Protective
Life Insurance Company
P.O. Box 2606 • BIRMINGHAM, AL 35202

APPLICATION FOR REINSTATEMENT OR POLICY CHANGE

Owner's Address: _____ Phone: _____ E-mail: _____

☐ 1. Reinstate Policy No. _____ on the lives of _____. The Insured must complete the Declarations of Insurability section below, and both Owner and Insured must sign the application.

☐ 2. Amend, Endorse or Reissue Policy No. _____ on the life of _____ as follows: _____

_____

(Examples: Reduce face amount; Cancel ADB, etc.)

DO NOT USE THIS APPLICATION TO CONVERT TERM POLICIES OR TO ADD A COVERED INSURED, CHILD'S PROTECTOR OR FAMILY PROTECTOR RIDER . . . . . USE A STANDARD APPLICATION FORM. SPECIFY DOLLAR AMOUNTS FOR BENEFITS ON UNIVERSAL LIFE PLANS.

As a basis for such application, I make the following representations and agree that: (1) this application and declarations shall be an amendment and supplement to the original application and it shall form a part of the policy; (2) the change or reinstatement requested shall not take effect until it has been approved at the Home Office and any required premium has been paid. I represent and certify that no insolvency or bankruptcy proceedings are now pending against me.

DECLARATIONS OF INSURABILITY

1. To the best of your knowledge and belief, have you or any dependents who are insured:

A. Consulted a physician or practitioner, been in a hospital or clinic or sought treatment for any symptoms, diseases, abnormalities, or disorders or had a periodic health examination since the policy issue date?	☐ YES	☐ NO
B. Been advised by a physician or practitioner that the use of alcohol is or was sufficient to impair or possibly impair health within the last 5 years?	☐ YES	☐ NO
C. Been advised to seek treatment or been treated for or used marijuana, amphetamines, LSD, barbiturates, heroin, opiates, or other narcotics except as prescribed by a physician within the last 5 years?	☐ YES	☐ NO
D. Current Height _____ Weight _____.	☐ YES	☐ NO
E. Applied for issuance or reinstatement of any policy and been rejected, postponed or rated during the last 5 years?	☐ YES	☐ NO
F. Ever made claim or received indemnity for injury or illness?	☐ YES	☐ NO
G. Used any form of tobacco since the original policy issue date? Date last used _____.	☐ YES	☐ NO
H. Been diagnosed by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS)?	☐ YES	☐ NO
I. Are you currently taking any medication? (If so, please provide complete details to include the name of the medication and the physician who prescribed it.)	☐ YES	☐ NO
J. Are you planning to travel outside of the U.S., Puerto Rico or Canada in the next 12 months? (If yes, complete a Foreign Travel Questionnaire.)	☐ YES	☐ NO
K. Have you participated in any hazardous activity such as aviation, scuba diving, racing, hang gliding, mountain climbing, or skydiving in the last 24 months? (If yes, complete a separate questionnaire.)	☐ YES	☐ NO
L. Had any motor vehicle accidents, DUIs, DWIs, speeding tickets, or other traffic violations in the past 7 years?	☐ YES	☐ NO

2. Please provide details of all questions answered "Yes" in Section (1). Give question number, dates, and if applicable, provide the full name and address of all physicians or practitioners consulted, and all hospitals and clinics in which treatment has been received.

_____

_____

Date Signed _____

Witness _____ Insured _____

Address _____ Owner _____

IMPORTANT

PLEASE COMPLETE THE ATTACHED AUTHORIZATION. PLEASE READ AND DETACH THE DESCRIPTION OF INFORMATION PRACTICES AND RETAIN FOR YOUR RECORDS.

HOME OFFICE ENDORSEMENTS _____

Your application for Policy Change has been approved by the Company. Your policy is amended. This form shall be an Endorsement to your policy and shall be proof of such change.

Date _____ By _____
Authorized Officer

PROTECTIVE LIFE INSURANCE COMPANY

P. O. Box 2606 • Birmingham, AL 35202

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 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, including but not limited to information about 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 and life partner may be used to evaluate an application for insurance on either me or my spouse and 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 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 and The Mayo Clinic; (v) insurers; (vi) reinsurers; (vii) Medical Information Bureau, Inc. (**MIB**); (viii) my (our) current and previous employers; and (ix) commercial consumer reporting agencies (**CRA**). All of these persons and organizations other than **MIB** may release the information described above to a **CRA** acting for Protective Life. **MIB** may not release the information described in paragraph 1 to a **CRA**.
3. I (we) authorize Protective Life to draw and test my (our) blood, and/or oral fluids, and urine as may be necessary to obtain information to be used to underwrite my (our) application for insurance. These tests may include, but are not limited to, tests for cholesterol and related blood lipids, diabetes, liver or kidney disorders, immune disorders (other than HIV/AIDS; reference number 5 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 and 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. Protective Life may release and disclose the information described in paragraphs 1 and 3 to other insurers if I (we) have applied or apply to the other insurers for insurance. Protective Life may 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.
5. **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**.
6. This authorization shall be valid for 24 months from the date shown below or, in the event of a claim for benefits, for the duration of such claim.
7. 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 5 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.
8. ❑ 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 the box if you wish to be interviewed if an investigative consumer report will be made.)*

   ❑ If performed, I (we) would like copies of my (our) blood profile test results.
9. 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.

   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 our ability to process this application.
10. I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment).

_____ **Date of Authorization:** _____

Proposed Insured 1 (Signature) When applicable, print name(s) of minor(s) below:

_____ _____

Print Name

_____ _____

Proposed Insured 2 (Signature)

_____

Print Name

_____

Parent or Legal Guardian (Signature)

THIS AUTHORIZATION MUST BE SIGNED WITHOUT MODIFICATION BEFORE THE APPLICATION CAN BE PROCESSED. PLEASE RETURN THIS AUTHORIZATION WITH THE APPLICATION.

Applicant Copy Home Office Copy

PROTECTIVE LIFE INSURANCE COMPANY

P. O. Box 2606 • Birmingham, AL 35202

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2. I (we) authorize the following persons and organizations to release and disclose the information described in paragraph 1 to Protective Life 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 and The Mayo Clinic; (v) insurers; (vi) reinsurers; (vii) Medical Information Bureau, Inc. (**MIB**); (viii) my (our) current and previous employers; and (ix) commercial consumer reporting agencies (**CRA**). All of these persons and organizations other than **MIB** may release the information described above to a **CRA** acting for Protective Life. **MIB** may not release the information described in paragraph 1 to a **CRA**.

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   (Please check the box if you wish to be interviewed if an investigative consumer report will be made.)

   ❑ If performed, I (we) would like copies of my (our) blood profile test results.

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   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 our ability to process this application.

10. I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment).

_____ **Date of Authorization:** _____

Proposed Insured 1 (Signature) When applicable, print name(s) of minor(s) below:

_____ _____

Print Name

_____ _____

Proposed Insured 2 (Signature)

_____

Print Name

_____

Parent or Legal Guardian (Signature)

THIS AUTHORIZATION MUST BE SIGNED WITHOUT MODIFICATION BEFORE THE APPLICATION CAN BE PROCESSED. PLEASE RETURN THIS AUTHORIZATION WITH THE APPLICATION.

PROTECTIVE LIFE INSURANCE COMPANY
P.O. Box 2606
Birmingham, Alabama 35202

DESCRIPTION OF INFORMATION PRACTICES

(Including Medical Information Bureau Notice and Fair Credit Reporting Act Notice)

In considering your application for insurance, information from various sources must be considered. These include the results of your physical examination, if required, and any reports Protective Life may receive from doctors and hospitals who have attended you.

Information regarding your insurability will be treated as confidential. Protective Life, or its reinsurers, may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such company, the Bureau upon request, will supply such company with the information it may have in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, their telephone number is 866-692-6901 (TTY 866-346-3642).

Protective Life, or its reinsurers, may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

Furthermore, as part of our procedures for processing your insurance application, an investigative consumer report may be prepared by one or more of the commercial agencies offering this service whereby information is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics and mode of living except as may be related directly or indirectly to your sexual orientation. You have the right to be personally interviewed if we order an investigative consumer report. You also have the right to receive a copy of the report, and by making a written request to Protective Life within a reasonable period of time to receive additional detailed information about the nature and scope of this investigation.

As a general practice, we will not disclose personal or privileged information about you to anyone else without your consent, unless a legitimate business need exists or disclosure is required or permitted by law. You are entitled, upon request, to receive a more detailed statement of our information practices. You also have the right to access the personal information about you that we have in our records. You may see and copy the information, or we will send it to you, whichever you prefer. You also have the right to request correction of personal information we may have about you which you think is wrong. To exercise these rights, please write to us at the address appearing at the end of this notice.

Ask our agent for assistance, or call or write us at Protective Life Insurance Company, Attention: Vice President-Underwriting, P.O. Box 830619, Birmingham, Alabama 35283-0619. Telephone (205) 879-9230

THIS NOTICE MUST BE GIVEN TO PROPOSED INSURED