

Protective Life Insurance Company  
2801 Highway 280 South  
Birmingham, AL 35223  
(888) 800-6608



Fax to: 1-888-615-9619 (TeleLife – Elgin, IL)

Date: February 11, 2020

Applicant's Name: Jesus Romero

Number of Pages: 10 4

Policy Number: (to be provided by TeleLife)

Agent Name: \_\_\_\_\_

Companion Name: \_\_\_\_\_

Agent Number: \_\_\_\_\_

Companion Policy Number: (to be provided by TeleLife)

BGA Number: \_\_\_\_\_

Fax: \_\_\_\_\_

Regional Sales Manager: \_\_\_\_\_

BGA Sales Rep: (if other than BGA Contact)

Agent / BGA Contact Name: \_\_\_\_\_

Contact Information: \_\_\_\_\_

► Check all included forms; Note that all forms listed may not be applicable. Make sure to provide any state required forms that were included in the TeleLife Fax Application Package signed [at least] by the agent.

- 1) Pre-Application  \_\_\_\_\_
- 2) Supplement I (required)  \_\_\_\_\_
- 3) Replacement Form  \_\_\_\_\_
- 4) Pre-Auth Withdrawal  \_\_\_\_\_
- 5) Conditional Receipt  \_\_\_\_\_
- 6) TIADB  \_\_\_\_\_
- 7) Additional (Please Specify)  \_\_\_\_\_
- 8) Full Illustration, UL Only  \_\_\_\_\_

Special Instructions:

Policy Number



TeleLife®  
FAX # 1-888-615-9619

**APPLICATION FOR INDIVIDUAL LIFE INSURANCE**

Proposed Primary Insured  Proposed Other Insured

Name Last First MI  Male  
Romero, Jesus  Female

Street  
2241 Pinnacle Ct.

City Hollister State CA Zip 95023

Social Security Number 554-08-6805 Occupation Admin Asst

Birthplace Tijuana BC, MEX Birthdate 11-25-1970 Driver's License # A3014112

Home Phone (831) 630-5787 Cell Phone (831) 801-7558 Business Phone (408) 522-8200

Where do you wish to be reached for additional information?  
 Home  Work  Cell Best times:  a.m.  p.m.

Annual Income 10700 Net Worth 500000

Initial Death Benefit \$ 500000

Plan of Insurance: 20 year Term

Riders:  WP  ADB  CTR  Other: \_\_\_\_\_

Indicate Amount for Riders: \$ \_\_\_\_\_

Mode of Premium Payment:  Annual  SA  Qtrly  PAC

Rate Class Quoted: \_\_\_\_\_ Premium Quoted: \_\_\_\_\_

Amount remitted with this application, in exchange for this Company receipt: \$ N/A

Owner, if other than proposed insured \_\_\_\_\_ Owner's Address \_\_\_\_\_

Relationship to Proposed Insured \_\_\_\_\_ Social Security or Tax ID # \_\_\_\_\_

Primary Beneficiary (name, relationship and percentage)  
Romero Trust 100%

Contingent Beneficiary (name, relationship and percentage)

Will this policy replace or change any existing life insurance or annuity in force?  Yes  No

Does the applicant have existing life insurance policies or annuity contracts other than group insurance in force?  Yes  No

Company Names	Face Amount	Year Issued	To Be Replaced?
State Farm	500000	4/25/2008	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Trustmark Life	100000	7/1/2020	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No

Do you have an application pending in another company?  Yes  No

Have you ever had any life or health insurance declined, postponed or offered other than as applied for?  Yes  No

Is Proposed Insured a U.S. Citizen?  Yes  No

Has Proposed Insured used tobacco in any form in the past 12 months?  Yes  No 36 months?  Yes  No 60 months?  Yes  No

Special Request:  
The falsity of any statement in the application shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of risk or the hazard assumed by the insurer.

Authorization To Obtain And Disclose Information: I (we) hereby authorize: any licensed physician or medical practitioner; any hospital, clinic or other medical or medically related facility; any insurance company and the Medical Information Bureau, to give Protective Life Insurance Company, its affiliates, or their reinsurers or the Medical Information Bureau, any records or knowledge of me or my health. This authorization is valid for two years from the date this form is signed. An exact copy of this authorization is as valid as the original. I (we) have read all the questions and answers in the application. All responses are true and complete to the best of my (our) knowledge and belief. I (we) have received the notification about the Federal Fair Credit Reporting Act and the Medical Information Bureau. No coverage will be in effect until: a full application has been signed by the proposed insured; and a policy has been issued; and the full first premium has been received by the company; and any amendments are signed. Any coverage will be subject to the terms and conditions of the policy.

Hollister, CA  
Signed at: (city and state) \_\_\_\_\_  
2/16/21  
Date signed: (month/day/year) \_\_\_\_\_

Signature of Proposed Insured (if age 18 or over) \_\_\_\_\_  
Signature of Owner/Applicant, if other than Proposed Insured \_\_\_\_\_

Agent: To the best of your knowledge will this policy replace or change any existing life insurance or annuity policies? (If "Yes", complete any required replacement forms.) \_\_\_\_\_  Yes  No  
Has the Owner been provided an illustration which conforms to this application? If "No", agent hereby certifies that no illustration was used in connection with the solicitation of the policy applied for. \_\_\_\_\_  Yes  No  
Is there any third party other than the proposed insured that will obtain any ownership rights on any policy issued as a result of this application? \_\_\_\_\_  Yes  No

Eric Holtz T06R674  
Print Agent's Name/Social Security Number or Agent Code \_\_\_\_\_  
800-325-8907  
Agent's Telephone Number \_\_\_\_\_

Agent's Signature \_\_\_\_\_ Date 2/16/21  
Agent's Email Address eric@ecoholtz.com



Protective Life 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): Jesus Romero

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?<br>If Yes, complete the "Statement of Owner Intent" (Application Supplement - Part II) | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |
| (2) Will any portion of the initial or future premiums be borrowed, loaned or otherwise financed?<br>If Yes, complete the "Premium Financing Disclosure" (Disclosure and Acknowledgement)   | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |
| (3) Will a trust, including family trust, own this policy?<br>If Yes, complete the "Trust Certification" (Application Supplement - Part III)  | <input checked="" type="checkbox"/> | <input type="checkbox"/>            |
| (4) Is the Proposed Insured age 65 or older AND total coverage applied for across all Protective companies \$1,000,000 or more?<br>If Yes, complete the "Statement of Owner Intent" (Application Supplement - Part II)  | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |

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 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 and is subject to the applicable Fraud Statement as provided in the Application for Life Insurance.

Signed in California, this 11 day of February, 2021  
(State) (Month) (Year)

Signature(s) of Proposed Insured(s): X [Signature]

Signature(s) of Owner(s)/Trustee(s): X \_\_\_\_\_  
(provide officer's title if policy is owned by a corporation)

Signature of Witness: X \_\_\_\_\_

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: Holxster CA Date: 2/16/21  
(City and State)

X [Signature] Producer Signature Eric Holtz Producer Name (Print)

**TEMPORARY LIFE INSURANCE RECEIPT**

THIS RECEIPT PROVIDES A LIMITED AMOUNT OF LIFE INSURANCE COVERAGE, FOR A LIMITED PERIOD OF TIME, SUBJECT TO THE TERMS OF THIS RECEIPT.

Premium payment in the amount of \$ 500000 is made for Life Insurance on each person proposed for insurance. ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO THE INSURANCE COMPANY - DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.

**QUALIFYING SCREENING QUESTIONS**

<b>1</b>	Has any person proposed for insurance in this application: a. within the past 90 days been admitted to a hospital or other medical facility, been advised to be admitted, or had surgery performed or recommended? ..... b. within the past 2 years, been treated for heart trouble, stroke, or cancer, or had such treatment recommended by a physician or other practitioner? .....	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
<b>2</b>	Is any person proposed for insurance in this application under 15 days of age or over the age of 80 years (nearest birthday)?.....	<input type="checkbox"/>	<input checked="" type="checkbox"/>
If any of the above questions, including any subpart thereof, is answered YES or LEFT BLANK, no representative of Protective Life Insurance Company is authorized to accept a premium and NO COVERAGE will take effect under this Receipt. No one is authorized to accept a premium on Proposed Insureds under 15 days of age or over age 80 and NO COVERAGE will take effect under this Receipt.			

**TERMS AND CONDITIONS**

**AMOUNT OF COVERAGE — \$1,000,000 OVERALL MAXIMUM FOR ALL POLICIES, APPLICATIONS, AND RECEIPTS**  
 If a premium has been accepted by Protective Life Insurance Company for an application for Life Insurance and any person proposed for Insurance in such application dies while this temporary life receipt is in effect, Protective Life will pay, subject to the conditions and limitations contained herein, to the beneficiary designated in such application a death benefit equal to the lesser of:  
 a. the amount of life insurance applied for under such application, or  
 b. the greater of (i) \$1,000,000 less the amount of death benefits due and payable by virtue of the insured's death under any other Protective Life policy, application, temporary receipt or the like, or (ii) \$50,000.  
**In no event shall Protective Life's liability under this Receipt exceed \$1,000,000. Any money received will be refunded.**

**DATE COVERAGE BEGINS**  
 Temporary Life Insurance under this Receipt will begin on the date this Receipt is executed and the application has been completed.

**DATE COVERAGE TERMINATES**  
 Temporary Life Insurance under this Receipt will terminate automatically on the earlier of:  
 a. the date that Protective Life mails notice of termination of coverage and refund of the advance premium payment to the Applicant at the address designated in this application, or  
 b. the date that Protective Life approves for issue the policy applied for at the rate class and for the amount indicated in this application.  
 In no event shall coverage be provided under this Receipt if the policy applied for has been issued.

**LIMITATIONS**  
 This receipt does not provide benefits for disability. If Temporary Life Insurance is terminated in accordance with (a) above, Protective Life's liability under this Receipt is limited to a refund of the premium payment made. If any person proposed for insurance dies by suicide, Protective Life's liability under this Receipt is limited to a refund of the payment made. There is no coverage under this Receipt if the check submitted as payment is not honored by the bank on first presentation. No one is authorized to waive or modify any of the provisions of this Receipt. **COVERAGE UNDER THIS RECEIPT SHALL BE VOID IF THERE IS FRAUD OR A MATERIAL MISREPRESENTATION IN THE APPLICATION FOR LIFE INSURANCE OR IN ANY ANSWER TO THE QUALIFYING SCREENING QUESTIONS OF THIS RECEIPT.**  
 I (WE) HAVE RECEIVED A COPY OF AND HAVE READ THIS TEMPORARY LIFE INSURANCE RECEIPT AND DECLARE THAT THE ANSWERS ARE TRUE TO THE BEST OF MY (OUR) KNOWLEDGE AND BELIEF. I (WE) UNDERSTAND AND AGREE TO ALL ITS TERMS.

Signed At Hollister CA (X) [Signature]  
 Date 2/16/21 (X) Proposed Insured 1 (Sign Name in Full)  
 (X) [Signature] Proposed Insured 2 (Sign Name in Full)  
 (X) [Signature] Witnessed by Agent  
Eric Holtz Agent Name (Printed)  
301 Yamato RD Suite 2222 Street Address  
Boca Raton FL 33431 City, State and Zip  
 (X) Signature of Parent or Guardian, if Minor  
 (X) \*Applicant/Owner, if Other than Proposed Insured  
 \*If owner is Corporation, Partnership or Trust, a Corporate Officer, Partner or the Trustee must sign and state title.

**NOTICE TO APPLICANT:**

You should retain the copy of this Receipt. The original will be retained by Protective Life. If you do not hear from us regarding the insurance applied for within 100 days from the date of this Receipt, notify us at Protective Life Insurance Company, P.O. Box 830619, Birmingham, Alabama 35283-0619, Attention: Vice President, Underwriting Services.

ORIGINAL - HOME OFFICE      COPY - APPLICANT