Protective Life and Annuity Insurance Company
P.O. Box 830619
Birmingham, AL 35283-0619

INDIVIDUAL LIFE INSURANCE APPLICATION PACKET - INSTRUCTIONS

These forms are required on all cases submitted. All forms must be dated on or before the application signed date.

FORM NUMBER	FORM NAME	INSTRUCTIONS
• PL-DIP-NY	• Description of Information Practices	• This notice MUST be given to the Proposed Insured on all cases submitted.
• PL-400-NY	• Individual Life Insurance Application	• Protective Life and Annuity can only accept or service an application from an applicant who speaks English or Spanish. Spanish speaking applicants must go through our TeleLife process. • Complete each question in the Application for Insurance. If completing by hand, please use a pen with black ink. • If applying for any riders see instructions for Rider Worksheet on Page 2.
• PL-701-NY	• Supplement to Life Insurance Application	• Must complete on ALL cases being submitted.

• PL-HIPAA-NY	• Authorization to Obtain and Disclose Information (HIPAA)	• Must complete on all cases being submitted.
		  • Leave a copy of this form with the applicant.
		  Signature and date is required.

• PLX-408-NY	• Broker/Representative Report	• Correct Broker/Representative PLICO Contract Number must be included in order to ensure commissions are paid correctly. Include Split Share Percentage.
• PL-406-NY	• Continuation of Information Form	• Use this form if additional space is needed for Information.
• B-7375NY; B-NY-Info	• Notice and Consent Form for AIDS (HIV) Testing	• Must complete on all cases submitted. • Leave a copy of this form with the applicant.
• B-8474(NY)	• NAIC No Illustration	• Only required for illustrated UL products when an illustration is not obtained. • Illustrations are required prior to issue.

NOT FOR USE WITH VARIABLE UNIVERSAL LIFE PRODUCTS

These forms may be required if circumstances apply.

FORM NUMBER	FORM NAME	INSTRUCTIONS

• PL-403-NY	• Rider Worksheet	• If applying for any additional benefits or riders, must complete the Rider Worksheet. In addition, the following riders require these supplemental application forms, which can be found online at protectivelifebrokerage.com.
		• Leave a copy of each form with the applicant.
		  • If applying for Children's Term Rider, Complete form # PL-404R-NY.
		  • If applying for Income Provider Option, Complete form # P-U-437R-NY.

• PL-104-NY	• Pre-Authorized Withdrawal Agreement	• Use in cases where the client elects to have premium payments drafted.
• PL-CR-NY	• Conditional Receipt Agreement	• If payment is submitted with the application, must complete and sign the Conditional Receipt. • Leave a copy of this form with the applicant.
• Reg 60 Replacement Packet	• Replacement Form	• Must complete and sign regarding existing coverage. • Leave a copy of this form with the Proposed Insured.
• B-8183-NY	• Assignment/Transfer of Ownership (Section 1035 Exchange)	• Must complete on 1035 Exchange/Transfer cases. • Leave a copy of this form with the owner. Send the Original to the Home Office.
• PL-405-NY	• Confidential Financial Statement	• Required if the Proposed Insured is under age 65 and the face amount is $3,000,000 or greater OR the Proposed Insured is 65 or older and the face amount is $1,000,000 or greater.
• PL-402-NY	• Part 1A-Supplemental Application (Medical Declarations)	• If the Proposed Insured is NOT being examined, this form must be completed.

E-mail Address: NBApps@protective.com
If e-mailing the application, you do not need to send the original application. However, we will need the original 1035 paperwork and assignment forms (if applicable).

Mailing Addresses:

Home Office – Regular Mail
Protective Life Insurance Company
ATTN: New Business
P.O. Box 830619
Birmingham, Alabama 35283-0619
Telephone: (800) 366-9378
Fax: (205) 268-5807

Home Office - Overnight
Protective Life Insurance Company
ATTN: New Business
2801 Highway 280 South
Birmingham, Alabama 35223
Telephone: (800) 366-9378
Fax: (205) 268-5807

Protective Life and Annuity Insurance Company
P.O. Box 830619
Birmingham, AL 35283-0619

DESCRIPTION OF INFORMATION PRACTICES

(Including MIB, Inc. Notice and Fair Credit Reporting Act Notice)

DISCLOSURE OF INFORMATION

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 and Annuity may receive from doctors and hospitals who have attended you.

Information regarding your insurability will be treated as confidential. Protective Life and Annuity, or its reinsurers, may, however, make a brief report of any personal health information thereon to the MIB, Inc., (MIB), formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901. If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

Protective Life and Annuity, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

INVESTIGATIVE CONSUMER REPORT

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 insurance risk score, character, general reputation, personal characteristics or behavioral and lifestyle factors, 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 by making a written request to Protective Life and Annuity, within a reasonable period of time, to receive additional detailed information about the nature and scope of this investigation.

YOU CAN REVIEW AND CORRECT YOUR INFORMATION

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 a copy of 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/producer for assistance or call or write us at Protective Life and Annuity Insurance Company, Attention: New Business, P.O. Box 830619, Birmingham, Alabama 35283-0619. Telephone: 800-366-9378

THIS NOTICE MUST BE GIVEN TO THE PROPOSED INSURED

THIS PAGE INTENTIONALLY LEFT BLANK.

Protective

Protective Life and Annuity Insurance Company
P.O. Box 830619
Birmingham, AL 35283-0619

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*	*Birthdate*	*Relationship to Prop Ins*
Phone Number	*SSN/Taxpayer ID No.*	*Email Address*	
Street Address, City, State, Zip Code			

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

Name/Relationship	*Street, Address, City, State, Zip Code*

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) ☐ *10 Yrs.* ☐ *15 Yrs.* ☐ *20 Yrs.* ☐ *25 Yrs.* ☐ *30 Yrs.*	*Underwriting Class Quoted:* *(Protective will issue best underwriting class.)*	
If Universal Life: ☐ *Level Face Amount* ☐ *Increasing Face Amount*	*Section 1035:* ☐ *Yes* ☐ *No*	*1035 Loan Transfer:* ☐ *Yes* ☐ *No*
CVAT: ☐ *(If not checked, the Guideline Premium Test will apply, subject to product availability.)*		

Is Proposed Insured Requesting Additional Benefits, Riders, or Child Coverage? ☐ *Yes* ☐ *No* *(If Yes, must complete the Rider Worksheet.)*	*Premium Payment:*	☐ *Annual* $	☐ *Quarterly* $	☐ *Semi-Annual* $
		☐ *Monthly (Pre-Authorized Withdrawal Only)* $		☐ *Cash with Application* $

SECTION III: BENEFICIARY DESIGNATIONS

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

	Primary Beneficiary Name(s)	*Address, Telephone # & Date of Birth*	*Social Security #*	*Relationship*	*Percentage*
1.					
2.	*Contingent Beneficiary Name(s)*	*Address, Telephone # & Date of Birth*	*Social Security #*	*Relationship*	*Percentage*

SECTION IV: EXISTING COVERAGE/PENDING INSURANCE AND REPLACEMENT

(Must be answered completely on all cases.)

1. 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.)

2. 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*

3. 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*

4. 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

5. 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

6. Is someone other than any Proposed Insured responsible for paying premiums? *If Yes, please explain.* ……..…… ☐ Yes ☐ No

7. Will anyone unrelated to any Proposed Insured receive any of the policy death benefit? *If Yes, please explain.* ……..…… ☐ Yes ☐ No

8. Has a mortality analysis or life expectancy analysis been performed on any Proposed Insured? ……..…… ☐ Yes ☐ No

9. Has any Proposed Insured made an agreement or put a plan in place for 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.**	☐ *Personal* ☐ *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?	☐	☐	☐	☐
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.*)	☐	☐	☐	☐
B. Narcotics, stimulants, sedatives, hallucinogenic drugs? (*If Yes, complete the Drug Use Questionnaire.*)	☐	☐	☐	☐
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 or do you have charges currently pending against you for driving while under the influence of alcohol?	☐	☐	☐	☐
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?	☐	☐	☐	☐
5. Flown as a pilot, student pilot or crew member, or intend to fly as such? (*If Yes, complete the Aviation Questionnaire.)*	☐	☐	☐	☐
6. Been a member of, or applied to be a member, or received a notice of required service in the armed forces, reserves or National Guard? (*If Yes, provide details below.*)	☐	☐	☐	☐
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.*)	☐	☐	☐	☐
☐ Racing ☐ Scuba Diving ☐ Hang Gliding ☐ Mountain Climbing, excluding recreational biking ☐ Sky Diving ☐ 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.*)	☐	☐	☐	☐
Country of Citizenship / *Visa Type* / *Expiration Date* / *Length of U.S. Residency*				
b. Intending to travel or reside outside the United States or Canada within the next 12 months?	☐	☐	☐	☐
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 and shall be attached to and made part of any policy issued. My (our) answers are material to the decision as to whether the risk is accepted by Protective Life and Annuity Insurance Company.
2. No representative or medical examiner can make, alter or discharge any contract, accept risks, or waive Protective Life and Annuity Company's rights or requirements.
3. 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.

Signed At _____ Date _____
(City and State)

(X) _____ (X) _____
Signature of Proposed Insured 1 Signature of Proposed Insured 2

(X) _____ Date _____
Signature of Parent or Guardian

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

Protective Life and Annuity Insurance Company
P.O. Box 830619
Birmingham, AL 35283-0619

SUPPLEMENT TO LIFE INSURANCE APPLICATION — APPLICATION SUPPLEMENT – PART I

The statements and answers to the questions listed below shall become a part of the attached application; shall be subject to the terms of the attached application; and shall become a part of any policy based on this application.

Print Name of Proposed Insured(s): _____

For any policy to be issued as a result of this application:	Yes	No
(1) Will anyone other than the Insured, his or her family, or employer/business partner pay any portion of the initial or future premiums or obtain any right, title or interest in this policy? If Yes, complete the "Statement of Owner Intent" (Application Supplement – Part II)	☐	☐
(2) Will any portion of the initial or future premiums be borrowed, loaned or otherwise financed? If Yes, complete the "Premium Financing Disclosure" (Disclosure and Acknowledgement)	☐	☐
(3) Will a trust, including family trust, own this policy? If Yes, complete the "Trust Certification" (Application Supplement – Part III)	☐	☐
(4) Is the Proposed Insured age 65 or older AND total coverage applied for across all Protective companies $1,000,000 or more? If Yes, complete the "Statement of Owner Intent" (Application Supplement – Part II)	☐	☐

SIGNATURES

I (We) have read or have had read to me (us) the completed Supplement before signing below. All statements and answers in the Supplement are correctly recorded and are full, complete and true to the best of my (our) knowledge and belief. I (We) understand that the information being provided in this Supplement is being relied upon in considering the application for life insurance.

Signed in _____ (State), this _____ day of _____ (Month), _____ (Year).

SIGN HERE _____
Signature of Proposed Insured 1

_____
Address, Date of Birth, Telephone Number, Social Security Number

SIGN HERE _____
Signature of Proposed Insured 2

_____
Address, Date of Birth, Telephone Number, Social Security Number

SIGN HERE _____
Signature of Owner/Trustee & Title if Corporation 1

_____
Address, Date of Birth, Telephone Number, Social Security Number

SIGN HERE _____
Signature of Owner/Trustee & Title if Corporation 2

_____
Address, Date of Birth, Telephone Number, Social Security Number

SIGN HERE _____
Signature of Witness

PRODUCER CERTIFICATION

By signing below, I hereby certify that to the best of my knowledge and belief, the information provided herein is complete, accurate, and correct and that the life insurance being applied for conforms to the Company's guidelines.

Signed at: _____ (City and State)

_____
Date

X SIGN HERE _____
Producer Signature

_____
Producer Name (Print)

PL-701-NY 10/2014

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Protective Life and Annuity Insurance Company
P.O. Box 830619
Birmingham, AL 35283-0619

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

This Authorization to Obtain and Disclose Information complies with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") as related to Life Insurance.

USE OF MEDICAL, NON-HEALTH AND NON-MEDICAL INFORMATION

I (we) authorize Protective Life and Annuity Insurance Company (Protective Life and Annuity) and its reinsurers to obtain, directly or through designated third parties, and to use any information about or relating to me (us) that may affect my (our) insurability. Protective Life and Annuity and its reinsurers, Life Insurance Representative(s) or regional sales office representing me on my (our) application for insurance may:

a. obtain and use health and medical information from all dates of service, including but not limited to information about chart notes, EKG's, nicotine use, physical and mental diseases and illness, and psychiatric disorders (excluding psychotherapy notes);
b. obtain and use non-health and non-medical information, including but not limited to financial information, credit reports, consumer reports, driving record, criminal record, character, general reputation, personal characteristics or behavioral and lifestyle factors and information about avocations and aviation activity;
c. use all of this information to evaluate an application for insurance, a claim for insurance benefits, or both;
d. use any information relating to communicable diseases and other risk factors relating to me or to my spouse or life partner to evaluate an application for insurance on either me or my spouse or life partner.

RELEASE AND DISCLOSE INFORMATION FROM THIRD PARTIES

I (we) authorize the following persons and organizations to release and disclose the information described in the ***USE OF MEDICAL, NON-HEALTH AND NON-MEDICAL INFORMATION*** section to Protective Life and Annuity, directly through the following designated third parties or its representative(s) acting on its behalf:

a. my (our) doctor(s); medical practitioners; pharmacists and Pharmacy Benefit Managers;
b. 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;
c. insurers; reinsurers;
d. my (our) current and previous employers;
e. MIB, Inc. **(MIB**); and 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 and Annuity. **MIB** may not release the information described in the ***USE OF MEDICAL, NON-HEALTH AND NON-MEDICAL INFORMATION*** section to a **CRA**.

TESTING OF BLOOD, ORAL FLUIDS AND URINE

I (we) authorize Protective Life and Annuity to draw and test my (our) blood, and/or oral fluids, and urine as necessary to underwrite my (our) application for insurance. These tests may include, but are not limited to:

a. tests for cholesterol and related blood lipids, diabetes, liver or kidney disorders, immune disorders (other than HIV/AIDS).
b. tests for the presence of drugs, nicotine, or their metabolites.

This authorization does not include genetic testing. Unless otherwise required by law or regulation, Protective Life and Annuity may, but is not obligated to, release any of these test results directly to me or to my spouse or life partner.

RELEASE OF MEDICAL, NON-HEALTH, NON-MEDICAL AND TESTING INFORMATION

I (we) authorize Protective Life to release and disclose the information described in the ***USE OF MEDICAL, NON-HEALTH AND NON-MEDICAL INFORMATION*** section and the ***TESTING OF BLOOD, ORAL FLUIDS AND URINE*** section:

a. to its affiliates, its reinsurers, persons or organization providing services relating to insurance underwriting for Protective Life and Annuity, **MIB** and as otherwise required by law.
b. to release and disclose the information to other duly licensed life insurers if I (we) have applied or apply to the other insurers for insurance.
c. to its reinsurers, to make a brief report of my personal health information to **MIB**.
d. to the Life Insurance Representative(s) representing me to duly licensed specific life insurers for the purpose of applying for life insurance if my (our) application with Protective Life and Annuity is declined or if Protective Life and Annuity is unable to offer coverage at an acceptable rate.
e. to the Life Insurance Representative(s) and its staff, affiliated companies and/or entities, insurance companies and their re-insurers representing me on my (our) application for insurance if it is necessary to provide an explanation of the reasons for Protective Life and Annuity's decision to impose special underwriting requirements, whenever my application cannot be approved as submitted, or in connection with a claim for benefits.

SPECIAL REQUIREMENT FOR HIV/AIDS TESTING

If Protective Life and Annuity 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 and Annuity may require a separate authorization. I (we) hereby authorize Protective Life and Annuity:

a. to obtain and use the results of any HIV tests that I (we) separately authorize.
b. (if permitted by law) to disclose the results of any tests to its reinsurers and **MIB**.

GENERAL INFORMATION

a. This authorization shall be valid for 24 months from the Date of Authorization shown below.
b. During the evaluation of my (our) insurance application, I (we) understand that I (we) have the right to revoke the authorizations in the previous sections (above) by writing to Protective Life and Annuity at P.O. Box 830619 • Birmingham, Alabama 35283-0619. If this authorization is revoked, this would result in the file being closed and no coverage provided.
c. I understand I do not have to sign this authorization in order to obtain **health care benefits (treatment, payment or enrollment).**
d. I (we) understand that any information about me (us) that is disclosed pursuant to this authorization may be subject to re-disclosure and no longer covered by certain federal rules governing privacy and confidentiality of health information. The information contained in these medical and financial records will be held in confidence and may be used only for the purpose of the procurement, or underwriting for the possible procurement or the evaluation of life, health, long term care, or other insurance products.
e. I (we) understand that my (our) personal information, including my (our) protected health information disclosed under this authorization will be incorporated into and made a part of any life and/or disability insurance policy(ies) issued by the Company and that the policy(ies) will be delivered to the policy owner.
f. *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 and Annuity's ability to process this application.*

AUTHORIZATIONS AND INVESTIGATIVE CONSUMER REPORT

☐ I (we) have been given a copy of this **Authorization to Obtain and Disclose Information** along with the **Description of Information Practices**.

☐ I (we) authorize the preparation of an investigative consumer report and would like to be interviewed if an investigative consumer report will be made. (Please refer to the **Description of Information Practices** for additional information regarding the interview for an **Investigative Consumer Report**.)

THIS AUTHORIZATION <u>MUST</u> BE SIGNED WITHOUT MODIFICATION AND RETURNED WITH THE APPLICATION BEFORE PROCESSING.

SIGNATURES

Date of Authorization: X_____

_____

List Health Care Providers

X_____	_____	_____	_____
Proposed Insured 1 (Signature)	Print Name of Proposed Insured 1	Birthdate	Social Security Number
X_____	_____	_____	_____
Proposed Insured 2 (Signature)	Print Name of Proposed Insured 2	Birthdate	Social Security Number

_____	X_____	_____
If Minor, Print Name	Parent or Legal Guardian (Signature)	Print Name of Parent or Legal Guardian

Home Office – ORIGINAL Applicant - COPY

Protective Life and Annuity Insurance Company
P.O. Box 830619
Birmingham, AL 35283-0619

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

This Authorization to Obtain and Disclose Information complies with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") as related to Life Insurance.

USE OF MEDICAL, NON-HEALTH AND NON-MEDICAL INFORMATION

I (we) authorize Protective Life and Annuity Insurance Company (Protective Life and Annuity) and its reinsurers to obtain, directly or through designated third parties, and to use any information about or relating to me (us) that may affect my (our) insurability. Protective Life and Annuity and its reinsurers, Life Insurance Representative(s) or regional sales office representing me on my (our) application for insurance may:

a. obtain and use health and medical information from all dates of service, including but not limited to information about chart notes, EKG's, nicotine use, physical and mental diseases and illness, and psychiatric disorders (excluding psychotherapy notes);
b. obtain and use non-health and non-medical information, including but not limited to financial information, credit reports, consumer reports, driving record, criminal record, character, general reputation, personal characteristics or behavioral and lifestyle factors and information about avocations and aviation activity;
c. use all of this information to evaluate an application for insurance, a claim for insurance benefits, or both;
d. use any information relating to communicable diseases and other risk factors relating to me or to my spouse or life partner to evaluate an application for insurance on either me or my spouse or life partner.

RELEASE AND DISCLOSE INFORMATION FROM THIRD PARTIES

I (we) authorize the following persons and organizations to release and disclose the information described in the ***USE OF MEDICAL, NON-HEALTH AND NON-MEDICAL INFORMATION*** section to Protective Life and Annuity, directly through the following designated third parties or its representative(s) acting on its behalf:

a. my (our) doctor(s); medical practitioners; pharmacists and Pharmacy Benefit Managers;
b. 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;
c. insurers; reinsurers;
d. my (our) current and previous employers;
e. MIB, Inc. **(MIB**); and 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 and Annuity. **MIB** may not release the information described in the ***USE OF MEDICAL, NON-HEALTH AND NON-MEDICAL INFORMATION*** section to a **CRA**.

TESTING OF BLOOD, ORAL FLUIDS AND URINE

I (we) authorize Protective Life and Annuity to draw and test my (our) blood, and/or oral fluids, and urine as necessary to underwrite my (our) application for insurance. These tests may include, but are not limited to:

a. tests for cholesterol and related blood lipids, diabetes, liver or kidney disorders, immune disorders (other than HIV/AIDS).
b. tests for the presence of drugs, nicotine, or their metabolites.

This authorization does not include genetic testing. Unless otherwise required by law or regulation, Protective Life and Annuity may, but is not obligated to, release any of these test results directly to me or to my spouse or life partner.

RELEASE OF MEDICAL, NON-HEALTH, NON-MEDICAL AND TESTING INFORMATION

I (we) authorize Protective Life to release and disclose the information described in the ***USE OF MEDICAL, NON-HEALTH AND NON-MEDICAL INFORMATION*** section and the ***TESTING OF BLOOD, ORAL FLUIDS AND URINE*** section:

a. to its affiliates, its reinsurers, persons or organization providing services relating to insurance underwriting for Protective Life and Annuity, **MIB** and as otherwise required by law.
b. to release and disclose the information to other duly licensed life insurers if I (we) have applied or apply to the other insurers for insurance.
c. to its reinsurers, to make a brief report of my personal health information to **MIB**.
d. to the Life Insurance Representative(s) representing me to duly licensed specific life insurers for the purpose of applying for life insurance if my (our) application with Protective Life and Annuity is declined or if Protective Life and Annuity is unable to offer coverage at an acceptable rate.
e. to the Life Insurance Representative(s) and its staff, affiliated companies and/or entities, insurance companies and their re-insurers representing me on my (our) application for insurance if it is necessary to provide an explanation of the reasons for Protective Life and Annuity's decision to impose special underwriting requirements, whenever my application cannot be approved as submitted, or in connection with a claim for benefits.

SPECIAL REQUIREMENT FOR HIV/AIDS TESTING

If Protective Life and Annuity 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 and Annuity may require a separate authorization. I (we) hereby authorize Protective Life and Annuity:

a. to obtain and use the results of any HIV tests that I (we) separately authorize.
b. (if permitted by law) to disclose the results of any tests to its reinsurers and **MIB**.

GENERAL INFORMATION

a. This authorization shall be valid for 24 months from the Date of Authorization shown below.
b. During the evaluation of my (our) insurance application, I (we) understand that I (we) have the right to revoke the authorizations in the previous sections (above) by writing to Protective Life and Annuity at P.O. Box 830619 • Birmingham, Alabama 35283-0619. If this authorization is revoked, this would result in the file being closed and no coverage provided.
c. I understand I do not have to sign this authorization in order to obtain **health care benefits (treatment, payment or enrollment).**
d. I (we) understand that any information about me (us) that is disclosed pursuant to this authorization may be subject to re-disclosure and no longer covered by certain federal rules governing privacy and confidentiality of health information. The information contained in these medical and financial records will be held in confidence and may be used only for the purpose of the procurement, or underwriting for the possible procurement or the evaluation of life, health, long term care, or other insurance products.
e. I (we) understand that my (our) personal information, including my (our) protected health information disclosed under this authorization will be incorporated into and made a part of any life and/or disability insurance policy(ies) issued by the Company and that the policy(ies) will be delivered to the policy owner.
f. *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 and Annuity's ability to process this application.*

AUTHORIZATIONS AND INVESTIGATIVE CONSUMER REPORT

☐ I (we) have been given a copy of this **Authorization to Obtain and Disclose Information** along with the **Description of Information Practices**.

☐ I (we) authorize the preparation of an investigative consumer report and would like to be interviewed if an investigative consumer report will be made. (Please refer to the **Description of Information Practices** for additional information regarding the interview for an **Investigative Consumer Report**.)

THIS AUTHORIZATION <u>MUST</u> BE SIGNED WITHOUT MODIFICATION AND RETURNED WITH THE APPLICATION BEFORE PROCESSING.

SIGNATURES

Date of Authorization: X_____

_____
List Health Care Providers

X_____	_____	_____	_____
Proposed Insured 1 (Signature)	Print Name of Proposed Insured 1	Birthdate	Social Security Number
X_____	_____	_____	_____
Proposed Insured 2 (Signature)	Print Name of Proposed Insured 2	Birthdate	Social Security Number

_____	X_____	_____
If Minor, Print Name	Parent or Legal Guardian (Signature)	Print Name of Parent or Legal Guardian

Home Office – ORIGINAL Applicant - COPY

Protective Life and Annuity Insurance Company
P.O. Box 830619
Birmingham, AL 35283-0619

BROKER / REPRESENTATIVE REPORT

		Yes	No
1.	In what language were the questions on the application asked? *Please remember that Protective Life cannot accept or service any application from an applicant who does not speak English or Spanish. ☐ English ☐ Spanish ☐ Other* **List Other Language* : _____		
2.	Is the Proposed Insured a relative or does the Proposed Insured have a business relationship with you? *If Yes, Details:* _____	☐	☐
3.	(a) Will this policy replace or change existing policy(ies)?	☐	☐
	(b) If replacement of existing insurance is involved, have you complied with all relevant state requirements, including any Disclosure and Comparison Statements?	☐	☐
	If No, Explain: _____		
	Answer questions (c) and (d) *only* if this is a replacement:		
	(c) Did you use any pre-printed company approved sales materials? *If Yes, List Name or Form Number:* _____	☐	☐
	(d) Did you use any Company approved, electronically generated, individualized sales materials (such as illustrations or concept materials)? *(If Yes, you must provide a copy of these materials with the application.)*	☐	☐
4.	Have you advised the proposed policyowner or do you know of any advice that has been given to the policyowner to transfer ownership 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 are you otherwise aware that the policyowner may be contemplating such a transfer? *If Yes, please explain in Special Requests/Remarks below.*	☐	☐
5.	Has a mortality analysis or life expectancy analysis been performed on the Proposed Insured?	☐	☐
6.	Has a medical examination been ordered? *If Yes, Name of Examiner:* _____ *Date of Exam:* _____	☐	☐
7.	Is Premium Financing involved in this case? (If Yes, please submit a cover letter describing the parameters.)	☐	☐
	I have verified the identity of the Owner by picture I.D. (*Authorized Representative if Business or Trustee if Trust)* *Identification Type:* _____ *Driver's License Number:* _____ Please include Driver's License Number if Owner is an individual and is other than the Proposed Insured. NOTE: Does not apply to direct marketing situations	☐	☐

I certify that:

a) both the Proposed Insured(s) and the Owner(s) read, speak and understand either the English or Spanish language; and
b) each has explicitly told me that they understood each question and item contained in this application; and
c) the answers given in this application are complete and true to the best of my knowledge and belief; and
d) I know of nothing affecting the risk which is not set forth in my representative's report or this life insurance application; and
e) I carefully explained each question before recording each answer and before the application was signed.

Signature of Broker/Representative	*Date*	*PLICO Contract Number*	*Share %*	*Business Phone Number*
Print Name of Above Signature	*Email Address*		*Signed at (City and State)*	
Signature of Additional Broker/Representative	*Date*	*PLICO Contract Number*	*Share %*	*Business Phone Number*
Print Name of Above Additional Signature	*Email Address*		*Signed at (City and State)*	
BGA/Broker Dealer Name	*PLICO Contract Number*			
New Business Key Contact	*Email Address*		*Phone Number*	

Broker/Representative Special Requests/Remarks:

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Protective Life and Annuity Insurance Company
P.O. Box 830619
Birmingham, AL 35283-0619

CONTINUATION OF INFORMATION

Proposed Insured 1: _____ _____

First Name | Middle Name | Last Name | Policy Number

Proposed Insured 2: _____ _____

First Name | Middle Name | Last Name | Policy Number

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 attached to and made 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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Protective Life and Annuity Insurance Company
Home Office: 2801 Highway 280 South, Birmingham, AL 35223
P.O. Box 2606, Birmingham, AL 35202-2606
Administrative Office: P.O. Box 830735, Birmingham, AL 35283
Telephone: 1-800-265-1545

NOTICE AND CONSENT FOR BLOOD TESTING WHICH MAY INCLUDE AIDS VIRUS (HIV) ANTIBODY/ANTIGEN TESTING AND AUTHORIZATION OF RELEASE OF HIV TEST INFORMATION

EXAMINER: _____

ADDRESS: _____

To determine your insurability, the Insurer named above has requested that you provide a sample of your blood for testing and analysis. All tests will be performed by a licensed laboratory.

1. What tests may be performed?
   Tests which may be performed include: determinations of blood cholesterol and related lipids (fats) and screening for liver or kidney disorders, diabetes, immune disorders, and the presence of HIV antibodies/antigens.

2. What is the HIV Antibody Test?
   The HIV antibody test is a blood test. The test shows if you have antibodies to the virus that causes AIDS. A sample of your blood will be taken from your arm with a needle. If the first test shows that you have antibodies, a different test will then be done on the same blood sample to make sure the first test was right. The HIV antigen test directly identifies AIDS viral particles.

   A positive test result means that you have been exposed to the virus and are infected. It does not mean that you have AIDS or that you will become sick with AIDS in the future; *but it is an indication that you may develop AIDS and may wish to consider further independent testing.*

   A negative test result means that you are probably not infected with the virus. It takes the body time to produce HIV antibodies. If you have been exposed to HIV recently, you need to be retested in several months to make sure you are not infected. Your doctor or counselor will explain this to you.

3. What are the benefits of taking the test?
   If you test negative:
   - You can learn how to protect yourself from getting infected with the virus in the future. Ask your doctor or counselor how.

   If you test positive:
   - You can learn how to avoid giving the virus to others.
   - Knowing that you are infected is important for your health. Your doctor can care for you better.
   - If you are a woman or man who is thinking of having a child, you can learn about the risks of passing the virus to your baby.
   - If you are a woman who is already pregnant, your doctor can provide information on the full range of options and services available to you.

4. Voluntary Testing
   Taking an HIV antibody test is voluntary. You do not have to take the test.
   If you do not wish anyone to know your test results or even that you have been tested, you can go to an anonymous test site. This is a place where you can receive counseling and the HIV test without giving your name or address. You can find the nearest anonymous test site by calling the AIDS Hotline at 1-800-541-2437.

5. Confidentiality of Test Results

If you take the HIV antibody test, your test results are confidential. Under New York State Law, confidential HIV related information can only be given to people you allow to have it by signing this consent and release form, or to those persons included on the back of this form.

By signing this release form, you agree that the test results will be reported by the laboratory to the insurer. When necessary for business reasons in connection with insurance you have or have applied for with the insurer, the insurer may disclose test results to others involved solely in the underwriting process such as its affiliates, reinsurers, employees or contractors. If the insurer is a member of the MIB, Inc., and if the test results for HIV antibodies/antigens are other than normal, the insurer will report to the MIB, Inc., a generic code which signifies only a non-specific blood and/or urine test abnormality. If your HIV test is normal, no report will be made about it to the MIB, Inc. Other test results may be reported to the MIB, Inc., in a more specific manner. The organizations described in this paragraph may maintain the test results in a file or data bank. There will be no other disclosure of test results or even that the tests have been done except as may be required or permitted by law or as authorized by you.

If your HIV test results are normal, no routine notification will be sent to you. If the HIV test results are other than normal, the insurer will contact you. The insurer may also contact you if there are other abnormal test results which, in the insurer's opinion, are significant. The insurer will ask you for the name of a physician, other health care provider, or other designee to whom you may authorize disclosure and with whom you may wish to discuss the results. *If you elect to receive the HIV test results directly, you may call the State Health Department's toll-free number for further information about AIDS, the meaning of HIV test results and the availability and location of HIV counseling services. You should consult your physician about the meaning of and need for counseling, where appropriate, as to the HIV test results.*

6. Risks Involved with Disclosure and Sources of Help

If you test positive, you should be careful about telling others what your test showed. Some HIV positive people have been discriminated against by employers, landlords and others. If you experience discrimination because of release of HIV related information, you may contact the New York State Division of Human Rights at (212) 870-8624 or the New York City Commission of Human Rights at (212) 566-5493. These agencies are responsible for protecting your rights.

7. For More Information

If you have further questions about informed consent for HIV antibody testing, you may contact the New York State Department of Health at (518) 486-1595.

Name and address of facility/provider obtaining release:

Name: _____

Address: _____

Name of person whose HIV related information will be released: _____

Name and address of person signing this form (if other than above):

Name: _____

Address: _____

Relationship to person whose HIV information will be released: _____

Name and address of person who will be given HIV related information:

Name: _____

Address: _____

Reason for release of HIV related information: _____

Time during which release is authorized: From: _____ To: _____

My questions about this form have been answered. I know that I do not have to allow release of HIV related information, and that I can change my mind at any time.

_____ _____

Date Signature

My questions about the HIV test have been answered. I agree to take the HIV antibody test.

_____

Date

_____ _____

Signature of person who will be tested Signature of person authorized to consent for person to be tested

_____ _____

Name of person who will be tested *(Please print)* Name of person authorized to consent *(Please print)*

I have explained the means by which the HIV antibody test is done, the meaning of the results and the possible consequences of disclosure of the test results to the individual above, and have answered any questions she/he had about the test.

_____ _____

Name Title

_____

Facility/Provider Name

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Protective Life and Annuity Insurance Company
Home Office: 2801 Highway 280 South, Birmingham, AL 35223
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Administrative Office: P.O. Box 830735, Birmingham, AL 35283
Telephone: 1-800-265-1545

NOTICE AND CONSENT FOR BLOOD TESTING WHICH MAY INCLUDE AIDS VIRUS (HIV) ANTIBODY/ANTIGEN TESTING AND AUTHORIZATION OF RELEASE OF HIV TEST INFORMATION

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   - Knowing that you are infected is important for your health. Your doctor can care for you better.
   - If you are a woman or man who is thinking of having a child, you can learn about the risks of passing the virus to your baby.
   - If you are a woman who is already pregnant, your doctor can provide information on the full range of options and services available to you.

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5. Confidentiality of Test Results

If you take the HIV antibody test, your test results are confidential. Under New York State Law, confidential HIV related information can only be given to people you allow to have it by signing this consent and release form, or to those persons included on the back of this form.

By signing this release form, you agree that the test results will be reported by the laboratory to the insurer. When necessary for business reasons in connection with insurance you have or have applied for with the insurer, the insurer may disclose test results to others involved solely in the underwriting process such as its affiliates, reinsurers, employees or contractors. If the insurer is a member of the MIB, Inc., and if the test results for HIV antibodies/antigens are other than normal, the insurer will report to the MIB, Inc., a generic code which signifies only a non-specific blood and/or urine test abnormality. If your HIV test is normal, no report will be made about it to the MIB, Inc. Other test results may be reported to the MIB, Inc., in a more specific manner. The organizations described in this paragraph may maintain the test results in a file or data bank. There will be no other disclosure of test results or even that the tests have been done except as may be required or permitted by law or as authorized by you.

If your HIV test results are normal, no routine notification will be sent to you. If the HIV test results are other than normal, the insurer will contact you. The insurer may also contact you if there are other abnormal test results which, in the insurer's opinion, are significant. The insurer will ask you for the name of a physician, other health care provider, or other designee to whom you may authorize disclosure and with whom you may wish to discuss the results. *If you elect to receive the HIV test results directly, you may call the State Health Department's toll-free number for further information about AIDS, the meaning of HIV test results and the availability and location of HIV counseling services. You should consult your physician about the meaning of and need for counseling, where appropriate, as to the HIV test results.*

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If you test positive, you should be careful about telling others what your test showed. Some HIV positive people have been discriminated against by employers, landlords and others. If you experience discrimination because of release of HIV related information, you may contact the New York State Division of Human Rights at (212) 870-8624 or the New York City Commission of Human Rights at (212) 566-5493. These agencies are responsible for protecting your rights.

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Name: _____

Address: _____

Name of person whose HIV related information will be released: _____

Name and address of person signing this form (if other than above):

Name: _____

Address: _____

Relationship to person whose HIV information will be released: _____

Name and address of person who will be given HIV related information:

Name: _____

Address: _____

Reason for release of HIV related information: _____

Time during which release is authorized: From: _____ To: _____

My questions about this form have been answered. I know that I do not have to allow release of HIV related information, and that I can change my mind at any time.

_____ _____

Date Signature

My questions about the HIV test have been answered. I agree to take the HIV antibody test.

_____

Date

_____ _____

Signature of person who will be tested Signature of person authorized to consent for person to be tested

_____ _____

Name of person who will be tested *(Please print)* Name of person authorized to consent *(Please print)*

I have explained the means by which the HIV antibody test is done, the meaning of the results and the possible consequences of disclosure of the test results to the individual above, and have answered any questions she/he had about the test.

_____ _____

Name Title

_____

Facility/Provider Name

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Protective Life and Annuity Insurance Company
Home Office: 2801 Highway 280 South, Birmingham, AL 35223
P.O. Box 2606, Birmingham, AL 35202-2606
Administrative Office: P.O. Box 830735, Birmingham, AL 35283
Telephone: 1-800-265-1545

Who Can Receive HIV Related Information?

Under New York State Public Health Law, HIV related information is confidential and may only be given:

a. To you (or a person authorized by law who consented to the test for you);

b. To anyone whom you have specifically authorized to receive such information by signing a written release;

c. To a health care facility (such as a hospital, blood bank, or clinical laboratory) or a health care provider (such as a physician, nurse, or mental health counselor) providing care to you or your child, and anyone working for such a facility or provider who reasonably needs the information to supervise, monitor or administer a health service;

d. To a person who your doctor believes is at significant risk for HIV infection, if you do not notify that person after being counseled to do so;

e. To a committee or organization responsible for reviewing or monitoring a health facility;

f. To a federal, state, country, or local health officer when state or federal law requires disclosure;

g. To a government agency, when the agency needs the information to supervise, monitor or administer a health or social service;

h. To an authorized foster care or adoption agency;

i. To insurance companies and other third party payors such as Medicaid, if necessary for the payment of services to you;

j. To any person to whom a court orders disclosure under limited circumstances set forth by law. Except in an emergency situation, advance notice and an opportunity to oppose the release of such information would be given to you;

k. To the Division of Parole, the Division of Probation, the Commission of Correction, or a medical director of a local correctional facility, as permitted by HIV confidentiality regulations of such organization;

l. By a physician to the person who consents for your health care (parent, guardian, etc.) if disclosure is necessary to provide timely care for you, and you have been counseled regarding the need for disclosure. A physician may not disclose such information if it is against your best interest to do so.

You can ask your doctor if HIV related information about you has been released to anyone listed above.

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Protective

Protective Life and Annuity Insurance Company
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 or Income Provider Option, please complete the rider specific supplemental application(s) per Application Instructions.*

1. ADDITIONAL BENEFITS
   - ☐ Accidental Death Benefit Rider $ ___________ *(Range $10,000 - $250,000)*
   - ☐ * Child Rider
   - ☐ Death Benefit Plus Rider ______% (Optional Interest Rate)
   - ☐ Disability Benefit Rider *(Universal Life Only)* Monthly Benefit Amount $ ___________
   - ☐ * Income Provider Option Endorsement
   - ☐ Protected Insurability Rider $ ___________
   - ☐ Waiver of Premium Rider (*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 attached to and made 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

____
Signature of Proposed Insured if Aged 14 ½ or Older

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Protective Life and Annuity Insurance Company
P.O. Box 830619
Birmingham, AL 35283-0619

PRE-AUTHORIZED WITHDRAWAL AGREEMENT

FOR DRAFTING OF PREMIUM PAYMENTS

The person paying the premium on the life insurance policy listed below must sign this agreement.

I request and authorize Protective Life and Annuity Insurance Company to draw against the account listed below to pay premiums once a policy has been issued. I understand that no coverage exists until a policy is issued or I receive a Conditional Receipt.

Policy Number: _____ Name of Insured: _____

Name of Bank: _____

Street Address or P.O. Box: _____

City: _____ State: _____ Zip Code: _____

Type of Account: ☐ Checking ☐ Savings

Routing Number: ___ ___ ___ ___ ___ ___ ___ ___ ___

Account Number: _____

Premium Frequency: ☐ *Monthly (*Only available by bank draft) ☐ Quarterly

☐ Semi-Annually ☐ Annually

☐ **Draft the initial premium** - I understand that authorizing the drafting of the initial premium and providing the account information does not provide any life insurance coverage on myself or any applicant listed on the application for life insurance unless I have signed, dated and met the terms and conditions of the Protective Life and Annuity Conditional Receipt.

If the Company receives a Conditional Receipt with this form your premium will be drafted immediately and you will be provided with conditional coverage subject to limited terms and conditions.

Variable life insurance premiums will not be deducted unless a policy is issued.

I request future drafts be made on the _____ *(1st - 28th)* day of the month.

_____
Premium Payer - Depositor (Please Print)

_____ _____
Date Signature

PLEASE INCLUDE A VOIDED CHECK WITH APPLICATION. IF THIS IS TO DRAFT FROM A BROKERAGE ACCOUNT, A VOIDED CHECK IS NOT NECESSARY. DO NOT USE STAPLES.

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☐ Term
☐ UL

PROTECTIVE LIFE AND ANNUITY INSURANCE COMPANY
P.O. Box 830619, Birmingham, AL 35283

CONDITIONAL RECEIPT AGREEMENT

This agreement provides only a limited amount of insurance, for a limited period of time, and then only if all the terms and conditions of this agreement are met. No Agent of Protective Life and Annuity Insurance Company (the Company) can alter or waive any of the provisions of this Agreement. No life insurance is provided under the terms of this document in the event of the death of the proposed insured(s) by suicide. In the event of suicide the Company's sole liability will be the return of any money received.

Received: ☐ Check in the amount of $ _____, ☐ Pre-Authorized Funds Withdrawal, ☐ Other _____ as conditional payment of the first premium for an insurance policy on the life of Proposed Insured(s) _____.

An application for life insurance on each person proposed for insurance is being made today to the Company. This conditional payment is received under and is subject to the exact conditions set out below, all of which are a part of this Agreement.

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO PROTECTIVE LIFE AND ANNUITY INSURANCE COMPANY.

DO NOT MAKE CHECKS PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK. CASH, MONEY ORDERS AND CASHIER'S CHECKS WILL NOT BE ACCEPTED.

NOTE: Premium may not be collected (1) where the face amount applied for plus any other life insurance and accidental death benefits (but not in force) on Proposed Insured(s) with the Company and its affiliates exceeds $1,000,000; OR (2) on Proposed Insured(s) under 15 days of age or over age 80; OR (3) for cases in which the Proposed Insured(s) intends to leave the United States within the next 60 days. Any premium received under (1), (2) or (3) of this note will be refunded.

CONDITIONS UNDER WHICH INSURANCE MAY BECOME EFFECTIVE PRIOR TO POLICY DELIVERY

Unless each and every condition below has been fulfilled exactly, no insurance will become effective prior to policy delivery to the Owner:

(A) on the Effective Date the Proposed Insured(s) is (are) insurable exactly as applied for under the Company's published underwriting rules for the plan, amount and premium rate class applied for;
(B) the amount paid with the application and shown above is equal to the first full modal premium for the plan, amount and premium rate class applied for; and
(C) the Proposed Insured(s) has/have completed all examinations and/or tests requested by the Company. No more than two examinations will be requested.

EFFECTIVE DATE OF COVERAGE

Insurance issued based on the application will take effect on the latest of:

(A) the date of the application;
(B) the date requested in the application; or
(C) the date of the last of any medical examinations or tests required under the rules and practices of the Company. No more than two examinations will be requested.

AMOUNT OF COVERAGE - $1,000,000 MAXIMUM (per Proposed Insured)

The total amount of insurance on Proposed Insured(s) which may become effective prior to delivery of the policy to the Owner shall not exceed $1,000,000 with the Company and its affiliates. This amount includes other life insurance and accidental death benefits on such Proposed Insured(s) applied for (but not currently in force) with the Company and its affiliates.

TERMINATION AND REFUND OF PREMIUM

There shall be no insurance coverage under this Agreement and this Agreement shall be void if:

(A) premium payment is
  (1) by check, and it is not honored by the drawee bank upon presentation;
  (2) by Pre-Authorized Funds Withdrawal (PAW), and the deduction is not honored by the drawee bank;
  (3) by Payroll Deduction Authorization (PDA) and the Employer does not make payroll deductions as authorized by the Employee; or
(B) if the application to which this Agreement was attached is not approved as applied for by the Company within ninety days from its date, the Company's only liability in such event(s) will be to return any money received.

NOTICE TO APPLICANT: You should retain a copy of this Agreement. The Original will be retained by Protective Life and Annuity Insurance Company.

Date: _____ Agent Signature: _____

Date: _____ Owner Signature: _____

ALL MONIES WILL BE DRAFTED/DEPOSITED IMMEDIATELY UPON RECEIPT OF THIS FORM.

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☐ Term
☐ UL

PROTECTIVE LIFE AND ANNUITY INSURANCE COMPANY
P.O. Box 830619, Birmingham, AL 35283

CONDITIONAL RECEIPT AGREEMENT

This agreement provides only a limited amount of insurance, for a limited period of time, and then only if all the terms and conditions of this agreement are met. No Agent of Protective Life and Annuity Insurance Company (the Company) can alter or waive any of the provisions of this Agreement. No life insurance is provided under the terms of this document in the event of the death of th e proposed insured(s) by suicide. In the event of suicide the Company's sole liability will be the return of any money received.

Received: ☐ Check in the amount of $ _____, ☐ Pre-Authorized Funds Withdrawal, ☐ Other _____as conditional payment of the first premium for an insurance policy on the life of Proposed Insured(s) _____.

An application for life insurance on each person proposed for insurance is being made today to the Company. This conditional payment is received under and is subject to the exact conditions set out below, all of which are a part of this Agreement.

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO PROTECTIVE LIFE AND ANNUITY INSURANCE COMPANY.

DO NOT MAKE CHECKS PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK. CASH, MONEY ORDERS AND CASHIER'S CHECKS WILL NOT BE ACCEPTED.

NOTE: Premium may not be collected (1) where the face amount applied for plus any other life insurance and accidental death benefits (but not in force) on Proposed Insured(s) with the Company and its affiliates exceeds $1,000,000; OR (2) on Proposed Insured(s) under 15 days of age or over age 80; OR (3) for cases in which the Proposed Insured(s) intends to leave the United States within the next 60 days. Any premium received under (1), (2) or (3) of this note will be refunded.

CONDITIONS UNDER WHICH INSURANCE MAY BECOME EFFECTIVE PRIOR TO POLICY DELIVERY

Unless each and every condition below has been fulfilled exactly, no insurance will become effective prior to policy delivery to the Owner:

(A) on the Effective Date the Proposed Insured(s) is (are) insurable exactly as applied for under the Company's published underwriting rules for the plan, amount and premium rate class applied for;
(B) the amount paid with the application and shown above is equal to the first full modal premium for the plan, amount and premium rate class applied for; and
(C) the Proposed Insured(s) has/have completed all examinations and/or tests requested by the Company. No more than two examinations will be requested.

EFFECTIVE DATE OF COVERAGE

Insurance issued based on the application will take effect on the latest of:

(A) the date of the application;
(B) the date requested in the application; or
(C) the date of the last of any medical examinations or tests required under the rules and practices of the Company. No more than two examinations will be requested.

AMOUNT OF COVERAGE - $1,000,000 MAXIMUM (per Proposed Insured)

The total amount of insurance on Proposed Insured(s) which may become effective prior to delivery of the policy to the Owner shall not exceed $1,000,000 with the Company and its affiliates. This amount includes other life insurance and accidental death benefits on such Proposed Insured(s) applied for (but not currently in force) with the Company and its affiliates.

TERMINATION AND REFUND OF PREMIUM

There shall be no insurance coverage under this Agreement and this Agreement shall be void if:

(A) premium payment is
  (1) by check, and it is not honored by the drawee bank upon presentation;
  (2) by Pre-Authorized Funds Withdrawal (PAW), and the deduction is not honored by the drawee bank;
  (3) by Payroll Deduction Authorization (PDA) and the Employer does not make payroll deductions as authorized by the Employee; or
(B) if the application to which this Agreement was attached is not approved as applied for by the Company within ninety days from its date, the Company's only liability in such event(s) will be to return any money received.

NOTICE TO APPLICANT: You should retain a copy of this Agreement. The Original will be retained by Protective Life and Annuity Insurance Company.

Date: _____ Agent Signature: _____

Date: _____ Owner Signature: _____

ALL MONIES WILL BE DRAFTED/DEPOSITED IMMEDIATELY UPON RECEIPT OF THIS FORM.

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Protective Life and Annuity Insurance Company
Administrative Office: 2801 Highway 280 South, Birmingham, AL 35223
P.O. Box 2606, Birmingham, AL 35202-2606
P.O. Box 830735, Birmingham, AL 35283
Telephone: 1-800-265-1545

APPENDIX 11
DEPARTMENT OF FINANCIAL SERVICES OF THE STATE OF NEW YORK
DEFINITION OF REPLACEMENT

In order to determine whether you are replacing or otherwise changing the status of existing life insurance policies or annuity contracts, and in order to receive the valuable information necessary to make a careful comparison if you are contemplating replacement, the agent or broker is required to ask you the following questions and explain any items that you do not understand.

As part of your purchase of a new life insurance policy or a new annuity contract, has existing coverage been, or is it likely to be:

(1) Lapsed, surrendered, partially surrendered, forfeited, assigned to the insurer replacing the life insurance policy or annuity contract, or otherwise terminated? ☐ Yes ☐ No

(2) Changed or modified into paid-up insurance; continued as extended term insurance or under another form of nonforfeiture benefit; or otherwise reduced in value by the use of nonforfeiture benefits, dividend accumulations, dividend cash values or other cash values? ☐ Yes ☐ No

(3) Changed or modified so as to effect a reduction either in the amount of the existing life insurance or annuity benefit or in the period of time the existing life insurance or annuity benefit will continue in force? ☐ Yes ☐ No

(4) Reissued with a reduction in amount such that any cash values are released, including all transactions wherein an amount of dividend accumulations or paid-up additions is to be released on one or more of the existing policies? ☐ Yes ☐ No

(5) Assigned as collateral for a loan or made subject to borrowing or withdrawal of any portion of the loan value, including all transactions wherein any amount of dividend accumulations or paid-up additions is to be borrowed or withdrawn on one or more existing policies? ☐ Yes ☐ No

(6) Continued with a stoppage of premium payments or reduction in the amount of premium paid? ☐ Yes ☐ No

If you have answered Yes to any of the above questions, a replacement as defined by New York Insurance Regulation No. 60 has occurred or is likely to occur and your agent or broker is required to provide you with a completed Disclosure Statement and the IMPORTANT notice regarding replacement or change of life insurance policies or annuity contracts.

Date: _____ Signature of Applicant: _____

Date: _____ Signature of Applicant: _____

To the best of my knowledge, a replacement is involved in this transaction. ☐ Yes ☐ No

Date: _____ Signature of Agent/Broker: _____

I hereby certify that my electronic approval serves as my signature for legal and regulatory purposes for this application.

Electronic Signature of _____ was obtained
Broker or Authorized Representative

_____ at _____. Broker Number: _____
Date *Time*

_____ _____
Broker Dealer or Financial Institution (Name and Number) *Phone Number*

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Protective Life and Annuity Insurance Company
Administrative Office: 2801 Highway 280 South, Birmingham, AL 35223
P.O. Box 2606, Birmingham, AL 35202-2606
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APPENDIX 11
DEPARTMENT OF FINANCIAL SERVICES OF THE STATE OF NEW YORK
DEFINITION OF REPLACEMENT

In order to determine whether you are replacing or otherwise changing the status of existing life insurance policies or annuity contracts, and in order to receive the valuable information necessary to make a careful comparison if you are contemplating replacement, the agent or broker is required to ask you the following questions and explain any items that you do not understand.

As part of your purchase of a new life insurance policy or a new annuity contract, has existing coverage been, or is it likely to be:

(1) Lapsed, surrendered, partially surrendered, forfeited, assigned to the insurer replacing the life insurance policy or annuity contract, or otherwise terminated? ☐ Yes ☐ No

(2) Changed or modified into paid-up insurance; continued as extended term insurance or under another form of nonforfeiture benefit; or otherwise reduced in value by the use of nonforfeiture benefits, dividend accumulations, dividend cash values or other cash values? ☐ Yes ☐ No

(3) Changed or modified so as to effect a reduction either in the amount of the existing life insurance or annuity benefit or in the period of time the existing life insurance or annuity benefit will continue in force? ☐ Yes ☐ No

(4) Reissued with a reduction in amount such that any cash values are released, including all transactions wherein an amount of dividend accumulations or paid-up additions is to be released on one or more of the existing policies? ☐ Yes ☐ No

(5) Assigned as collateral for a loan or made subject to borrowing or withdrawal of any portion of the loan value, including all transactions wherein any amount of dividend accumulations or paid-up additions is to be borrowed or withdrawn on one or more existing policies? ☐ Yes ☐ No

(6) Continued with a stoppage of premium payments or reduction in the amount of premium paid? ☐ Yes ☐ No

If you have answered Yes to any of the above questions, a replacement as defined by New York Insurance Regulation No. 60 has occurred or is likely to occur and your agent or broker is required to provide you with a completed Disclosure Statement and the IMPORTANT notice regarding replacement or change of life insurance policies or annuity contracts.

Date: _____ Signature of Applicant: _____

Date: _____ Signature of Applicant: _____

To the best of my knowledge, a replacement is involved in this transaction. ☐ Yes ☐ No

Date: _____ Signature of Agent/Broker: _____

I hereby certify that my electronic approval serves as my signature for legal and regulatory purposes for this application.

Electronic Signature of _____ was obtained
Broker or Authorized Representative

_____ at _____. Broker Number: _____
Date *Time*

_____ _____
Broker Dealer or Financial Institution (Name and Number) *Phone Number*

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Protective Life and Annuity Insurance Company
Administrative Office: 2801 Highway 280 South, Birmingham, AL 35223
P.O. Box 2606, Birmingham, AL 35202-2606
P.O. Box 830735, Birmingham, AL 35283
Telephone: 1-800-265-1545

DISCLOSURE STATEMENT

DEPARTMENT OF FINANCIAL SERVICES OF THE STATE OF NEW YORK
LICONY DISCLOSURE STATEMENT
LICONY Appendix 10A[1]

IMPORTANT – It may not be in your best interest to surrender, lapse, change or borrow from existing life insurance policies or annuity contracts in connection with the purchase of a new life insurance policy or annuity contract whether issued by the same or a different insurance company.

This Disclosure Statement is required to be provided to you no later than upon delivery of the new policy or contract. Please review this document carefully as it contains important information comparing your existing policy or contract to the new policy or contract.

IMPORTANT 60 DAY REFUND PERIOD: Within 60 days from the date of delivery of your new life insurance policy or annuity contract, you have the right to return it and receive a refund, if you are not satisfied with the new policy or contract. For further details on the terms of the refund, see the IMPORTANT Notice form provided to you when you applied for your new policy or contract.

Please contact the Company, Agent or Broker if you have any questions.

FOR YOUR PROTECTION, the Department of Financial Services of the State of New York requires that you be given the *IMPORTANT Notice Regarding Replacement or Change of Life Insurance Policies or Annuity Contracts* and the *Definition of Replacement* forms at the time you apply for your coverage. This *Disclosure Statement*, which contains information on all proposed and existing coverage affected, may be provided to you at the time you apply for your coverage or at a later date, but no later than at the time of policy or contract delivery.

Name of Applicant(s): _____ Telephone Number: _____

Address: _____

Name of Agent or Broker: _____ Telephone Number: _____

Company: _____ Address: _____

The information on existing coverage on this form was obtained from:

☐ The following replaced company(ies): _____

☐ Approximations, if the following replaced company(ies) failed to provide information in the prescribed time: _____

_____

[1] For use when:

- an existing life insurance policy is being used to fund a life insurance policy;
- an existing annuity contract is being used to fund a life insurance policy; or
- an existing life insurance policy is being used to fund an annuity contract.

DISCLOSURE STATEMENT CONTINUED:

1. DESCRIPTION OF TRANSACTION:

Proposed Policy/Contract		Existing Policies/Contracts Affected (1)	(2)	(3)
		As of _____	As of _____	As of _____
_____	Company	_____	_____	_____
_____	Customer Service Phone #	_____	_____	_____
	Contract Number	#_____	#_____	#_____
	Issue Date	_____	_____	_____
_____	Type of Insurance	_____	_____	_____
$_____	Base Policy Face Amount	$_____	$_____	$_____
_____	Rider _____	_____	_____	_____
_____	Rider _____	_____	_____	_____
_____	Rider _____	_____	_____	_____
_____	Rider _____	_____	_____	_____
_____	Rider _____	_____	_____	_____
$_____	Total Annualized Premium	$_____	$_____	$_____
N/A	Current Surrender Charge	$_____	$_____	$_____
_____%	Guaranteed Interest Rate	_____%	_____%	_____%
_____%	Current Loan Interest Rate	_____%	_____%	_____%
_____	Current Loan Balance	_____	_____	_____
_____	Contestable Expiry Date	_____	_____	_____
_____	Suicide Expiry Date	_____	_____	_____

Existing coverage to be changed by:	(1)	(2)	(3)
Lapse or Surrender	[ ]	[ ]	[ ]
Amendment or Reissue	[ ]	[ ]	[ ]
Loan or Withdrawal	[ ]	[ ]	[ ]
Death Benefit Reduction To	$_____	$_____	$_____
Reduced Paid-Up For	$_____	$_____	$_____
Extended Term To	_____	_____	_____
Other	_____	_____	_____
Cash released by change	$_____	$_____	$_____

Use of cash released: _____

DISCLOSURE STATEMENT CONTINUED:

2. SUMMARY RESULT COMPARISON:

Proposed With Existing Coverage Changed			Existing Coverage Unchanged	
Guaranteed	Non-Guaranteed	Annual Premium	Guaranteed	Non-Guaranteed
$_____	$_____	Current Year	$_____	$_____
$_____	$_____	5 Years Hence	$_____	$_____
$_____	$_____	10 Years Hence	$_____	$_____
Guaranteed	Non-Guaranteed	Surrender Value	Guaranteed	Non-Guaranteed
$_____	$_____	End of 1st Year	$_____	$_____
$_____	$_____	5 Years Hence	$_____	$_____
$_____	$_____	10 Years Hence	$_____	$_____
Guaranteed	Non-Guaranteed	Death Benefit	Guaranteed	Non-Guaranteed
$_____	$_____	End of 1st Year	$_____	$_____
$_____	$_____	5 Years Hence	$_____	$_____
$_____	$_____	10 Years Hence	$_____	$_____
Guaranteed	Non-Guaranteed	Dividends	Guaranteed	Non-Guaranteed
$_____	$_____	End of 1st Year	$_____	$_____
$_____	$_____	5 Years Hence	$_____	$_____
$_____	$_____	10 Years Hence	$_____	$_____

DISCLOSURE STATEMENT CONTINUED:

AGENT/BROKER'S STATEMENT:

1. The primary reason(s) for recommending the new life insurance policy or annuity contract is (are):

_____

_____

2. The existing life insurance policy or annuity contract cannot meet the applicant's objectives because:

_____

_____

3. The advantages of continuing the existing life insurance policy or annuity contract without changes are:

_____

_____

REMARKS:

☐ The attached proposal, including sales material, was used in this sale.

☐ No proposal or sales material was used in this sale.

If sales material and/or a proposal was used in this transaction, such material and/or proposal, or a list of such information used in the sale of the proposed life insurance policy or annuity contract, must accompany the submission of this form to the replacing insurer. Copies of the sales materials, and any proposals, must also be given to the applicant.

If more than three existing life insurance policies or annuity contracts are to be affected by this transaction or if more than one new life insurance policy or annuity contract is proposed, Section 1 of this Disclosure Statement must be completed for such additional life insurance policies and annuity contracts.

I have personally completed this form and certify that it is correct to the best of my knowledge and ability.

Date: _____ Signature of Agent/Broker_____

I hereby acknowledge that I received and read the above Disclosure Statement.

Date: _____ Signature of Applicant: _____

Date: _____ Signature of Applicant: _____

Protective Life and Annuity Insurance Company
Administrative Office: 2801 Highway 280 South, Birmingham, AL 35223
P.O. Box 2606, Birmingham, AL 35202-2606
P.O. Box 830735, Birmingham, AL 35283
Telephone: 1-800-265-1545

DISCLOSURE STATEMENT

DEPARTMENT OF FINANCIAL SERVICES OF THE STATE OF NEW YORK
LICONY DISCLOSURE STATEMENT
LICONY Appendix 10A[1]

IMPORTANT – It may not be in your best interest to surrender, lapse, change or borrow from existing life insurance policies or annuity contracts in connection with the purchase of a new life insurance policy or annuity contract whether issued by the same or a different insurance company.

This Disclosure Statement is required to be provided to you no later than upon delivery of the new policy or contract. Please review this document carefully as it contains important information comparing your existing policy or contract to the new policy or contract.

IMPORTANT 60 DAY REFUND PERIOD: Within 60 days from the date of delivery of your new life insurance policy or annuity contract, you have the right to return it and receive a refund, if you are not satisfied with the new policy or contract. For further details on the terms of the refund, see the IMPORTANT Notice form provided to you when you applied for your new policy or contract.

Please contact the Company, Agent or Broker if you have any questions.

FOR YOUR PROTECTION, the Department of Financial Services of the State of New York requires that you be given the *IMPORTANT Notice Regarding Replacement or Change of Life Insurance Policies or Annuity Contracts* and the *Definition of Replacement* forms at the time you apply for your coverage. This *Disclosure Statement*, which contains information on all proposed and existing coverage affected, may be provided to you at the time you apply for your coverage or at a later date, but no later than at the time of policy or contract delivery.

Name of Applicant(s): _____ Telephone Number: _____

Address: _____

Name of Agent or Broker: _____ Telephone Number: _____

Company: _____ Address: _____

The information on existing coverage on this form was obtained from:

☐ The following replaced company(ies): _____

☐ Approximations, if the following replaced company(ies) failed to provide information in the prescribed time: _____

_____

[1] For use when:

- an existing life insurance policy is being used to fund a life insurance policy;
- an existing annuity contract is being used to fund a life insurance policy; or
- an existing life insurance policy is being used to fund an annuity contract.

DISCLOSURE STATEMENT CONTINUED:

1. DESCRIPTION OF TRANSACTION:

Proposed Policy/Contract		Existing Policies/Contracts Affected (1)	(2)	(3)
		As of _____	As of _____	As of _____
_____	Company	_____	_____	_____
_____	Customer Service Phone #	_____	_____	_____
	Contract Number	#_____	#_____	#_____
	Issue Date	_____	_____	_____
_____	Type of Insurance	_____	_____	_____
$_____	Base Policy Face Amount	$_____	$_____	$_____
_____	Rider _____	_____	_____	_____
_____	Rider _____	_____	_____	_____
_____	Rider _____	_____	_____	_____
_____	Rider _____	_____	_____	_____
_____	Rider _____	_____	_____	_____
$_____	Total Annualized Premium	$_____	$_____	$_____
N/A	Current Surrender Charge	$_____	$_____	$_____
_____%	Guaranteed Interest Rate	_____%	_____%	_____%
_____%	Current Loan Interest Rate	_____%	_____%	_____%
_____	Current Loan Balance	_____	_____	_____
_____	Contestable Expiry Date	_____	_____	_____
_____	Suicide Expiry Date	_____	_____	_____

Existing coverage to be changed by:	(1)	(2)	(3)
Lapse or Surrender	[ ]	[ ]	[ ]
Amendment or Reissue	[ ]	[ ]	[ ]
Loan or Withdrawal	[ ]	[ ]	[ ]
Death Benefit Reduction To	$_____	$_____	$_____
Reduced Paid-Up For	$_____	$_____	$_____
Extended Term To	_____	_____	_____
Other	_____	_____	_____
Cash released by change	$_____	$_____	$_____

Use of cash released: _____

DISCLOSURE STATEMENT CONTINUED:

2. SUMMARY RESULT COMPARISON:

Proposed With Existing Coverage Changed			Existing Coverage Unchanged	
Guaranteed	Non-Guaranteed	Annual Premium	Guaranteed	Non-Guaranteed
$_____	$_____	Current Year	$_____	$_____
$_____	$_____	5 Years Hence	$_____	$_____
$_____	$_____	10 Years Hence	$_____	$_____
Guaranteed	Non-Guaranteed	Surrender Value	Guaranteed	Non-Guaranteed
$_____	$_____	End of 1st Year	$_____	$_____
$_____	$_____	5 Years Hence	$_____	$_____
$_____	$_____	10 Years Hence	$_____	$_____
Guaranteed	Non-Guaranteed	Death Benefit	Guaranteed	Non-Guaranteed
$_____	$_____	End of 1st Year	$_____	$_____
$_____	$_____	5 Years Hence	$_____	$_____
$_____	$_____	10 Years Hence	$_____	$_____
Guaranteed	Non-Guaranteed	Dividends	Guaranteed	Non-Guaranteed
$_____	$_____	End of 1st Year	$_____	$_____
$_____	$_____	5 Years Hence	$_____	$_____
$_____	$_____	10 Years Hence	$_____	$_____

DISCLOSURE STATEMENT CONTINUED:

AGENT/BROKER'S STATEMENT:

1. The primary reason(s) for recommending the new life insurance policy or annuity contract is (are):

_____

_____

2. The existing life insurance policy or annuity contract cannot meet the applicant's objectives because:

_____

_____

3. The advantages of continuing the existing life insurance policy or annuity contract without changes are:

_____

_____

REMARKS:

☐ The attached proposal, including sales material, was used in this sale.

☐ No proposal or sales material was used in this sale.

If sales material and/or a proposal was used in this transaction, such material and/or proposal, or a list of such information used in the sale of the proposed life insurance policy or annuity contract, must accompany the submission of this form to the replacing insurer. Copies of the sales materials, and any proposals, must also be given to the applicant.

If more than three existing life insurance policies or annuity contracts are to be affected by this transaction or if more than one new life insurance policy or annuity contract is proposed, Section 1 of this Disclosure Statement must be completed for such additional life insurance policies and annuity contracts.

I have personally completed this form and certify that it is correct to the best of my knowledge and ability.

Date: _____ Signature of Agent/Broker_____

I hereby acknowledge that I received and read the above Disclosure Statement.

Date: _____ Signature of Applicant: _____

Date: _____ Signature of Applicant: _____

Protective Life and Annuity Insurance Company
Home Office: 2801 Highway 280 South, Birmingham, AL 35223
P.O. Box 2606, Birmingham, AL 35202-2606
Administrative Office: P.O. Box 830735, Birmingham, AL 35283
Telephone: 1-800-265-1545

NOTICE TO INSURER OF PROPOSED REPLACEMENT

DATE: _____

TO: Insurance Company to be replaced: _____

Address: _____

Fax #: _____

FROM: Name of Agent: _____ Telephone: _____

Address: _____

Fax #: _____

Policyowner: _____

Existing Policy Number(s): _____

Please be advised that the policyowner named is considering replacing the policy(ies) listed above. The policyowner authorizes the insurer proposed to be replaced to release the information needed for completing the alternate New York State Disclosure statement attached. In accordance with New York State Insurance Department Regulation No. 60, it is required that this information be furnished within twenty (20) days to:

1. The agent named above
2. PROTECTIVE LIFE AND ANNUITY INSURANCE COMPANY
3. The agent of record of the existing policy and/or contract

This notice has been: ☐ Mailed ☐ Faxed

AUTHORIZATION TO DISCLOSE POLICY INFORMATION

In accordance with New York State Insurance Department Regulation No. 60, please furnish the information needed for completing the enclosed alternate New York State Disclosure Statement.

Please forward this information the the Agent named above and to:

PROTECTIVE LIFE AND ANNUITY INSURANCE COMPANY
P.O. Box 830735
Birmingham, Alabama 35283-0735
1-800-265-1545

This authorization is valid until revoked by the undersigned in writing.

Policyowner's Name (Printed) Policyowner's Signature

Address (Street, City, State, Zip Code)

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Protective Life and Annuity Insurance Company
Home Office: 2801 Highway 280 South, Birmingham, AL 35223
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Administrative Office: P.O. Box 830735, Birmingham, AL 35283
Telephone: 1-800-265-1545

NOTICE TO INSURER OF PROPOSED REPLACEMENT

DATE: _____

TO: Insurance Company to be replaced: _____

Address: _____

Fax #: _____

FROM: Name of Agent: _____ Telephone: _____

Address: _____

Fax #: _____

Policyowner: _____

Existing Policy Number(s): _____

Please be advised that the policyowner named is considering replacing the policy(ies) listed above. The policyowner authorizes the insurer proposed to be replaced to release the information needed for completing the alternate New York State Disclosure statement attached. In accordance with New York State Insurance Department Regulation No. 60, it is required that this information be furnished within twenty (20) days to:

1. The agent named above
2. PROTECTIVE LIFE AND ANNUITY INSURANCE COMPANY
3. The agent of record of the existing policy and/or contract

This notice has been: ☐ Mailed ☐ Faxed

AUTHORIZATION TO DISCLOSE POLICY INFORMATION

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Please forward this information the the Agent named above and to:

PROTECTIVE LIFE AND ANNUITY INSURANCE COMPANY
P.O. Box 830735
Birmingham, Alabama 35283-0735
1-800-265-1545

This authorization is valid until revoked by the undersigned in writing.

Policyowner's Name (Printed) Policyowner's Signature

Address (Street, City, State, Zip Code)

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Protective Life and Annuity Insurance Company
Administrative Office: 2801 Highway 280 South, Birmingham, AL 35223
P.O. Box 2606, Birmingham, AL 35202-2606
P.O. Box 830735, Birmingham, AL 35283
Telephone: 1-800-265-1545

IMPORTANT NOTICE REGARDING REPLACEMENT OR CHANGE OF LIFE INSURANCE POLICIES OR ANNUITY CONTRACTS

APPENDIX 10C
DEPARTMENT OF FINANCIAL SERVICES OF THE STATE OF NEW YORK
IMPORTANT NOTICE REGARDING REPLACEMENT OR CHANGE OF LIFE INSURANCE POLICIES OR ANNUITY CONTRACTS

THIS IMPORTANT NOTICE IS FOR YOUR BENEFIT AND REQUIRED BY REGULATION NO. 60

You are contemplating the purchase of a life insurance policy or annuity contract in connection with the surrender, lapse or change of existing life insurance policies or annuity contracts. The agent or broker is required to give you this notice together with a signed Disclosure Statement containing the summary result comparison for the new life insurance policy or annuity contract and any life insurance policies or annuity contracts to be changed that sets forth the facts of the transaction and its advantages and disadvantages to you. Your decision could be a good one – or a mistake – so make sure you understand the facts. You should:

1. Carefully study the Disclosure Statement, which includes a summary result comparison, until you are sure you understand fully the effect of the transaction.

2. Ask the Company, Agent or Broker from whom you bought your existing life insurance policies or annuity contracts to review with you the transaction and the Disclosure Statement. You may be able to effect the changes you desire more advantageously with them. Their customer service telephone number is contained in the Disclosure Statement.

3. Consult your tax advisor. There may be unfavorable tax implications associated with the contemplated changes to your existing life insurance policies or annuity contracts.

As a general rule, it is often not advantageous to drop or change existing coverage in favor of new coverage, whether issued by the same or a different insurance company. Some of the reasons it may be disadvantageous are:

1. The amount of the annual premium under an existing life insurance policy may be lower than that called for by a new life insurance policy having the same or similar benefits. Any replacement of the same type of policy will normally be at a higher premium rate based upon the insured's then attained age.

2. Since the initial costs of a life insurance policy are charged against the cash value increases in the earlier life insurance policy years, the replacement of an old life insurance policy by a new one results in the policyholder sustaining the burden of these costs twice. Annuity contracts usually contain provisions for surrender charges, therefore a replacement involving annuity contracts may result in the imposition of surrender charges.

3. The incontestable and suicide clauses begin anew in a new life insurance policy. This could result in a claim being denied under the new life insurance policy that would have been paid under the life insurance policy that was replaced.

4. An existing life insurance policy or annuity contract often has more favorable provisions than a new life insurance policy or annuity contract in areas such as loan interest rate, settlement options, disability benefits and tax treatment.

5. There may have been changes in your health since the purchase of the existing coverage.

6. The insurance company with which you have existing coverage can often make a desired change on terms that would be more favorable than if you replaced existing coverage with new coverage.

You have the right, within 60 days from the date of delivery of a new life insurance policy or annuity contract, to return it to the insurer and receive an unconditional full refund of all premiums or considerations paid on it, or in the case of a variable or market value adjustment policy or contract, a payment of the cash surrender benefits provided under the policy or contract, plus the amount of all fees and other charges deducted from gross considerations or imposed under the life insurance policy or annuity contract, and may have the right to reinstate or restore any life insurance policies and annuity contracts that were surrendered, lapsed or changed in the transaction to their former status to the extent possible and in accordance with the insurer's published reinstatement rules to the extent such rules are not inconsistent with the provisions of this part.

IMPORTANT: This right should not be viewed as reinstating or restoring your life insurance policy or annuity contract to the same condition as if it had never been replaced. There may be consequences in reinstating or restoring your life insurance policy or annuity contract, including but not limited to:

- The right to reinstate or restore your life insurance policy or annuity contract applies only to companies subject to New York Insurance Laws;
- Your life insurance policy or annuity contract is subject to your specific company's reinstatement rules, which may vary from company to company. These rules may require payment of both premium and interest; however, you will not be subject to evidence of insurability, or a new contestable or suicide period;
- You may not receive the interest or investment performance during the period the life insurance policy or annuity contract was replaced; and
- There may be unfavorable federal income tax consequences as a result of the reinstatement of your life insurance policy or annuity contract.

IMPORTANT: In the case of a variable or market value adjustment policy or contract, the value of the policy or contract may increase or decrease during the 60 day period depending on the performance of the underlying investments, which may effect the value of the refund you receive.

I hereby acknowledge that I read the above "IMPORTANT NOTICE" and have received a copy of same.

Date: _____ Signature of Applicant: _____

Date: _____ Signature of Applicant: _____

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1. Carefully study the Disclosure Statement, which includes a summary result comparison, until you are sure you understand fully the effect of the transaction.

2. Ask the Company, Agent or Broker from whom you bought your existing life insurance policies or annuity contracts to review with you the transaction and the Disclosure Statement. You may be able to effect the changes you desire more advantageously with them. Their customer service telephone number is contained in the Disclosure Statement.

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2. Since the initial costs of a life insurance policy are charged against the cash value increases in the earlier life insurance policy years, the replacement of an old life insurance policy by a new one results in the policyholder sustaining the burden of these costs twice. Annuity contracts usually contain provisions for surrender charges, therefore a replacement involving annuity contracts may result in the imposition of surrender charges.

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IMPORTANT: This right should not be viewed as reinstating or restoring your life insurance policy or annuity contract to the same condition as if it had never been replaced. There may be consequences in reinstating or restoring your life insurance policy or annuity contract, including but not limited to:

- The right to reinstate or restore your life insurance policy or annuity contract applies only to companies subject to New York Insurance Laws;
- Your life insurance policy or annuity contract is subject to your specific company's reinstatement rules, which may vary from company to company. These rules may require payment of both premium and interest; however, you will not be subject to evidence of insurability, or a new contestable or suicide period;
- You may not receive the interest or investment performance during the period the life insurance policy or annuity contract was replaced; and
- There may be unfavorable federal income tax consequences as a result of the reinstatement of your life insurance policy or annuity contract.

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I hereby acknowledge that I read the above "IMPORTANT NOTICE" and have received a copy of same.

Date: _____ Signature of Applicant: _____

Date: _____ Signature of Applicant: _____

Protective Life and Annuity Insurance Company
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P.O. Box 830735, Birmingham, AL 35283-0735
Telephone: 1-800-265-1545

ASSIGNMENT/TRANSFER OF OWNERSHIP SECTION 1035 EXCHANGE

INSURED: _____

OWNER: _____

INSURER: _____

(Provide Name of Existing Insurance Company with Street Address, City, State and Zip Code) _____

_____

_____

POLICY NUMBER(S): _____

ESTIMATED VALUE: $_____

PHONE NUMBER(S): _____

For value received, I hereby assign and transfer to Protective Life and Annuity Insurance Company ("Protective Life and Annuity") all right, title, and interest to the above listed policy(ies) in an exchange intended to qualify under Section 1035 of the Internal Revenue Code. However, this assignment and all other terms and agreements set forth below are conditioned upon Protective Life and Annuity's underwriting and approving a new life insurance policy on the life of the Insured(s) named above. This conditional assignment will not become effective unless and until Protective Life and Annuity approves a new life insurance policy.

I understand that if Protective Life and Annuity approves a new life insurance policy on the life of the Insured(s) named above, then Protective Life and Annuity will surrender the assigned policy(ies) and it/they will no longer be in force or effect as of the date of surrender. I further understand that, if Protective Life and Annuity approves the new life insurance policy, Protective Life and Annuity will collect whatever cash surrender values are available from the existing insurance company on the assigned policy(ies) and apply such amount received as premium on the new life insurance policy. I agree that Protective Life and Annuity assumes no responsibility if the full scheduled cash surrender values of the assigned policy(ies) are not received.

I certify that the above listed policy(ies) is/are currently in force and not subject to any prior assignments, any legal or equitable claims, or liens. I further certify that there is no proceeding in bankruptcy pending against me.

I hereby designate Protective Life and Annuity as beneficiary of the above listed policy(ies) to the extent of the cash surrender value thereof at the date of death of the Insured(s) named above. All other beneficiary designations under the above listed policy(ies) will remain in effect. I further understand that the policy(ies) to be issued by Protective Life and Annuity will have the same designated Insured(s) and Owner(s) as the above listed policy(ies).

I certify that if the above listed policy(ies) is/are not attached to this conditional assignment that it/they has/have been lost or destroyed. I hereby waive all rights and benefits under such policy(ies) and agree to return it/them to you if it/they comes/come into my possession.

I understand and agree that I will be responsible for keeping the above listed policy(ies) in force by paying any premiums as they become due until such time as Protective Life and Annuity notifies me in writing that I have been issued a new life insurance policy.

I understand that under Section 1035, reporting may be required for federal income tax purposes. The replaced company is required to report all exchanges of insurance contracts on Form 1099-R, including tax-free exchanges under Section 1035 in situations in which a policyholder has an outstanding policy loan at the time of exchange. If there is an outstanding policy loan at the time of the exchange, the transaction may not be characterized as tax-free. In fact, any gain will be taxed to the extent of the outstanding policy loan. Accordingly, I understand that it is advisable when filing my individual federal income tax return that I enclose a copy of the reporting form (Form 1099-R) with an explanation that the policy was exchanged pursuant to Section 1035 of the Internal Revenue Code.

Check One: ☐ I have enclosed the policy(ies). ☐ I certify that the policy(ies) has/have been lost or destroyed. After due search and inquiry, to the best of my knowledge, it/they is/are not in the possession or control of any other person.

Insured(s) Signatures(s)	Witness	Date
Owner Signature	Witness	Date
Owner Signature	Witness	Date
Collateral Assignee/Irrevocable Beneficiary Signature, if any	Witness	Date

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Protective Life and Annuity Insurance Company
Admin. Office: 2801 Highway 280 South, Birmingham, AL 35223
P.O. Box 2606, Birmingham, AL 35202-2606
P.O. Box 830735, Birmingham, AL 35283-0735
Telephone: 1-800-265-1545

ASSIGNMENT/TRANSFER OF OWNERSHIP SECTION 1035 EXCHANGE

INSURED: _____

OWNER: _____

INSURER: _____

(Provide Name of Existing Insurance Company with Street Address, City, State and Zip Code) _____

_____

_____

POLICY NUMBER(S): _____

ESTIMATED VALUE: $_____

PHONE NUMBER(S): _____

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Insured(s) Signatures(s)	Witness	Date
Owner Signature	Witness	Date
Owner Signature	Witness	Date
Collateral Assignee/Irrevocable Beneficiary Signature, if any	Witness	Date

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Protective Life and Annuity Insurance Company
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: *(Primary Residence)*	$
Mortgage: *(2nd Home)*	$
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: *(Describe)*	$
Pending Suits, Tax Liens or Other Liabilities: *(Describe)*	$

TOTAL LIABILITIES: $ _____

NET WORTH: $ _____

(assets minus liabilities)

ANNUAL INCOME	LAST YEAR	PRIOR YEAR
Annual Salary: *(Salary paid to you as an employee or business owner)*	$	$
Social Security Income:	$	$
Bonuses:	$	$
Interest:	$	$
Income Derived from Investments, Dividends, Bonds, etc:	$	$
Retirement Income: *(Pension, 401K, Annuities, etc)*	$	$
Other Income: *(Give details)*	$	$
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 attached to and made part of the application and shall be considered the basis of any insurance issued.

Signature of Proposed Insured | Date | Signature of Agent

Protective Life and Annuity Insurance Company
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*	☐ *Gain* ☐ *Loss* *Pounds in past year?*
Reason for Weight Gain or Loss		
Currently pregnant ☐ *Yes* ☐ *No* *If "Yes," anticipated delivery date*		

Proposed Insured 2		
Name (First, Middle, Last)		
Height	*Weight*	☐ *Gain* ☐ *Loss* *Pounds in past year?*
Reason for Weight Gain or Loss		
Currently pregnant ☐ *Yes* ☐ *No* *If "Yes," anticipated delivery date*		

Please use and attach 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 Yes No	Proposed Insured 2 Yes No
(a)	Any disorder or disease of the brain or nervous system (such as paralysis, epilepsy, stroke, convulsions, chronic headache).....	☐ ☐	☐ ☐
(b)	Any disorder or disease of the heart, blood vessels, or circulatory system (such as high blood pressure, heart attack, heart murmur, chest pain).....	☐ ☐	☐ ☐
(c)	Any disorder or disease of the respiratory system (such as Asthma, bronchitis, emphysema, tuberculosis).....	☐ ☐	☐ ☐
(d)	Any disorder or disease of the stomach, liver, intestines, rectum, pancreas, or abdominal organs.....	☐ ☐	☐ ☐
(e)	Any disorder or disease of the genitourinary organs (such as kidneys, urinary tract, blood or sugar in the urine, chronic inflammation).....	☐ ☐	☐ ☐
(f)	Any disorder or disease of the skeletal system (such as arthritis, osteoporosis, joints, bones, spine, muscles).....	☐ ☐	☐ ☐
(g)	Any disorder or disease of eyes, ears, nose or throat	☐ ☐	☐ ☐
(h)	Any disorder or disease (excluding HIV) of the blood, skin, thyroid, lymph or other glands (such as anemia, diabetes).....	☐ ☐	☐ ☐
(i)	Any psychiatric or mental health disorders or diseases (such as attempted suicide, Bipolar, Obsessive-compulsive).....	☐ ☐	☐ ☐
(j)	Any gynecological disorders or diseases (such as irregular Pap Smear, Toxic Shock Syndrome).....	☐ ☐	☐ ☐
(k)	Any cancer, tumor, cyst or nodule.....	☐ ☐	☐ ☐
(l)	Any sexually transmitted disorders or diseases (exlcuding HIV).....	☐ ☐	☐ ☐
(m)	Any disorders or diseases of the immune system *except those related to the Human Immunodeficiency Virus (AIDS Virus)*.....	☐ ☐	☐ ☐

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……..	☐ ☐	☐ ☐
(b) Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS)……..	☐ ☐	☐ ☐

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……..	☐ ☐	☐ ☐
(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……..	☐ ☐	☐ ☐
(c) Been a member of any self-help group such as Alcoholics Anonymous or Narcotics Anonymous……..	☐ ☐	☐ ☐

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……..	☐ ☐	☐ ☐
(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……..	☐ ☐	☐ ☐
(c) Been an inpatient or outpatient in a hospital, clinic, medical facility, or any similar entity……..	☐ ☐	☐ ☐
(d) Had any diagnostic tests such as: an electrocardiogram (EKG), MRI, CT-Scan or X-ray……..	☐ ☐	☐ ☐
(e) Been on, or advised to be on any prescribed, non-prescribed (over the counter) medication or prescribed diet……..	☐ ☐	☐ ☐
(f) Been unable to work, attend school or perform normal activities of life age and gender or been confined at home…...	☐ ☐	☐ ☐
(g) Has made a claim for or received benefits, compensation or pension for any injury, sickness, disability or impaired condition……..	☐ ☐	☐ ☐

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 Yes No	Proposed Insured 2 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……	☐ ☐	☐ ☐

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 and attach 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 attached to and made 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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Protective Life and Annuity Insurance Company

Home Office
2801 Highway 280 South, Birmingham, Alabama 35223
P.O. Box 2606, Birmingham, Alabama 35202-2606

Administrative Office
P.O. Box 830735, Birmingham, Alabama 35283
1-800-265-1545

STATEMENT REGARDING ILLUSTRATIONS

(This form must be submitted with the application in lieu of a signed illustration)

Sales illustrations are required for any product sold by Protective Life and Annuity Insurance Company which sets out non-guaranteed elements. An illustration conforming in all respects to the policy applied for by the applicant may not always be immediately available. To avoid confusion as to whether or not you have received an illustration or a representation form a Protective Life and Annuity representative, we ask you sign the appropriate statement below:

_____ 1. I have received an illustration for the policy applied for with Protective Life and Annuity and acknowledge that this illustration differs from the policy which I expect to receive, and if issued by Protective Life and Annuity, I understand that I will be provided with an illustration which does conform to the policy issued no later than the time when the policy is delivered to me.

_____ 2. I acknowledge that I have not received a printed illustration from Protective Life and Annuity's agent either because I viewed the illustration on a computer screen only or because the application was based on premium or face amount requirements which differed from those illustrated for me. I understand that I will be provided with an illustration which does not conform to the policy issued no later than the time when the policy is delivered to me.

_____ _____
Applicant Signature Date

_____ A. I certify that the policy applied for is other than as illustrated to the applicant. I have informed the applicant that an illustration conforming to the policy as issued will be provided no later than at the time the policy is delivered.

_____ B. I certify that no printed illustration was used in the sale of this policy. I have informed the applicant that an illustration was used in the sale of this policy. I have informed the applicant that an illustration conforming to the policy as issued will be provided no later than at the time the policy is delivered.

_____ _____
Protective Life and Annuity Agent Signature Date

A completed copy of this form must be provided to the Home Office, Applicant, and Agent

B-8474 (NY)