arkansas	Filing Company:	Protective Life Insurance Company		
TOI/Sub-TOI:	L08 Life - Other/L08.000 Life - Other				
Product Name:	PL-400, et al				
Project Name/Number:	PL-400, et al/PL-400, et al				

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification		
Comments:			
Attachment(s):			
Readability Certification.pdf			
AR Certification.pdf			

		Item Status:	Status Date:
Satisfied - Item:	Statement of Variables		
Comments:			
Attachment(s):			
Statement of Variables.pdf			

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

NAIC 458-68136
 FEIN 63-0169720

READABILITY CERTIFICATION

Regarding: SERFF Filing Submission

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.

Form Number	Form Title	Words	Sentences	Syllables	Score
PL-400	Application	1793	74	2754	52.2985
PL-401	Authorization To Obtain And Disclose Information	963	46	1521	51.9656
PL-402	Part 1A Supplemental Application - Medical Declarations	937	39	1413	54.8718
PL-403	Rider Worksheet	273	7	371	52.2808
PL-404	Supplemental Application - Child Rider Medical Declarations	867	30	1298	50.8454
PL-405	Confidential Financial Statement	318	27	543	50.4221
PL-406	Continuation of Information	171	6	244	57.1917



Keith Kirkley, J.D., MBA
 2ND Vice President, Compliance Officer
 Life and Annuity Division
 Protective Life Insurance Company

July 13, 2012

PROTECTIVE LIFE INSURANCE COMPANY BIRMINGHAM, ALABAMA

CERTIFICATION OF COMPLIANCE

Arkansas

Regarding: SERFF Submission PRTA-128570361

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
2ND Vice President, Compliance Officer
Life and Annuity Division
Protective Life Insurance Company
July 13, 2012

Protective Life Insurance Company
Birmingham, Alabama 35282-9887

NAIC 458-68136
FEIN 63-0169720

Statement of Variability

Form Number*	Form Title
PL-400	Individual Life Insurance Application
PL-401	Individual Life Insurance - Authorization To Obtain And Disclose Information
PL-402	Individual Life Insurance - Part 1A Supplemental Application - Medical Declarations
PL-403	Individual Life Insurance - Rider Worksheet
PL-404	Individual Life Insurance - Supplemental Application - Child Rider Medical Declarations
PL-405	Individual Life Insurance - Confidential Financial Statement
PL-406	Continuation of Information

**Including state variations thereof*

General Variables / All Forms

Company Address and Phone Number

Top / Right Corner of each Page 1: Will only be changed to accurately disclose the company's correct mailing address and phone number.

Specific Variables / Form PL-403 Individual Life Insurance Application - Rider Worksheet

Section 1. Additional Benefits: List of available optional riders [bracketed] to allow for the removal of rider selections upon discontinuation by the Company.

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.

Any change or modification to a variable item shall be administered in accordance with the requirements in the Variability of Information section, including any requirement for prior approval of a change or modification.

Signed for the Company by:



Keith Kirkley, J.D., MBA
2ND Vice President, Compliance Officer
Life and Annuity Division
Protective Life Insurance Company
July 13, 2012