Application Part II
Statements Made to Examiner

P. O. Box 830619 • Birmingham, AL 35283-0619

Protective. Life Insurance Company

Proposed Insured _____ Birth Date _____
First Name Middle Initial Last Name

1. a. Name and address of your personal physician? (If none, check box) ☐ None _____

b. Date and reason last consulted? _____

c. What treatment was given or medication prescribed?

2. Last use of tobacco in any form?
☐ Within 1 year ☐ 1-3 years ☐ 3-5 years ☐ Never
Type: ☐ cigarettes ☐ cigars ☐ chewing tobacco or snuff
☐ pipe ☐ nicotine gum ☐ nicotine patch
Date last used: _____
Frequency used (Day/Month/Year): _____

3. Have you ever had, been told you had, or been treated for:	Yes	No
a. Disorder of eyes, ears, nose or throat?	☐	☐
b. Chest pain, pulse irregularity, high blood pressure, rheumatic fever, heart murmur, heart attack, stroke, or other disorder of the heart or circulatory system?	☐	☐
c. Cancer, tumor, disorders of lymph glands, cyst, or disorder of skin?	☐	☐
d. Diabetes, thyroid or other endocrine disorders?	☐	☐
e. Sugar, albumin, blood or pus in urine; venereal disease; stone or other disorder of kidney, bladder, prostate, reproductive organs or breasts?	☐	☐
f. Pancreatitis, jaundice, intestinal bleeding, ulcer, chronic diarrhea, colitis, diverticulitis,hemorrhoids, recurrent indigestion, or other disorder of the stomach, intestines, liver or gallbladder?	☐	☐
g. Blood spitting, asthma, emphysema, pleurisy, bronchitis, tuberculosis or chronic respiratory disorder?	☐	☐
h. Dizziness, fainting, headache, convulsions, seizures, epilepsy, paralysis, mental or nervous disorder?	☐	☐
i. Allergies, anemia, or other disorder of the blood, or immune system?	☐	☐
j. Rheumatism, arthritis, gout, or disorder of the muscles, bones or joints, including the spine?	☐	☐
k. Deformity, or amputation?	☐	☐

4. Other than above, have you within the past 5 years:		
a. Had a checkup, consultation, illness, injury, surgery?	☐	☐
b. Been a patient in a hospital, clinic, sanatorium or other medical facility?	☐	☐
c. Had electrocardiogram, x-ray, other diagnostic test?	☐	☐
d. Been advised to have any diagnostic test, hospitalization, or surgery which was not completed?	☐	☐
e. Had any mental or physical disorder not listed above?	☐	☐

5. a. Have you ever been advised by a physician that your use of alcohol or drugs was sufficient to impair or possibly impair your health?	☐	☐
b. Have you ever used narcotics, sedatives, depressants, stimulants or hallucinogens, other than under a doctor's prescription and direction?	☐	☐
c. Have you ever been or are you currently a member of any alcohol or drug rehabilitation program?	☐	☐
d. Had more than 2 moving violations in the past 3 years?	☐	☐
e. Been convicted for reckless driving or driving under the influence of alcohol or drugs within the past 7 years?	☐	☐
f. Have you ever been treated for alcohol or drug use?	☐	☐
g. Do you or have you ever smoked marijuana?	☐	☐
h. Do you or have you ever used cocaine?	☐	☐
i. Have you ever been convicted of a felony?	☐	☐

6. Have you been diagnosed by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS)?	Yes ☐	No ☐
7. a. Are you now under medical treatment or observation?	☐	☐
b. Has your weight changed in the past year?	☐	☐
Gain lbs. Loss lbs. Reason		
8. Have you ever requested or received a pension, or payment because of an injury, sickness or disability?	☐	☐
9. Do you participate in a regular, supervised exercise program, or any organized sport?	☐	☐
10. a. Do you know if any parent, brother or sister has had Cancer, Heart Disease, Stroke, High Blood Pressure or Diabetes? If yes, please indicate age of onset. _____	☐	☐
10. b. Did any die prior to age 60 due to any of these conditions?	☐	☐
11. Have you ever had military service deferment, rejection or discharge because of a physical or mental condition?	☐	☐
12. Are you pregnant?	☐	☐

13. DETAILS of "Yes" answers. If additional space is needed, please use the Continuation of Information form.

The above statements and answers are true and complete to the best of my knowledge and belief. I agree that such statements and answers shall be part of the application and shall be considered the basis of any insurance issued.

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

Witness _____ (X) _____
Medical Examiner or Interviewer

Signature of person proposed for insurance if age 15 or over, or Parent if proposed insured is under age 15

14. a. Height _____ ft. _____ in.
Weight _____ lbs.

Chest (Full Inspiration)	Chest (Forced Expiration)	Abdomen, at Umbilicus
in.	in.	in.

b. Did you weigh and measure applicant? ☐ Yes ☐ No
c. Is appearance unhealthy or older than stated age? ☐ Yes ☐ No

Applicant's identity was established by:

☐ Drivers License # _____
☐ Social Security # _____
☐ Other _____

15. Blood Pressure (Record all readings) (If Above 140/90 Record Additional Readings.)

	1st	2nd	3rd
Systolic			
Diastolic (5th phase)			

16. Pulse: Exercise if irregular, over 90 or less than 50 per min.

	At Rest	After Exercise	3 Minutes Later
Rate			
Irregularities per min.			

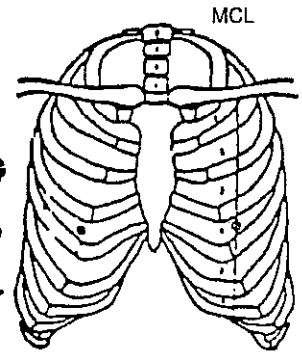
NOTE: DO NOT USE THIS SECTION FOR THE COMPLETION OF QUESTION #13. DETAILS- USE THE CONTINUATION OF INFORMATION FOR PART I AND PART II.

Details of Positive Findings by MD

17. Heart: Is there any:
Enlargement ☐ Yes ☐ No Dyspnea ☐ Yes ☐ No
Murmur(s) ☐ Yes ☐ No Edema ☐ Yes ☐ No
(describe below – if more than one, describe separately)

	Murmur 1.	Murmur 2.
Location		
Constant	☐	☐
Inconstant	☐	☐
Transmitted	☐	☐
Localized	☐	☐
Systolic	☐	☐
Diastolic	☐	☐
Soft (Gr. 1-2)	☐	☐
Mod. (Gr. 3-4)	☐	☐
Loud (Gr. 5-6)	☐	☐
After exercise:		
Increased	☐	☐
Absent	☐	☐
Unchanged	☐	☐
Decreased	☐	☐

Indicate:
Apex by X
Murmur area by ◌
Point of greatest intensity by O
Transmission by →



For comments and your impression?

18. Is there on examination any abnormality of the following:
(Circle applicable items and give details)

	Yes	No
(a) Eyes, ears, nose, mouth, pharynx? (If vision or hearing markedly impaired, indicate degree and correction.)	☐	☐
(b) Skin (include scars); lymph nodes; varicose veins or peripheral arteries?	☐	☐
(c) Nervous system (include reflexes, gait, paralysis)?	☐	☐
(d) Respiratory system?	☐	☐
(e) Abdomen (include scars)?	☐	☐
(f) Genitourinary system?	☐	☐
(g) Endocrine system (include thyroid and breasts)?	☐	☐
(h) Musculoskeletal system (include spine, joints, amputations, deformities)?	☐	☐

19. Are you aware of or do you suspect any other medical, alcoholic or drug history? (If yes, please send a confidential report to the Medical Director). ☐ ☐

20. Urinalysis: Albumin _____ Sugar _____ Specific Gravity _____
In Addition To Performing Above Urinalysis, Please Send Specimen To Lab On **ALL** Exams.

21. If required, was Blood Sample sent to Lab: ☐ Yes ☐ No
If required, was the following sent to the Home Office: EKG ☐ Yes ☐ No Stress Test ☐ Yes ☐ No X-Ray ☐ Yes ☐ No

I certify that I have made this examination with the results recorded on this _____ day of _____(month), _____(year)

Examination was made at: ☐ My Office
Person Examined is: ☐ Not My Patient
☐ Applicant's resident ☐ Applicant's place of business
☐ My Patient (If patient, please send copies of charts)

_____ (____)_____
Signature of Examiner Telephone No.

(Legibly print, type or rubber stamp name of examiner and office address below)

Name _____
Address _____
City, State & Zip _____

1. Name of agent requesting exam _____
2. Name of person examined _____
Address _____
City, State & Zip _____

Protective

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 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

Protective.

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

NOTICE AND CONSENT FOR HIV-RELATED TESTING

To evaluate your insurability, the Insurer named above, Protective Life Insurance Company, has requested that you provide a sample of your blood, oral fluid extracted from cheek and gum tissue, or urine, for testing and analysis to determine the presence of human immunodeficiency virus (HIV) antibodies. By signing and dating this form you agree that this test may be done and that underwriting decisions will be based on the test result. A series of three tests will be performed by a licensed laboratory through a medically accepted procedure.

Pre-Testing Considerations

Many public health organizations have recommended that before taking an HIV-related test a person seek counseling to become informed concerning the implications of such a test. You may wish to consider counseling, at your expense, prior to being tested.

Meaning of Positive Test Result

The test is not a test for AIDS. It is a test for antibodies to the HIV virus, the causative agents for AIDS, and shows whether you have been exposed to the virus. A positive test result does not mean that you have AIDS but that you are at significantly increased risk of developing problems with your immune system. The test for HIV antibodies is very sensitive. Errors are rare, but they do occur. Your private physician, a public health clinic, or an AIDS information organization in your city might provide you with further information on the medical implications of a positive test.

Positive HIV antibody test results will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged, or that other policy changes may be necessary.

Confidentiality of Test Results

All test results are required to be treated confidentially. They will be reported by the laboratory to the insurer. The test results may be disclosed as required by law or may be disclosed to employees of the insurer who have the responsibility to make underwriting decisions on behalf of the insurer or to outside legal counsel who needs such information to effectively represent the insurer in regard to your application. The test results may be disclosed to a reinsurer, if the reinsurer is involved in the underwriting process. A brief report of any personal health information and the test results may be released to an insurance medical information exchange under procedures that are designed to assure confidentiality, including the use of general codes that also cover results of tests for other diseases or conditions not related to AIDS, or for the preparation of statistical reports that do not disclose the identity of any particular person.

Notification of Test Result

If your test results are negative, no routine notification will be sent to you. If your test results are reported by the laboratory to the insurer as being positive, you will receive written notification of such results from a physician you have designated or, in the absence of such designation, from the Texas Department of Health. Because a trained person should deliver that information so that you can understand clearly what the test result means, please list your private physician so that the insurer can have him or her tell you the test result and explain its meaning.

Name of physician for reporting a possible positive test result: _____

Address: _____

In the event the test is positive and you are denied coverage because of that fact and you request the reason for the denial, the insurer may require you to name a physician at that time in order to receive the information.

If the test indicates a positive result, but you do not designate a private physician, the test results will be provided to you by a representative of the Texas Department of Health.

Consent

I have read and I understand this Notice and Consent for HIV-Related Testing. I voluntarily consent to the withdrawal of blood, oral fluid extracted from cheek and gum tissue, or urine from me, the testing of that sample, and the disclosure of the test results as described above. I have read the information on this form about what a test result means.

I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

_____ _____

Name of Proposed Insured | Signature of Proposed Insured or Parent/Guardian

_____ _____

Address | Date Signed