

State: Arkansas **Filing Company:** Protective Life Insurance Company
TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other
Product Name: PL-500, et al
Project Name/Number: PL-500, et al/PL-500, et al

Filing at a Glance

Company: Protective Life Insurance Company
Product Name: PL-500, et al
State: Arkansas
TOI: L08 Life - Other
Sub-TOI: L08.000 Life - Other
Filing Type: Form
Date Submitted: 09/13/2012
SERFF Tr Num: PRTA-128681881
SERFF Status: Closed-Approved-Closed
State Tr Num:
State Status: Approved-Closed
Co Tr Num: VICKIE-PL500

Implementation: 11/05/2012
Date Requested:
Author(s): Vickie Jerkins
Reviewer(s): Linda Bird (primary)
Disposition Date: 09/19/2012
Disposition Status: Approved-Closed
Implementation Date:

State Filing Description:

State: Arkansas
TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other
Product Name: PL-500, et al
Project Name/Number: PL-500, et al/PL-500, et al

Filing Company: Protective Life Insurance Company

General Information

Project Name: PL-500, et al
Project Number: PL-500, et al
Requested Filing Mode: Review & Approval

Status of Filing in Domicile: Authorized
Date Approved in Domicile: 09/06/2012
Domicile Status Comments: Versions of these forms have been approved for use in our domicile state of Tennessee as an IIPRC/Compact Submission, effective September 06, 2012.

Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:

Market Type: Individual
Individual Market Type:
Filing Status Changed: 09/19/2012
State Status Changed: 09/19/2012

Deemer Date:
Submitted By: Vickie Jerkins

Created By: Vickie Jerkins
Corresponding Filing Tracking Number:

Filing Description:

Form Number // Form Title

PL-500-AR // Individual Life Insurance Application For Reinstatement or Policy Change

PL-501-AR // Individual Life Insurance Application For Reinstatement or Policy Change - Medical Declarations

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 for use in our domicile state of Tennessee as an IIPRC/Compact Submission, effective September 06, 2012.

The applications submitted in this filing will be used by those within the Company's portfolio of Applications. The submitted applications will be used for reinstatement or policy change purposes for our full line of individual life products. 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.

PL-500-AR (Individual Life Insurance Application For Reinstatement or Policy Change) Is a standard Application for Reinstatement or Policy Change. Additional insurance, by way of face amount increases or rider selections are not available using this form, but must be applied for using full applications.

PL-501-AR (Individual Life Insurance Application For Reinstatement or Policy Change - Medical Declarations) Is used to collect Medical Declarations in cases when the Proposed Insured is NOT being examined for underwriting purposes. The questions in this application mirror those in the previously approved PL-402.

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-500, the only [bracketed] information is the Company contact information (Top/Right corner of each Page 1) which will only be changed to accurately

State: Arkansas **Filing Company:** Protective Life Insurance Company
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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: \$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	09/13/2012	62648230

State: Arkansas Filing Company: Protective Life Insurance Company
TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other
Product Name: PL-500, et al
Project Name/Number: PL-500, et al/PL-500, et al

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	09/19/2012	09/19/2012

SERFF Tracking #:

PRTA-128681881

State Tracking #:

Company Tracking #:

VICKIE-PL500

State: Arkansas
 TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other
 Product Name: PL-500, et al
 Project Name/Number: PL-500, et al/PL-500, et al

Filing Company: Protective Life Insurance Company

Disposition

Disposition Date: 09/19/2012

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 Variability		Yes
Form	Individual Life Insurance Application For Reinstatement or Policy Change		Yes
Form	Individual Life Insurance Application For Reinstatement or Policy Change - Medical Declarations		Yes

State: Arkansas
TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other
Product Name: PL-500, et al
Project Name/Number: PL-500, et al/PL-500, et al

Filing Company: Protective Life Insurance Company

Form Schedule

Lead Form Number: PL-500

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
1		PL-500-AR	AEF	Individual Life Insurance Application For Reinstatement or Policy Change	Initial:	55.127	PL-500-AR.pdf
2		PL-501-AR	AEF	Individual Life Insurance Application For Reinstatement or Policy Change - Medical Declarations	Initial:	54.872	PL-501-AR.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
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	SCH	Schedule Pages



SECTION I INDIVIDUAL LIFE INSURANCE APPLICATION FOR REINSTATEMENT OR POLICY CHANGE

POLICY AND INSURED(S) INFORMATION:

POLICY NUMBER:

1. INSURED(S)

Insured 1 Name: (First, Middle, Last)			
Gender	Birthdate	Birth State	Marital Status
Driver's License No. & State		SSN / Tax ID	
Home Phone	Work Phone	Cell Phone	
Address (Street, City, State, Zip Code & Number of Years)			
Email Address			

Insured 2 Name: (First, Middle, Last)			
Gender	Birthdate	Birth State	Marital Status
Driver's License No. & State		SSN / Tax ID	
Home Phone	Work Phone	Cell Phone	
Address (Street, City, State, Zip Code & Number of Years)			
Email Address			

2. EMPLOYMENT

Insured 1 Employer's Name		
Occupation/Duties		
Annual Income	Household Income	Net Worth
If unemployed, provide details:		

Insured 1 Employer's Name		
Occupation/Duties		
Annual Income	Household Income	Net Worth
If unemployed, provide details:		

3. OWNER (If other than Insured)

Name	Phone Number	Relationship to Insured	SSN/Tax ID
Address (Street, City, State, Zip Code)		Email Address	

SECTION II

TYPE OF CHANGE / ACTION BEING REQUESTED:

1. DEATH BENEFIT OPTION CHANGE
 (✓) OPTION

<input type="checkbox"/>	Level to Increasing
<input type="checkbox"/>	Increasing to Level

2. FACE AMOUNT DECREASE

(A full application is required for a face amount increase. Plan selection may be limited by product face amount ranges and state approval.)

- (✓) OPTION BY (\$) AMOUNT FOR A TOTAL FACE AMOUNT OF (\$) PREMIUM (\$) AMOUNT

<input type="checkbox"/>	Decrease Base Policy	\$	\$	\$
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3. MORTALITY CLASS IMPROVEMENT

4. RATE REDUCTION

5. REINSTATEMENT



INDIVIDUAL LIFE INSURANCE APPLICATION FOR REINSTATEMENT OR POLICY CHANGE – MEDICAL DECLARATIONS

SECTION 1

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:		

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 insured person 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.)	Insured 1		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 the 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 <i>except those related to the 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
Insured 1				
Insured 2				

SECTION 3

Has any insured person 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.)				Insured 1 Yes No		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			
Insured 1							
Insured 2							

SECTION 4

Has any insured person ever (Circle conditions to which "Yes" answer applies and give details below.)				Insured 1 Yes No		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			
Insured 1							
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 insured person (Circle items or conditions to which "Yes" answer applies and give details below.)				Insured 1 Yes No		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			
Insured 1							
Insured 2							

SECTION 6

For the following Family Medical History question, please provide details 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.					Insured 1	Insured 2
					Yes	No
Has any insured person 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"/>
Please provide details for any/all "Yes" responses.						
	Family Member	Age at Diagnosis	Diagnosis	Date Last Treated	Age – if still alive and if not alive, age, date, and cause of death.	
Insured 1						
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.	
Insured 1	Name:
	Address:
	Phone Number:
	Date and Reason of last consult:
	Name:
	Address:
	Phone Number:
	Date and Reason of last consult:
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.

No insurance shall take effect unless: (1) the change/reinstatement is issued on this application and delivered to and accepted by the Owner; (2) the first premium for the change/reinstatement is paid in full while the insured is alive; and (3) there has been no change in health and insurability from that described in this application.

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.

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.

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

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SERFF Tracking #:

PRTA-128681881

State Tracking #:

Company Tracking #:

VICKIE-PL500

State:

Arkansas

Filing Company:

Protective Life Insurance Company

TOI/Sub-TOI:

L08 Life - Other/L08.000 Life - Other

Product Name:

PL-500, et al

Project Name/Number:

PL-500, et al/PL-500, et al

Supporting Document Schedules

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

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

PROTECTIVE LIFE INSURANCE COMPANY BIRMINGHAM, ALABAMA

CERTIFICATION OF COMPLIANCE

Arkansas

FORM(S): PL-500-AR and PL-501-AR

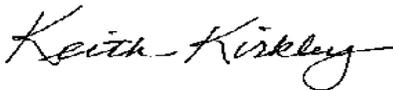
This is to certify that the Company is in compliance with Arkansas Insurance Department regarding:

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. 23-80-206 requirements for FLESCH Ease of Reading;

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
September 5, 2012

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

NAIC 458-68136
FEIN 63-0169720

READABILITY CERTIFICATION

Regarding: PL-500 and PL-501

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-500	Individual Life Insurance Application For Reinstatement or Policy Change	465	40	769	55.1272
PL-501	Individual Life Insurance Application For Reinstatement or Policy Change - Medical Declarations	937	39	1,413	54.8718



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

September 5, 2012

Protective Life Insurance Company
Birmingham, Alabama 35282-9887

NAIC 458-68136
FEIN 63-0169720

STATEMENT OF VARIABILITY

REGARDING:

Form Number Form Title

PL-500 Individual Life Insurance Application For Reinstatement or Policy Change

PL-501 Individual Life Insurance Application For Reinstatement or Policy Change - Medical Declarations
Including State Variations thereof.

General Variables

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-501 - Section 6. Benefit and Rider Changes

List of available optional riders [bracketed] to allow for the addition or removal of rider selections upon future approval and implementation or 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
September 13, 2012