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 Office Overhead Expense Disability Insurance Plan

Application for Insurance PLOEWS24IL

Protective Life Insurance Company (The "Company")
State of Domicile - Tennessee

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)*

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

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.

Eligibility Verification

☐ Yes ☐ No I am an Active Member of the ADA.

☐ Yes ☐ No I am under age 60.

☐ Yes ☐ No I am in the military on Active-Duty service.

☐ Yes ☐ No I work at least 20 hours per week, performing the substantial and material duties of my occupation.

Dental License Number State

Coverage Information

1. My office is organized as follows:

☐ Sole Proprietor ☐ S-corp. ☐ P-corp. ☐ C-corp. ☐ Partnership ☐ Other (define): _____

2. My share of total overhead expenses for which I am liable and legally responsible (**EXCLUDING** my own salary and the salaries of any dentists I employ, lab expenses, and dental supplies) is: $_____ per month

3. ☐ Yes ☐ No I understand that the total monthly amount I request, together with any other overhead expense insurance I have in force or have applied for, cannot exceed my actual monthly overhead expenses.

Coverage Information (Continued)

4. I am requesting this total of monthly ADA Office Overhead Expense insurance coverage: $_____ per month

*Please write the TOTAL amount of coverage desired, INCLUDING any **existing coverage** you may have under the ADA Plan. Coverage must be in increments of $500 and cannot exceed $25,000 per month.*

5. I select the following Benefit Plan:

☐ 24x Insured Amount

☐ 12x Insured Amount

A separate certificate will be issued with any increase in coverage.

Existing coverage will not be changed from this selection.

6. ☐ Yes ☐ No Other than ADA Office Overhead Expense income coverage, do you have any other office overhead expense insurance in force or for which you have applied? If "Yes", provide name of carrier(s) and monthly benefit amount(s) below:

Name	Amount
Name	Amount
Name	Amount

7. If coverage being applied for is to replace existing in force coverage, provide the name of the carrier(s) and the monthly benefit(s) this new coverage is intended to replace:

Name	Amount
Name	Amount

8. In the event of your death while receiving benefits, whom do you wish to receive any survivor benefits that may be payable?

Print Full Name	Relationship	Date of Birth
Address		
City	State	Zip

Health Care Providers

Please provide the names, addresses and phone numbers of any healthcare providers you have seen in the last 5 years (if more space is needed, please attach separate sheet).

Primary Care Physician (if any)	Date Last Seen	Reason Seen
Address		Phone Number
Name	Date Last Seen	Reason Seen
Address		Phone Number
Name	Date Last Seen	Reason Seen
Address		Phone Number

Have you ever had an application for life, health, or disability income insurance declined, postponed, or modified in any way? **If "Yes", give names of companies and reason:** ☐ **Yes** ☐ **No**

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).

1. Height _____ feet _____ inches Weight _____ lbs

2. In the past 10 years have you ever been diagnosed with or treated for:

a. Diabetes? ☐ **Yes** ☐ **No**

b. Multiple Sclerosis, Systemic Lupus, Parkinson's or Rheumatoid Arthritis? ☐ **Yes** ☐ **No**

c. Non-Hodgkin's Lymphoma or other cancer? ☐ **Yes** ☐ **No**

d. a Heart Attack (including stents or bypass surgery)? ☐ **Yes** ☐ **No**

If "Yes", to questions 2a-2d, please provide additional details.

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

3. **Tobacco/Nicotine:** Do you currently use or have you used any type of tobacco or nicotine products within the past 2 years? **If "Yes", please provide details and date of last usage:** ☐ **Yes** ☐ **No**

4. **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? **If "Yes", please provide details:** ☐ Yes ☐ No

Questionnaire *(Continued)*

Travel and Avocations

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

   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 as a pilot on 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

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

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

Additional Application Insurance *(optional)*

Please provide any additional instructions on processing your application.

Payment Information

Please select your premium payment preference for coverage issued under this application. I wish to pay premiums by **(select one):**

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

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

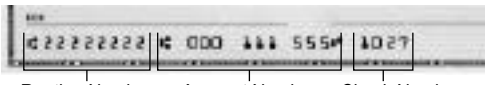
If you selected Autopay, please fill out the information below.

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 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 February 1 or August 1. If your application for insurance is not accepted, you will be informed promptly.

If you are not actively working full-time at least 20 hours per week doing all the duties of your profession or occupation on the date your application is approved by the Company, the coverage applied for will not begin until the date you are actively working full-time.

Benefits are provided under Group Policy No. 1106GDH-OEP 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. 1106GDH-OEP 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

HIPAA Authorization for Release of Medical Information *("Authorization")*

Please fill out and mail this Authorization form along with your application.
We cannot begin to process your application until we receive the signed HIPAA form.

ADA No.

Print Name of Insured/Patient Date of Birth

I authorize MIB, LLC (“MIB”), any health plan, physician, healthcare professional, hospital, clinic, laboratory, or holders of prescription information on me, including but not limited to: pharmacies and pharmacy benefits managers, and insurers, medical facilities, or other healthcare professionals that have provided payment, treatment or services to me or on my behalf (“My Providers”) to disclose my entire medical record, prescription history, medications prescribed, eligibility, prescribing physician, pharmacy information, insurance coverage information and any other protected health information concerning me to Protective Life Insurance Company (the "Company"). This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs and tobacco.

By my signature below, 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, healthcare professional, hospital, clinic, medical facility, or other healthcare provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that Protective Life Insurance Company may: 1) evaluate my application for insurance coverage or claims benefits, determine eligibility and risk rating; 2) obtain reinsurance; 3) administer coverage and claims; 4) conduct other legally permissible activities that relate to any coverage I have or have applied for with Protective Life Insurance Company.

This authorization shall remain in force for 24 months following the date of my signature below and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by providing written notification to the entity identified above. I understand that a revocation is not effective to the extent that any of My 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 understand that any information that is disclosed pursuant to this authorization is no longer covered by federal rules governing privacy and confidentiality of health information, but will not be re-disclosed by Protective Life Insurance Company except as authorized by me or as required by law.

I understand that my providers may not refuse to provide treatment or payment for health care services if I refuse to sign this Authorization. I further understand that if I refuse to sign this Authorization to release my complete medical record, Protective Life Insurance Company may not be able to process my application, or if coverage has been issued, may not be able to make any benefit payments.

Signature of Insured/Patient Date of Signature