PROTECTIVE LIFE INSURANCE COMPANY
P.O. Box 96
Birmingham, AL 35201

Notice to Applicants

Description of Information Practices

(Including MIB, LLC Notice and Fair Credit Reporting Act Notice)

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

Information regarding your insurability will be treated as confidential. Protective Life, or its reinsurers, may however make a brief report thereon to MIB, LLC ("MIB"), which operates an information exchange on behalf of insurance companies that are members of MIB Group, Inc. 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 in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of information in MIB's file, you may contact them directly 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, MA 02184-8734. Information for consumers about MIB may be obtained on its website at www.mib.com or by calling (866) 692-6901.

Protective Life Insurance Company, or its reinsurers, may also release information in 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 and to any other persons as allowed by law. A medical examination by an examiner, approved by the Company, may be requested for any applicant. The fee for the examination will be paid by the Company. Applications accepted for insurance will receive insurance certificates stating the terms and provisions of the group policy.

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, 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 incorrect. To exercise these rights, please write to us at the address appearing at the end of this notice. For assistance, call or write us at Protective Life Insurance Company, P.O. Box 96, Birmingham, AL 35201. Telephone (800) 607-5334.

THIS NOTICE MUST BE RETAINED BY THE PROPOSED INSURED(S).

ADA Level Term Life Plan

Application for Insurance LVWSPDF

Protective Life Insurance Company (The "Company")

State of Domicile - Nebraska

Read all forms | Complete all sections | Mail or Fax ALL completed forms

Questions? 866.607.5334 | ada.protective.com | ADAPlanSpecialist@protective.com

Submit to: P.O. Box 96 | Birmingham, AL 35201 | Fax: 303.262.5463

Member Information *(Please print legibly)*

Are you an ADA member under age 65? ☐ Yes ☐ No

ADA Number

Full Legal Name

Social Security Number

Address

City State ZIP

☐ State of residence is the same as address provided above.

If not, please provide: State

Date of Birth

☐ Male ☐ Female

Place of Birth

Driver's License Number State

Annual Income: $

Office Phone Home Phone

Fax Number Cell Phone

Email Address

Best way to be contacted: ☐ Home ☐ Cell ☐ Office ☐ Email

☐ Yes! Please sign me up to receive promotional information and announcements from ADA Members Insurance Plans via email.

Owner Information *(If other than the Member)*

Full Legal Name of Owner or Trustee

Address

E-Mail Address

Social Security Number / Tax ID Number

Relationship to Member

Name of Trust

Date of Trust

Note: Premium notices will be sent to the Owner if the Owner is different than the Member.

Spouse or Domestic Partner Information *(Complete if you are applying for Spouse or Domestic Partner Coverage.)*

Coverage is for: ☐ Spouse ☐ Domestic Partner*

Full Legal Name

Social Security Number

Address *(If different from the Member)*

City State ZIP

Place of Birth

Driver's License Number State

Occupation

Office Phone Home Phone

Fax Number Cell Phone

Spouse or Domestic Partner Information *(Continued)*

☐ State of residence is the same as address provided above.

If not, please provide: _____
State

_____
Date of Birth

_____
Email Address

Best way to be contacted: ☐ Home ☐ Cell ☐ Office ☐ Email

☐ Male ☐ Female

**When applying for coverage for a Domestic Partner, you and your partner must also complete an Affidavit of Domestic Partnership. Call 800.568.2001 or visit ada.protective.com to obtain this form.*

Coverage Amount

Check the amount of new or additional Coverage desired. You may apply for coverage for yourself and for your spouse or domestic partner under this Plan, as long as you are a current participant or applicant. You and your spouse or domestic partner, if applicable, must be under age 65 if electing the 10-year term and under age 60 if electing the 20-year term.

Member Coverage	Spouse or Domestic Partner Coverage
☐ $3,000,000 (Maximum amount of Coverage available under this plan.)	☐ $1,000,000 (Maximum amount of Coverage available under this plan.)
☐ $100,000 (Minimum amount of Coverage and the Minimum amount of an increase in Coverage available under this Plan)	☐ $100,000 (Minimum amount of Coverage and the Minimum amount of an increase in Coverage available under this Plan)
☐ Other _____ (You may elect any increment of $25,000.)	☐ Other _____ (You may elect any increment of $25,000, but the amount selected cannot exceed the Member amount.)
☐ 10-year term ☐ 20-year term	Spouse or Domestic Partner term will match Member term election.

Other Insurance

Member Coverage	Spouse or Domestic Partner Coverage
Do you have any other life insurance in force with Protective Life or any other company? ☐ Yes ☐ No	Does your spouse or domestic partner have any other life insurance in force with Protective Life or any other company? ☐ Yes ☐ No
If "Yes", total amount in all companies: $ _____	If "Yes", total amount in all companies: $ _____
Do you have other insurance applications pending with Protective Life or any other company? ☐ Yes ☐ No	Does your spouse or domestic partner have other insurance applications pending with Protective Life or any other company? ☐ Yes ☐ No
If "Yes", indicate amount and company: $ _____	If "Yes", indicate amount and company: $ _____
Company: _____	Company: _____
Do you intend to replace, discontinue or change an existing life insurance policy or contract? ☐ Yes ☐ No	Does your spouse or domestic partner intend to replace, discontinue or change an existing life insurance policy or contract? ☐ Yes ☐ No
If "Yes", total amount in all companies: $ _____	If "Yes", total amount in all companies: $ _____
Company: _____	Company: _____

Dependent Child Coverage

$15,000 for each eligible unmarried dependent child from 15 days to 21 years of age (or to age 27 if a full-time student) ☐ Yes ☐ No

If "Yes", name eligible dependent children:

Name: _____ Date of Birth: _____ Full-time student? ☐ Yes ☐ No

Name: _____ Date of Birth: _____ Full-time student? ☐ Yes ☐ No

Beneficiary

The person(s) who will receive insurance proceeds upon the insured person's death. Attach another sheet if space is not adequate.

Member Coverage

Any elections made here will not affect previous beneficiary designations under an earlier application or existing coverage issued under a separate Certificate. Call 800-568-2001 to verify your existing beneficiaries.

Percentages must be in whole percentages and must total 100% for each class of beneficiaries below.

Primary Beneficiary

Full Name	Relationship	Date of Birth	Percentage of Benefit
Full Name	Relationship	Date of Birth	Percentage of Benefit
Full Name	Relationship	Date of Birth	Percentage of Benefit

Contingent Beneficiary (Will receive insurance proceeds if the Primary Beneficiary: 1. predeceases the insured; or 2. dies after the Insured, but before the insurance proceeds are exhausted.)

Full Name	Relationship	Date of Birth	Percentage of Benefit
Full Name	Relationship	Date of Birth	Percentage of Benefit

Spouse, Domestic Partner, or Dependent Child Coverage

The beneficiary for any Spouse, Domestic Partner, or Dependent Child Coverage will be the ADA Member, unless otherwise named in an Appointment of New Beneficiary form. To obtain this form call 800.568.2001 or visit ada.protective.com.

Primary Care Physician

Additional information is required to determine eligibility and proof of insurability. Complete the information below.

Member Coverage	Spouse or Domestic Partner Coverage
Primary Care Physician _____ Date Last Seen _____	Primary Care Physician _____ Date Last Seen _____
Address _____	Address _____
City _____ State _____ Zip _____	City _____ State _____ Zip _____
Phone Number _____ Fax Number _____	Phone Number _____ Fax Number _____
If your medical records could be under a different name, please list the name: _____	If your medical records could be under a different name, please list the name: _____

Questionnaire

Please answer all questions and explain any "Yes" answers (attach additional sheet if necessary).

Qualification Questions

1. Member: Height _____ feet _____ inches Weight _____ lbs

   Spouse or Domestic Partner: Height _____ feet _____ inches Weight _____ lbs

	Member	Spouse or Domestic Partner
2. **Tobacco/Nicotine:** Do you currently use or have you used any type of tobacco or nicotine products within the past 2 years?	☐ Yes ☐ No	☐ Yes ☐ No
3. **Family Health History:** Did either of your parents or any of your siblings die prior to age 60 due to coronary heart disease, diabetes, cancer or stroke?	☐ Yes ☐ No	☐ Yes ☐ No
4. Have you been declined or turned down for life insurance?	☐ Yes ☐ No	☐ Yes ☐ No
5. Do you currently have felony charges pending against you, or are you currently on probation or parole?	☐ Yes ☐ No	☐ Yes ☐ No

If "Yes" to Questions 3-5, please provide details:

6. In the past 10 years:		
a. Have you used illegal drugs?	☐ Yes ☐ No	☐ Yes ☐ No
b. Have you used marijuana in any form?	☐ Yes ☐ No	☐ Yes ☐ No
c. Have you been diagnosed, treated, tested positive for or have been given medical advice by a licensed member of the medical profession for alcoholism or substance abuse?	☐ Yes ☐ No	☐ Yes ☐ No

If "Yes" to Questions 6a-6c, please provide details:

7. **Motor Vehicle Use:** In the last 10 years, have you had any motor vehicle violations, driving under the influence of alcohol or drugs (DUI's), accidents, or had your driver's license suspended or revoked?	☐ Yes ☐ No	☐ Yes ☐ No

If "Yes", please provide details:

Questionnaire *(Continued...)*

Please answer all questions and explain any "Yes" answers (attach additional sheet if necessary).

Qualification Questions	Member	Spouse or Domestic Partner

8. In the past 10 years have you had or have you been diagnosed, treated, tested positive for, or been given medical advice by a licensed member of the medical profession for:

		Member	Spouse or Domestic Partner
a.	Any disease or disorder of the heart, blood vessels excluding varicose veins, lungs (excluding asthma), kidneys, central nervous system, brain, spinal cord, blood including chronic anemia, immune system or liver?	☐ Yes ☐ No	☐ Yes ☐ No
b.	Asthma with associated hospitalizations or acute emergency visits or being treated with more than one oral steroid?	☐ Yes ☐ No	☐ Yes ☐ No
c.	Major depression, schizophrenia, or any of the following disorders: panic, psychotic, or bipolar?	☐ Yes ☐ No	☐ Yes ☐ No
d.	Diabetes (excluding gestational)?	☐ Yes ☐ No	☐ Yes ☐ No
e.	Pancreatitis?	☐ Yes ☐ No	☐ Yes ☐ No
f.	Crohn's Disease or Ulcerative Colitis?	☐ Yes ☐ No	☐ Yes ☐ No
g.	Cancer (other than basal cell carcinoma of the skin)?	☐ Yes ☐ No	☐ Yes ☐ No

If "Yes", please provide additional details.

Question #	Date Last Seen	Diagnosis/Reason Consulted	Physician's Name/Address	Current Status

9. In the last 10 years have you tested positive for Human Immunodeficiency Virus or its antibodies or been diagnosed with Acquired Immune Deficiency Syndrome related disease by a licensed member of the medical profession? ☐ Yes ☐ No ☐ Yes ☐ No

Travel and Avocations	Member	Spouse or Domestic Partner

1. Foreign Travel: Do you plan to travel to or reside in a country other than the USA at any time in the next 2 years? ☐ Yes ☐ No ☐ Yes ☐ No

   If "Yes", please indicate country of travel, dates and length of stay. You will be contacted for completion of a supplemental questionnaire:

2. Aviation: Have you ever flown a private aircraft, or do you intend to fly as a pilot or crew member? If "Yes", you will be contacted for completion of a supplemental questionnaire. ☐ Yes ☐ No ☐ Yes ☐ No

3. Avocations: In the past two years have you participated in, or do you contemplate participating in scuba diving, motor vehicle racing, rock or mountain climbing, skydiving, hang gliding, parachuting or other hazardous sports? ☐ Yes ☐ No ☐ Yes ☐ No

   If "Yes", please indicate which avocation(s). You will be contacted for completion of a supplemental questionnaire:

Payment Information

Please select your premium payment preference. I wish to pay premiums by (select one):

- ☐ Check (annual)*
- ☐ Check (semi-annual)
- ☐ Autopay (annual)*
- ☐ Autopay (semi-annual)
- ☐ Autopay (monthly, 1st of the month)**
- ☐ Autopay (monthly, 10th of the month)**

*A 3% discount will apply to premiums paid annually

**A 2% premium charge will be added to monthly Autopay withdrawals

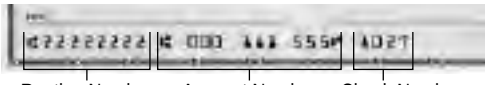
If you selected Autopay, please fill out the information below.

Bank Name

Routing No.

Account No.

Check one: ☐ Checking ☐ Savings



Routing Number Account Number Check Number

Autopay Terms and Conditions: All monthly withdrawals will be made, as elected, on the 1st or 10th of the month in which premium is due. Autopay will terminate (1) when you (or the bank depositor, if other than the Certificate owner) provide Protective Life Insurance Company a 30 days' written notice; or (2) at Protective Life Insurance Company's election, upon 30 days' written notice to you and/or the bank depositor; or (3) at the discretion of Protective Life Insurance Company, if your designated bank does not transfer funds. In this case, you will receive a lapse notice detailing how to reinstate your coverage. Should the Autopay program terminate, you will be notified to select another payment preference.

Fraud Warnings

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines, or confinement in prison, or any combination thereof. Alaska: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law. Arizona: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties. Arkansas, District of Columbia, Louisiana, Rhode Island, and West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. California: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison. Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies. Delaware: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony. Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree. Idaho: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony. Indiana: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony. Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime. Maine, Tennessee, and Washington: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or a denial of insurance benefits. Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties. New Mexico: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties. Ohio: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony. Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. Puerto Rico: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000); or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years; if extenuating circumstances are present, it may be reduced to a minimum of two (2) years. Texas: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison. Vermont: Any person who, with intent to defraud or knowing that they are facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, may be proven guilty of fraud or may be found guilty of fraud. Virginia: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law. All Other States: Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Signature and Declarations

Please read the following information carefully before you sign this.

This standard disclosure is required of all insurance providers. Be assured that Protective Life Insurance Company's business practices meet the highest industry standards.

I have read and understand the Description of Information Practices. I understand I have the right to receive a copy upon request. The Company, its reinsurers, and their authorized representatives, may obtain medical and other information in order to evaluate my application for insurance. The MIB, LLC ("MIB") consumer reporting agencies, state motor vehicle department or insurance company who possesses medical or other information about me or my health may furnish such information to the Company upon presenting this authorization or a photocopy. I authorize Protective Life Insurance Company, or its reinsurers, to make a brief report regarding me or my health to MIB or to other member companies to whom I have applied or may apply and have authorized to receive such information. I consent to a consumer report containing personal information that may be requested in connection with my application. This authorization is valid from the date signed for a period of 2 years.

Acceptance of your application is subject to the underwriting requirements of Protective Life Insurance Company. Depending on your medical history, coverage may be declined, or a rider(s) issued excluding coverage for certain condition(s).

The effective date of coverage will be the date your application is approved by the Company. Premiums will be due from that effective date to the next renewal date, either January 1 or July 1. If your application for insurance is not accepted, you will be informed promptly.

Benefits are provided under Group Policy No. 104LTLP issued by Protective Life Insurance Company to the American Dental Association ("ADA"). Benefits are provided through a group policy filed in the state of Illinois, and coverage is available to all eligible ADA members residing in any U.S. state or territory. This policy is filed in accordance with and governed by Illinois law. Premium credit discount not guaranteed but re-evaluated annually. Each Plan participant will receive a Certificate of Insurance explaining the terms and conditions of the group policy.

By my signature below, I hereby declare that my answers and statements to the questions contained herein are full, complete, true to the best of my knowledge and belief and a condition of obtaining this insurance. I understand and agree that providing false, incomplete, or misleading information as a part of this application, or in filing a claim may constitute fraud or misrepresentation that may result in the denial of claims, the rescission of coverage and potential criminal penalties. I understand that my answers and statements to the questions contained herein will, in the absence of fraud, be deemed representations and not warranties.

I or my authorized representative have the right to access my personal medical and financial information in my files and to request that any inaccurate information be corrected. I understand that I have the right to revoke this authorization in writing, at any time, by providing written notification to Protective Life Insurance Company. I understand that a revocation is not effective to the extent that the Company or any providers have already relied on this Authorization to disclose information about me or to the extent that Protective Life Insurance Company has a legal right to contest a claim under an insurance policy or to contest the policy itself.

I hereby apply for insurance under Group Policy No. 104LTLP issued by Protective Life Insurance Company to the American Dental Association subject to all terms, conditions, and provisions of said policy.

ADA No.

Print Name of Member

Signature of Member — Date of Signature

Print Name of Spouse or Domestic Partner

Signature of Spouse or Domestic Partner — Date of Signature

Print Name of Owner — Date of Birth

Signature of Owner — Date of Signature

FOR MEMBER

Protective Life Insurance Company
P.O. Box 96, Birmingham, AL 35201-0096
Phone: 800.568.2001

Please complete and sign this **Authorization to Obtain and Disclose Information** form. We will only start to process your application when we receive the completed and signed form.

ADA Member Number **Name of Proposed Insured (Please print):**

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")

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

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

a. obtain and use health and medical information from all dates of service, including but not limited to, medical records, prescription drugs, chart notes, electrocardiograms (EKG), and information about the diagnoses and/or treatments relating to Human Immunodeficiency Virus (HIV) infection or Acquired Immunodeficiency Syndrome (AIDS), sexually transmitted diseases, drug use, alcohol use, nicotine or tobacco use, physical and mental diseases and illnesses, 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 (both life and health insurance, including disability insurance), a claim for all insurance benefits, or both:
d. use any information relating to communicable diseases (e.g., hepatitis A, measles, influenza, tuberculosis) and other risk factors relating to me to evaluate an application for insurance.

RELEASE AND DISCLOSE INFORMATION FROM THIRD PARTIES

I 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, directly or through designated third parties or its representative(s) acting on its behalf:

a. my 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 current and previous employers;
e. MIB, LLC **(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. **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 authorize Protective Life to draw and test my blood, and/or oral fluids, and urine as necessary to underwrite my 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, see **SPECIAL REQUIREMENT FOR HIV/AIDS TESTING** section.
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 may, but is not obligated to, release any of these test results directly to me.

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

I 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:
to its affiliates, its reinsurers, persons or organizations providing services relating to insurance underwriting for Protective Life, **MIB** and as otherwise required by law.

a. to release and disclose the information to other duly licensed life insurers if I have applied or apply to the other insurers for insurance.
b. to the Life Insurance Representative(s) representing me to duly licensed specific life insurers for the purpose of applying for insurance if my application with Protective Life is declined or if Protective Life is unable to offer coverage at an acceptable rate.
c. to the Life Insurance Representative(s) and its staff, affiliated companies and/or entities, insurance companies and their reinsurers representing me on my application for life, supplemental health and disability insurance.

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

I 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 reinsurers, to make a brief report of my personal health information to **MIB**.

SPECIAL REQUIREMENT FOR HIV/AIDS TESTING

If Protective Life intends to test for the presence of antibodies to the Human Immunodeficiency Virus (HIV), which is the virus that has been associated with Acquired Immune Deficiency Syndrome (AIDS), Protective Life may require a separate authorization. I hereby authorize Protective Life:

a. to obtain and use the results of any HIV tests that I 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, or for the time limit, if any, permitted by applicable law in the state where the policy is delivered or issued for delivery, whichever period is shorter, or, in the event of a claim for benefits, for the duration of such claim.
b. During the evaluation of my insurance application, I understand that I have the right to revoke the authorizations in the previous sections (above) by writing to Protective Life at P.O. Box 96, Birmingham, Alabama 35201-0096. If this authorization is revoked or if you refuse to sign, this will result in the file being closed and no coverage provided, or if coverage has been issued, Protective Life may not be able to assess claims or make any benefit payments.
c. I understand that a revocation is not effective to the extent that any information already released and disclosed, and where already authorized and may have already been relied on, or to the extent that Protective Life has a legal right to contest a claim under an insurance policy or to contest the policy itself.
d. I understand that any information about me that is disclosed pursuant to this authorization may be subject to redisclosure 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, supplemental health, disability, or other insurance products.
e. I understand that my personal information, including my protected health information disclosed under this authorization will be incorporated into and made a part of any life, supplemental health and/or disability insurance policy(ies) issued by Protective Life 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.
g. Any modifications to this authorization may preclude Protective Life's ability to process the application for coverage or make any benefit payments for any policy(ies) issued.

AUTHORIZATIONS AND INVESTIGATIVE CONSUMER REPORT

☐ I have been given a copy or have saved/retained/printed this **Authorization to Obtain and Disclose Information** along with the **Description of Information Practices**.

☐ I 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**.)

Authorization Date Name of Proposed Insured Proposed Insured Signature Date of Birth Social Security Number

A COPY OF THIS NOTICE MUST BE SAVED/RETAINED BY THE PROPOSED INSURED

FOR SPOUSE or DOMESTIC PARTNER *(if applying for coverage)*

Protective Life Insurance Company
P.O. Box 96, Birmingham, AL 35201-0096
Phone: 800.568.2001

Please complete and sign this **Authorization to Obtain and Disclose Information** form. We will only start to process your application when we receive the completed and signed form.

ADA Member Number **Name of Proposed Insured (Please print):**

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")

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

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

a. obtain and use health and medical information from all dates of service, including but not limited to, medical records, prescription drugs, chart notes, electrocardiograms (EKG), and information about the diagnoses and/or treatments relating to Human Immunodeficiency Virus (HIV) infection or Acquired Immunodeficiency Syndrome (AIDS), sexually transmitted diseases, drug use, alcohol use, nicotine or tobacco use, physical and mental diseases and illnesses, 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 (both life and health insurance, including disability insurance), a claim for all insurance benefits, or both:
d. use any information relating to communicable diseases (e.g., hepatitis A, measles, influenza, tuberculosis) and other risk factors relating to me to evaluate an application for insurance.

RELEASE AND DISCLOSE INFORMATION FROM THIRD PARTIES

I 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, directly or through designated third parties or its representative(s) acting on its behalf:

a. my 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 current and previous employers;
e. MIB, LLC **(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. **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 authorize Protective Life to draw and test my blood, and/or oral fluids, and urine as necessary to underwrite my 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, see **SPECIAL REQUIREMENT FOR HIV/AIDS TESTING** section.
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 may, but is not obligated to, release any of these test results directly to me.

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

I 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:
to its affiliates, its reinsurers, persons or organizations providing services relating to insurance underwriting for Protective Life, **MIB** and as otherwise required by law.

a. to release and disclose the information to other duly licensed life insurers if I have applied or apply to the other insurers for insurance.
b. to the Life Insurance Representative(s) representing me to duly licensed specific life insurers for the purpose of applying for insurance if my application with Protective Life is declined or if Protective Life is unable to offer coverage at an acceptable rate.
c. to the Life Insurance Representative(s) and its staff, affiliated companies and/or entities, insurance companies and their reinsurers representing me on my application for life, supplemental health and disability insurance.

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

I 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 reinsurers, to make a brief report of my personal health information to **MIB**.

SPECIAL REQUIREMENT FOR HIV/AIDS TESTING

If Protective Life intends to test for the presence of antibodies to the Human Immunodeficiency Virus (HIV), which is the virus that has been associated with Acquired Immune Deficiency Syndrome (AIDS), Protective Life may require a separate authorization. I hereby authorize Protective Life:

a. to obtain and use the results of any HIV tests that I 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, or for the time limit, if any, permitted by applicable law in the state where the policy is delivered or issued for delivery, whichever period is shorter, or, in the event of a claim for benefits, for the duration of such claim.
b. During the evaluation of my insurance application, I understand that I have the right to revoke the authorizations in the previous sections (above) by writing to Protective Life at P.O. Box 96, Birmingham, Alabama 35201-0096. If this authorization is revoked or if you refuse to sign, this will result in the file being closed and no coverage provided, or if coverage has been issued, Protective Life may not be able to assess claims or make any benefit payments.
c. I understand that a revocation is not effective to the extent that any information already released and disclosed, and where already authorized and may have already been relied on, or to the extent that Protective Life has a legal right to contest a claim under an insurance policy or to contest the policy itself.
d. I understand that any information about me that is disclosed pursuant to this authorization may be subject to redisclosure 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, supplemental health, disability, or other insurance products.
e. I understand that my personal information, including my protected health information disclosed under this authorization will be incorporated into and made a part of any life, supplemental health and/or disability insurance policy(ies) issued by Protective Life 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.
g. Any modifications to this authorization may preclude Protective Life's ability to process the application for coverage or make any benefit payments for any policy(ies) issued.

AUTHORIZATIONS AND INVESTIGATIVE CONSUMER REPORT

☐ I have been given a copy or have saved/retained/printed this **Authorization to Obtain and Disclose Information** along with the **Description of Information Practices**.

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Authorization Date Name of Proposed Insured Proposed Insured Signature Date of Birth Social Security Number

A COPY OF THIS NOTICE MUST BE SAVED/RETAINED BY THE PROPOSED INSURED

Electronic Consent Form

Protective Life Insurance Company
State of Domicile - Nebraska

 Read all forms  Complete all sections  Mail or Fax ALL completed forms 

Questions? 866.607.5334 | ada.protective.com | ADAPlanSpecialist@protective.com
Submit to: P.O. Box 96 | Birmingham, AL 35201 | **Fax:** 303.262.5463

Owner's Name: _____ **Product:** _____

Optional - Consent for Electronic Delivery

☐ Yes, I consent to receive my certificate, documents, and notices related to my certificate as permitted by law and subject to the Company's ability to deliver documents and notices electronically.

- There is no charge for electronic delivery, and I may request a paper copy at no charge at any time.
- If my email address changes, I can update my information online or over the phone.
- This consent will remain in effect until I revoke my authorization by contacting Customer Service.

I understand that in order to receive these documents electronically. I need to register online to access my account information and any forms available electronically.

- I can complete the online account registration at ada.protective.com.

By providing my email address below, I confirm that I have access to the internet for the purpose of accepting/accessing documents via electronic delivery.

I can revoke or change my consent for electronic delivery by calling 800.568.2001 or emailing ada@protective.com

Owner's Email Address: _____

☐ No, I do not consent to receive documents and notices electronically.

Signatures

_____
Print Name of Member

➡ _____
Signature of Member Date of Signature