

State: Arkansas **Filing Company:** Protective Life Insurance Company
TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other
Product Name: PL-700
Project Name/Number: PL-700/PL-700

Filing at a Glance

Company: Protective Life Insurance Company
Product Name: PL-700
State: Arkansas
TOI: L08 Life - Other
Sub-TOI: L08.000 Life - Other
Filing Type: Form
Date Submitted: 01/10/2013
SERFF Tr Num: PRTA-128837521
SERFF Status: Closed-Approved-Closed
State Tr Num:
State Status: Approved-Closed
Co Tr Num: VICKIE-700

Implementation: 03/01/2013
Date Requested:
Author(s): Vickie Jerkins
Reviewer(s): Linda Bird (primary)
Disposition Date: 01/16/2013
Disposition Status: Approved-Closed
Implementation Date:

State Filing Description:

State: Arkansas
TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other
Product Name: PL-700
Project Name/Number: PL-700/PL-700

Filing Company: Protective Life Insurance Company

General Information

Project Name: PL-700
Project Number: PL-700
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 domicile state of Tennessee, concurrently.

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

Market Type: Individual
Individual Market Type:
Filing Status Changed: 01/16/2013
State Status Changed: 01/16/2013

Deemer Date:
Submitted By: Vickie Jerkins

Created By: Vickie Jerkins
Corresponding Filing Tracking Number:

Filing Description:

The intended implementation date for the form in this filing is March 01, 2013, or upon approval by your Department. The captioned form is being submitted for review and approval. This filing does not contain any unusual or possibly controversial items that vary from normal company or industry standards. This filing has been submitted to our domicile state of Tennessee, concurrently. The submitted form has achieved a FLESCHEase of Reading Test Score of 60.8.

The submitted form is substantially similar to version PL-226 (07/11); Approved 06/30/2011; Tracking No. PRTA-127295696. The new form has been revised to remove the original Question 6, "How far can the Proposed Insured walk without needing to stop and rest on level ground?", which the Companies Underwriting Division found to be unnecessary. Additionally, we have incorporated the Companies Fraud Notice (not applicable where state language is required or notice not allowed). For your convenience in reviewing, a Redline Compare Document has been provided.

This stand-alone supplemental application will be used to gather information to assist in underwriting the insurance applied for on existing applications. In most situations, the form 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.

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 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.

While this form has 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 will not allow a disclosure or fraud warning to be split from the signature section. While the formatting of this form 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

State: Arkansas **Filing Company:** Protective Life Insurance Company
TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other
Product Name: PL-700
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versions of this form will be in a minimum of 10-point font.

This Supplemental Application 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:

- U-664 (1/07); Approved 01/25/2007; Tracking No. PRTA-125077646
- PLB-300-AR 2/11; Approved 03/15/2011; Tracking No. PRTA-127061881
- PL-400-AR; Approved 07/19/2012; Tracking No. PRTA-128570361

If you are in need of any further information to complete the review of this filing, please do not hesitate to contact me. I can be reached 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:	\$50.00
Retaliatory?	No
Fee Explanation:	\$50.00 per form
Per Company:	No

Company	Amount	Date Processed	Transaction #
Protective Life Insurance Company	\$50.00	01/10/2013	66420958

State: Arkansas Filing Company: Protective Life Insurance Company
TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other
Product Name: PL-700
Project Name/Number: PL-700/PL-700

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	01/16/2013	01/16/2013

SERFF Tracking #:

PRTA-128837521

State Tracking #:

Company Tracking #:

VICKIE-700

State:

Arkansas

Filing Company:

Protective Life Insurance Company

TOI/Sub-TOI:

L08 Life - Other/L08.000 Life - Other

Product Name:

PL-700

Project Name/Number:

PL-700/PL-700

Disposition

Disposition Date: 01/16/2013

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 and John Doe Sample		Yes
Supporting Document	Compare Document		Yes
Form	Individual Life Insurance - Supplemental Underwriting Application		Yes

SERFF Tracking #:

PRTA-128837521

State Tracking #:

Company Tracking #:

VICKIE-700

State: Arkansas

Filing Company:

Protective Life Insurance Company

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

Product Name: PL-700

Project Name/Number: PL-700/PL-700

Form Schedule

Lead Form Number: PL-700

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1		Individual Life Insurance - Supplemental Underwriting Application	PL-700	AEF	Initial		60.800	PL-700.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

INDIVIDUAL LIFE INSURANCE - 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 medical professional, date diagnosed, medications, and current condition. If additional space is needed, please use the Continuation of Information form.

- 1. Has the Proposed Insured been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession within the past 10 years for:
a) Alzheimer's disease or dementia, memory loss, Mild Cognitive Impairment (MCI), or organic brain syndrome?
b) Connective Tissue, Lupus or other auto-immune disorder, excluding HIV?
c) Nervous disorders such as seizures, fainting spells, Parkinson's disease, tremor, Amyotrophic Lateral Sclerosis (ALS), Multiple Sclerosis, Aphasia or other disorders of the brain or nervous system?
d) Any history of fractures or falls?

- 2. Has the Proposed Insured been:
a) Declined, refused, rated or turned down for life insurance, long-term care insurance, medical or disability insurance?
b) Required to have home care, nursing home care, or adult care for any reason within the past 12 months?
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?

	Yes	No
<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)</p> <p>[DETAILS: _____]</p>	<input type="checkbox"/>	<input type="checkbox"/>
<p>b) Participate in any type of exercise program? (If "Yes", provide type and frequency)</p> <p>[DETAILS: _____]</p>	<input type="checkbox"/>	<input type="checkbox"/>
<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?)</p> <p>[DETAILS: _____]</p>	<input type="checkbox"/>	<input type="checkbox"/>
<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.)</p> <p>[DETAILS: _____]</p>	<input type="checkbox"/>	<input type="checkbox"/>
<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.)</p> <p>[DETAILS: _____]</p>	<input type="checkbox"/>	<input type="checkbox"/>
<p>f) Live alone? (If "No", who do you live with?)</p> <p>[DETAILS: _____]</p>	<input type="checkbox"/>	<input type="checkbox"/>

<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)</p> <p>[DETAILS: _____]</p>	<input type="checkbox"/>	<input type="checkbox"/>
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<p>5. Is the Proposed Insured's activity limited by shortness of breath or pain? (If "Yes", explain)</p> <p>[DETAILS: _____]</p>	<input type="checkbox"/>	<input type="checkbox"/>
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<p>6. Additional details or comments:</p>		
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I represent that all statements and answers made in this application are full, complete and true, to the best of my knowledge and belief.

Any person who knowingly with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties according to state law.

Signed at: _____	(City)	_____	(State)	Date: _____
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Signature of Proposed Insured _____	Signature of Witness _____
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SERFF Tracking #:

PRTA-128837521

State Tracking #:

Company Tracking #:

VICKIE-700

State: Arkansas

Filing Company:

Protective Life Insurance Company

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

Product Name: PL-700

Project Name/Number: PL-700/PL-700

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification		
Comments:	The submitted form has achieved a FLESCH Ease of Reading Test Score of 60.8.		
Attachment(s):	Readability Certification.pdf AR Certification.pdf		

		Item Status:	Status Date:
Satisfied - Item:	Statement of Variables and John Doe Sample		
Comments:	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).		
Attachment(s):	Statement of Variables.pdf PL-700 JohnDoeSAMPLE.pdf		

		Item Status:	Status Date:
Satisfied - Item:	Compare Document		
Comments:	The submitted form is substantially similar to version PL-226. The new form has been revised to remove the original Question 6, "How far can the Proposed Insured walk without needing to stop and rest on level ground?", which the Companies Underwriting Division found to be unnecessary. Additionally, we have incorporated the Companies Fraud Notice (not applicable where state language is required or notice not allowed). For your convenience in reviewing, a Redline Compare Document has been provided.		
Attachment(s):	Compare PL226 to PL700.pdf		

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-700 Individual Life Insurance – Supplemental Underwriting Application

This is to certify that the enclosed form (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 a score as outlined in the following table.

	PL-700
Words:	500
Sentences:	30
Syllables:	763
FLESCH Score:	60.8



Keith Kirkley, JD, MBA
2ND Vice President, Compliance Officer
Life and Annuity Division
Protective Life Insurance Company
January 02, 2013

PROTECTIVE LIFE INSURANCE COMPANY BIRMINGHAM, ALABAMA

CERTIFICATION OF COMPLIANCE

Arkansas

FORM(S): **PL-700**

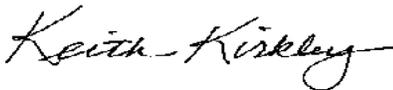
This is to certify that the Company is in compliance with Arkansas Insurance Department regarding:

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
January 2, 2013

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-700 Individual Life Insurance - Supplemental Underwriting Application

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
2ND Vice President, Compliance Officer
Life and Annuity Division
Protective Life Insurance Company
January 02, 2013

INDIVIDUAL LIFE INSURANCE - 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
1.	Has the Proposed Insured been diagnosed with or been treated within the past 10 years for:		
	a) Alzheimer's disease or dementia, memory loss, Mild Cognitive Impairment (MCI), or organic brain syndrome? DETAILS: [Yes]	<input checked="" type="checkbox"/>	<input type="checkbox"/>
	<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]		
	b) Connective Tissue, Lupus or other auto-immune disorder, excluding HIV ? DETAILS: [Yes]	<input checked="" type="checkbox"/>	<input type="checkbox"/>
	<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]		
	c) Nervous disorders such as seizures, fainting spells, Parkinson's disease, tremor, Amyotrophic Lateral Sclerosis (ALS), Multiple Sclerosis Aphasia or other disorders of the brain or nervous system? DETAILS: [Yes]	<input checked="" type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> Which diagnosis: [Fainting Spells]		
	<input type="checkbox"/> Date of Diagnosis: [05/05/2010]		
	<input type="checkbox"/> Type of Treatment: [Medical Supervision]		
	d) Any history of fractures or falls? DETAILS: [Yes]	<input checked="" type="checkbox"/>	<input type="checkbox"/>
	<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: [Slipped on Ice]		
2.	Has the Proposed Insured been:		
	a) Declined, refused, rated or turned down for life insurance, long-term care insurance, medical or disability insurance? DETAILS: [Yes]	<input checked="" type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> Status: [Declined]		
	<input type="checkbox"/> Date: [01/05/2010]		
	<input type="checkbox"/> Company: [ABC Insurance]		
	<input type="checkbox"/> Reason: [Medical History]		
	b) Required to have home care, nursing home care, or adult care for any reason within the past 12 months? DETAILS: [Yes]	<input checked="" type="checkbox"/>	<input type="checkbox"/>
	<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]		
	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 checked="" type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> Which Facility: [Adult Day Care]		
	<input type="checkbox"/> Date: [01/05/2010]		
	<input type="checkbox"/> Reason/Frequency: [Recovery from fall]		
3.	Does the Proposed Insured:		
	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 checked="" type="checkbox"/>	<input type="checkbox"/>
	<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]		
	b) Participate in any type of exercise program? (If "Yes", provide type and frequency) DETAILS: [Yes]	<input checked="" type="checkbox"/>	<input type="checkbox"/>
	<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]		
	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"/>	<input checked="" type="checkbox"/>
	<input type="checkbox"/> When did you last drive: [01/05/2010]		

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.

1. Has the Proposed Insured been diagnosed with or been treated within the past 10 years for: Yes No

a) Alzheimer's disease or dementia, memory loss, Mild Cognitive Impairment (MCI), or organic brain syndrome?
 DETAILS: _____

b) Connective Tissue, Lupus or other auto-immune disorder?
 DETAILS: _____

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: _____

d) Any history of fractures or falls?
 DETAILS: _____

2. Has the Proposed Insured been:

a) Declined, refused, rated or turned down for life insurance, long-term care insurance, medical or disability insurance?
 DETAILS: _____

b) Required to have home care, nursing home care, or adult care for any reason within the past 12 months?
 DETAILS: _____

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: _____

3. Does the Proposed Insured:

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: _____

b) Participate in any type of exercise program? (If "Yes", provide type and frequency)
 DETAILS: _____

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: _____

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: _____

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: _____

f) Live alone? (If "No", who do you live with?)
 DETAILS: _____

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: _____

5. Is the Proposed Insured's activity limited by shortness of breath or pain? (If "Yes", explain)
 DETAILS: _____

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?)

a) 50 feet or 1/2 block. DETAILS:

b) 100 feet or one block. DETAILS:

c) 400 feet or four blocks. DETAILS:

7. Additional details or comments:

The above represent that all statements and answers made in this application are true and full, complete and true, to the best of my knowledge and belief.

Any person who knowingly with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties according to state law.

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

Witness _____ Proposed Insured _____