

POLICY ASSEMBLY PAGE

DCLCI 05/24/24
B01130915
ENP93 FL
CARLOS BLANCO SANCHEZ
PRINT ID: LAN390 - M 08803-LCM@P83 -05/24/2024-13055074-DCLCI

Partial Print Includes:

Home Office Copy Includes:

Full Policy Print Includes (see reverse):

DSOLBLUE	00000	DCU0VLY1	00001
LBLPT0V	00000	DSOLFUF	00000
DCU0VLY1	00001	EPD06PL	00000
DCU0VLY1	00001	PL104	00000
DCU0VLY1	00001	U350	00000
DCU0VLY1	00001	PDA14	00000
A447C2FL	00000	DCU0VLY1	00001
GEICOLTR	00000	FLSA	00000
PLPN21	00000	DCU0VLY1	00001
DSOL900S	00000	DCU0VLY1	00001
RTENVPO1	00000	DSOLBNDP	00000
CVRALL	00000	POLOVLY	00001
DCU0VLY1	00001	T21RFFL	00000
POLOVLY	00001	DCU0VLY1	00001
S21R23	00000	DCU0VLY1	00001
A447C1FL	00000	DCU0VLY1	00001
CBIS	00000	CBIS	00000
CBIS	00000	CBIS	00000
CBIS	00000	CBIS	00000
CBIS	00000	CBIS	00000
CBIS	00000	CBIS	00000
CBIS	00000	CBIS	00000
CBIS	00000	CBIS	00000
FLID	00000	DCU0VLY1	00001
DCU0VLY1	00001	POLOVLY	00001
DCU0VLY1	00001	T21RFL	00000
POLOVLY	00001	L637FL	00000
T21RBFL	00000	DCU0VLY1	00001
LETTER	00000	DCU0VLY1	00001
T21CD1	00000	DCU0VLY1	00001
T21CD2	00000	T21CD3	00000
DCU0VLY1	00001	BG18	00000

Protective 
Life Insurance Company

PO BOX 830570
BIRMINGHAM, AL 35283

B01130915 665

66395

000T02N946
DOYLE INSURANCE INC
840 US HIGHWAY ONE
STE 435
NORTH PALM BEACH FL 33408

B01130915
LabelForm LBLPTOV

Mailmode 2nd Day Air

LAN390 - M 08803-LCM@P83 -05/24/2024 -13055074 -DCLCI

PROTECTIVE LIFE INSURANCE COMPANY

MAY 24, 2024

Re: Policy Number: B01130915
Policy Effective Date: JUNE 23, 2024
Insured: CARLOS BLANCO SANCHEZ

Thank you for allowing Protective Life Insurance Company the opportunity to service your insurance needs. Please review the enclosed life insurance policy carefully.

The following items are required by Protective Life Insurance Company:

- * Amendment Sign, Date & Return All Pages
- * Delivery Date Expires Delivery Date: 07/08/24
- * Premium Due \$33,071.60

PLEASE NOTE: Protective Life Insurance Company CANNOT accept cash or cash equivalents (money orders, traveler's check, cashier's check, third party check or agency checks).

All items should be sent to Protective Life Insurance Company in the enclosed envelope before the delivery date expires. Formal coverage will not begin until the above requirements are received.

Any forms that require a witness signature should be witnessed by a disinterested third party.

For assistance, please contact us at 800-366-9378.

Thank you for the opportunity to serve your insurance needs.

New Business Department
Protective Life Insurance Company



**PRE-AUTHORIZED WITHDRAWAL AGREEMENT (PAW) - FOR DRAFTING OF PREMIUM PAYMENTS
and ELECTRONIC BILLING OPTIONS**

B01130915 667

(1) AUTO-PAY OPTION

The person paying the premium on the life insurance policy listed below must complete the Auto-Pay section of this agreement. If choosing to allow Protective Life to draft the initial and/or subsequent premiums you:

- authorize Protective Life Insurance Company to draft the account listed below to pay premiums;
- understand that no coverage exists until all outstanding requirements are received by the Home Office.

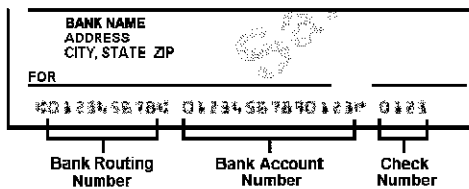
Policy Number	Name of Insured	Name of Policy Owner

Type of Account: Checking Savings

Name of Bank: _____

Routing Number: _____

Account Number: _____



← This sample check illustrates the location of routing and account numbers

Premium Frequency: Monthly (Only available by PAW) Quarterly Semi-Annual Annual

INITIAL PREMIUM

- DRAFT IMMEDIATELY
- PAY BY CHECK

FUTURE PREMIUMS

- DRAFT DATE _____ (Must be 1st - 28th)
- BILL FOR FUTURE PREMIUMS

(2) ELECTRONIC BILLING OPTION (not available on Monthly premiums)

By checking this box, I confirm that I am electing to OPT-in for Electronic billing. I consent to the paperless delivery of my documents. I understand by selecting this option that I will not receive paper copies of my billing statements, unless I make a request for them or withdraw this consent.

Email Address

Premium Payor - Depositor (Please Print)

Date

Payor Signature

LAN390 - M 08803-LCM@P83 -05/24/2024 - 13055074 -DCLCI



PROTECTIVE LIFE INSURANCE COMPANY / P. O. BOX 2606 / BIRMINGHAM, ALABAMA 35202

NOTICE OF CHANGE

IN ORDER FOR THIS POLICY TO BE ISSUED CORRECTLY, WE EITHER HAD TO AMEND YOUR POLICY, ADD AN EXCLUSION RIDER OR ASK THE APPLICANT TO COMPLETE A STATEMENT OF HEALTH. IN ORDER TO PLACE YOUR POLICY IN FORCE, WE NEED YOU TO SIGN AND RETURN THE FORM THAT IS ENCLOSED. WE HAVE PROVIDED A RETURN ENVELOPE FOR YOUR CONVENIENCE. A COPY OF THE FORM YOU ARE RETURNING IS IN YOUR POLICY.

B01130915 668

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Life Insurance Company

Protective Life Insurance Company
A Stock Company

P. O. Box 2606; Birmingham, Alabama 35202
1-800-866-9933

POLICY DELIVERY ACKNOWLEDGEMENT

POLICY NUMBER: B01130915

INSURED: CARLOS BLANCO SANCHEZ

The date of issue shown on the schedule page of your policy may have been forward-dated up to thirty (30) days from the date your policy was printed and issued at the Company's home office, unless this forward-dating results in an age change, in which case the policy has been forward-dated only to one day before your age change would occur.

The coverage under your policy goes into effect under the policy terms as soon as your policy is delivered and your first modal premium is paid and any other delivery requirements received, even if this is before the date of issue shown on your policy.

You are entitled to request a different date of issue for your policy. The premiums are billed from this date and if you are paying your first premium now, today is the first day you have coverage. If you are paying your first premium today and your policy is dated earlier than today's date, you are paying premiums for a period of time during which your policy did not provide insurance coverage. You are not required to pay premiums for a period of time for which your policy did not provide insurance coverage.

B01130915 669

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Protective Life Insurance Company

P. O. Box 2606
Birmingham, AL 35202
Phone: (800) 866-9933
www.myaccount.protective.com

MAY 24, 2024

Policy Number: B01130915
Insured: CARLOS BLANCO SANCHEZ

Dear CARLOS BLANCO SANCHEZ :

Thank you for selecting Protective for your new life insurance policy. Enclosed are your policy materials. Our goal is to provide easy access to all your documentation and to answer any questions you might have at this time. With that in mind, please take a minute to review the following information.

Understanding Your Term Life Insurance Contract

The enclosed packet contains:

- General policy and supplemental information
- Any endorsements or riders included with your policy
- A policy schedule highlighting details such as your policy number, policy amount, premium and rate class
- A copy of your application
- A privacy notice outlining how we manage your personal information

What should I do with this information?

While you'll have access to much of this information online, we recommend keeping a copy of this packet with your other important financial documents. It may be helpful to you or your family in the future to have all your information in one location.

Something else to note for the future: Because this policy is a term life insurance policy, it offers a specific amount of coverage for a set period of time based on the length you select. The technical name for this is the initial level benefit period, and you can find information about it in your enclosed policy schedule. During this period, your coverage amount and your premium payments remain the same. However, when this initial period ends many years from now, your coverage amount will remain the same but your premiums will begin increasing. We recommend that as your policy nears the end of your initial level benefit period you take the time to evaluate your life insurance needs and options, and we'll be happy to help with that process when the time comes. We'll remind you of your period end date in your annual statements to help you keep track of this as well, but it is also something good to remember as you develop your long-term financial plans.

Manage Your Policy Online

With online access, managing your policy has never been more convenient.

From making a premium payment to changing beneficiaries, you can do it online. And now you can sign up for payment alerts, automatic payments, electronic billing and more. Sign up today at www.myaccount.protective.com.

Again, we'd like to thank you for choosing Protective. If you have any questions about this packet, or if we can be of service in the future please contact us at 1-800-866-9933. We're always happy to help.

Sincerely,

Protective Life

B01130915 671

LAN390 - M 08803-LCM@P83 -05/24/2024-13055074-DCLCI

PROTECTIVE LIFE INSURANCE COMPANY

A Stock Company; Domiciled in Tennessee
www.protective.com

P. O. Box 2606; Birmingham, Alabama 35202; (800) 866-9933

NOTIFICATION OF RIGHT TO NAME A SECONDARY ADDRESSEE

Under Florida law, you have the right to designate a secondary addressee to receive a notice concerning the potential lapse of your policy. The notice to the secondary addressee will be sent when the policy has been in force for at least one year, the Insured is 64 years or older, and the policy is in danger of lapsing.

If you wish to name a secondary addressee, please call us at 1-800-866-9933, or fax us at 205-268-3402, or write us at: P.O. Box 12687, Birmingham, AL 35202-6687.

Please Print the Following Information:

Policy Number (if known) _____

Policyowner's Name _____

Insured's Name _____

Secondary Addressee

NAME: _____

ADDRESS: _____

B01130915 672

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IMPORTANT PRIVACY CHOICES FOR CONSUMERS

**Protective Life Insurance Company
P.O. Box 2606
Birmingham, Alabama 35202**

B01130915 673

Protecting the privacy of information about our customers is important. This notice tells you how we treat information about our customers. We treat information about our former customers the same as we treat information about our current customers.

We get most of the information we need from customer applications and other forms. If a customer authorizes it, we may get information from other sources. For example, when a person applies for life insurance we may ask for permission to get information from

- Insurance support organizations and
- Consumer reporting agencies.

We also get information as we process customer transactions.

The information we may have includes

Identifying Information such as

- Name,
- Address,
- Telephone Number,
- Demographic Data;

Financial Information such as

- Credit History,
- Income,
- Assets,
- Other Insurance Products; and

Health Information such as

- Medical history and
- Other factors affecting insurability.

We use the information for business and marketing purposes, such as

- Processing applications, claims, and transactions,
- Servicing your business,
- Offering you additional products and services, and
- Conducting research related to our business.

We share the information with affiliates and others who provide services to help us process or administer our business. For example, we may share information with others who

- Print our customer statements,
- Help us underwrite life insurance applications,
- Help us process claims, and
- Conduct surveys, analyze information, or help us market our own products to you.

Protective Life Insurance Company
West Coast Life Insurance Company
Protective Life and Annuity Insurance Co.
ProEquities, Inc.
First Protective Insurance Group, Inc.
Protective Property & Casualty Insurance Company

Western Diversified Services, Inc.
The Advantage Warranty Corporation
First Protection Corporation
Protective Administrative Services, Inc.
Western General Dealer Services, Inc.
First Protection Corporation of Florida
National Warranty of Florida, Inc.
Western General Warranty Corporation

Western General Warranty, Inc.
Lyndon-DFS Administrative Services Inc.
Acceleration National Service Corporation
Warranty Business Services Corporation
United States Warranty Corporation

RESTRICT INFORMATION SHARING WITH COMPANIES WE OWN OR CONTROL (AFFILIATES) AND RESTRICT INFORMATION SHARING WITH OTHER COMPANIES WE DO BUSINESS WITH TO PROVIDE FINANCIAL PRODUCTS AND SERVICES

Unless you opt out, our affiliates (including the list below) may use the information we share with them to market to you. We may also share information with other companies so that we can jointly market a product or service to you.

You can opt out by calling the toll-free number 1-855-907-6137.

ADDITIONAL INFORMATION

We will not share information with anyone else unless we have your permission, or we are allowed or required by law to disclose it.

We maintain physical, electronic and procedural safeguards to protect it. Access to customer information is limited to people who need access to it in order to do their jobs.

We require that our service providers limit their use of the information we share and keep it confidential.

You should know that your insurance sales agent is independent. The use and security of information an agent gets is his or her responsibility. Please contact your agent if you have questions about his or her privacy policy.

We have the right to change our Privacy Policy. If we make a material change to our Privacy Policy, we will notify you before we put it into effect.

CONTACT INFORMATION

If you have questions about our privacy policy, please call us at 1-855-907-6137 or write to us at

Protective Life Insurance Company
P.O. Box 2606
Birmingham, Alabama 35202

CALIFORNIA RESIDENTS: To learn about our information practices and your rights under the California Consumer Privacy Act ("CCPA"), visit <http://www.protective.com/privacy-policy>

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PLEASE COMPLETE DELIVERY REQUIREMENTS AND RETURN IN THIS ENVELOPE.

B01130915 674

FOLD ALONG PERFORATED LINE DIRECTLY BELOW THESE INSTRUCTIONS AND REMOVE THIS INSTRUCTION FLAP.

OPEN THE ENVELOPE FROM THE BACK ALONG THE FOLD LINE.

INSERT DELIVERY REQUIREMENTS/FORMS. REMOVE ADHESIVE, FOLD AND SEAL.

ADD POSTAGE AND MAIL

PLACE
STAMP
HERE

PROTECTIVE LIFE INSURANCE COMPANY
UNDERWRITING SERVICES
P O BOX 8306 19
BIRMINGHAM AL 35283-0619

PROTECTIVE LIFE INSURANCE COMPANY

A Stock Company; Domiciled in Tennessee
www.protective.com

P. O. Box 2606; Birmingham, Alabama 35202; (800) 866-9933

LIFE INSURANCE POLICY

INSURED: CARLOS BLANCO SANCHEZ

POLICY NUMBER: B01130915

This is a legal contract (the "Policy") between the Owner (also referred to as "you" or "your") and Protective Life Insurance Company (also referred to as "the Company", "we", "us", or "our"). Please read it carefully.

Subject to the terms of this Policy, we will pay the Death Benefit Proceeds to the Beneficiary upon due proof the Insured died while this Policy was in force.

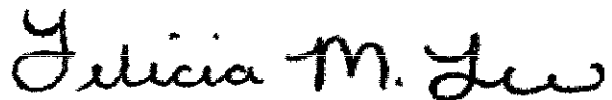
The terms of this Policy are contained on this and the following pages.

YOU HAVE THE RIGHT TO CANCEL THIS INSURANCE POLICY. If you decide not to keep this Policy, return it to us or to the agent who sold it to you within thirty (30) days after it is first delivered to you. We will cancel the Policy and promptly refund any premium paid, so the Policy will be as if it had never been issued.

NOTICE: For inquiries or information about Policy coverage or for assistance in resolving complaints, the Owner may contact the agent who sold the Policy or may call the Company at 1-800-866-9933.



Richard J. Bielen
President



Felicia M. Lee
Secretary

TERM LIFE INSURANCE POLICY

RENEWABLE TERM COVERAGE TO AGE 95

POLICY IS CONVERTIBLE

NON-PARTICIPATING - DOES NOT PAY DIVIDENDS

A DEATH BENEFIT IS PAYABLE IF THE INSURED DIES BEFORE THE POLICY END DATE

Policy **B01130915**

TL-21R-FL 11-20

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POLICY SCHEDULE

POLICY NUMBER: B01130915

INSURED:
CARLOS BLANCO SANCHEZ

AGE:
40

GENDER CLASS:
MALE

PREMIUM CLASS:
STANDARD - NON-TOBACCO

POLICY EFFECTIVE DATE:
JUNE 23, 2024

POLICY END DATE:
JUNE 23, 2079

**STANDARD LATEST
CONVERSION DATE:**
JUNE 23, 2042

INITIAL FACE AMOUNT:
\$30,000,000

MINIMUM INITIAL FACE AMOUNT:
\$100,000

OWNER:
CARLOS BLANCO SANCHEZ

SCHEDULE OF BENEFITS AND PREMIUMS ON THE POLICY EFFECTIVE DATE

BENEFIT	INITIAL BENEFIT AMOUNT	INITIAL ANNUAL PREMIUM	INITIAL PREMIUM PERIOD
LIFE INSURANCE	\$30,000,000	\$33,071.60 *	20 YEARS

***INCLUDES POLICY FEE OF \$65.00**

TOTAL PREMIUM FOR ALL BENEFITS ON THE POLICY EFFECTIVE DATE

	ANNUAL	SEMI-ANNUAL	QUARTERLY	MONTHLY PRE-AUTHORIZED CHECK
PER PAYMENT	\$33,071.60	\$17,197.23	\$8,929.33	\$2,811.09
PER YEAR	\$33,071.60	\$34,394.46	\$35,717.32	\$33,733.08

THE AMOUNTS SHOWN ABOVE AS "TOTAL PREMIUM FOR ALL BENEFITS ON THE POLICY EFFECTIVE DATE" INCLUDE THE POLICY PREMIUM, POLICY FEE, IF ANY, AND PREMIUM FOR ANY RIDERS ATTACHED TO THE POLICY.

POLICY SCHEDULE (CONTINUED)

POLICY NUMBER: B01130915 **INSURED:** CARLOS BLANCO SANCHEZ

SCHEDULE OF GUARANTEED ANNUAL PREMIUMS AND FACE AMOUNTS

POLICY YEAR	AGE	ANNUAL PREMIUM	FACE AMOUNT	POLICY YEAR	AGE	ANNUAL PREMIUM	FACE AMOUNT
1	40	\$33,071.60	\$30,000,000	29	68	\$965,465.00	\$30,000,000
2	41	33,071.60	30,000,000	30	69	1,068,065.00	30,000,000
3	42	33,071.60	30,000,000	31	70	1,188,665.00	30,000,000
4	43	33,071.60	30,000,000	32	71	1,331,765.00	30,000,000
5	44	33,071.60	30,000,000	33	72	1,502,765.00	30,000,000
6	45	33,071.60	30,000,000	34	73	1,701,665.00	30,000,000
7	46	33,071.60	30,000,000	35	74	1,928,465.00	30,000,000
8	47	33,071.60	30,000,000	36	75	2,181,365.00	30,000,000
9	48	33,071.60	30,000,000	37	76	2,458,565.00	30,000,000
10	49	33,071.60	30,000,000	38	77	2,763,665.00	30,000,000
11	50	33,071.60	30,000,000	39	78	3,101,165.00	30,000,000
12	51	33,071.60	30,000,000	40	79	3,486,365.00	30,000,000
13	52	33,071.60	30,000,000	41	80	3,930,965.00	30,000,000
14	53	33,071.60	30,000,000	42	81	4,451,165.00	30,000,000
15	54	33,071.60	30,000,000	43	82	5,033,465.00	30,000,000
16	55	33,071.60	30,000,000	44	83	5,711,165.00	30,000,000
17	56	33,071.60	30,000,000	45	84	6,496,865.00	30,000,000
18	57	33,071.60	30,000,000	46	85	7,410,365.00	30,000,000
19	58	33,071.60	30,000,000	47	86	8,467,865.00	30,000,000
20	59	33,071.60	30,000,000	48	87	9,684,665.00	30,000,000
21	60	142,265.00	30,000,000	49	88	11,060,765.00	30,000,000
22	61	246,965.00	30,000,000	50	89	12,553,865.00	30,000,000
23	62	351,365.00	30,000,000	51	90	14,146,265.00	30,000,000
24	63	456,065.00	30,000,000	52	91	15,781,565.00	30,000,000
25	64	560,765.00	30,000,000	53	92	17,416,865.00	30,000,000
26	65	665,465.00	30,000,000	54	93	19,034,165.00	30,000,000
27	66	769,865.00	30,000,000	55	94	20,552,465.00	30,000,000
28	67	874,565.00	30,000,000				

THE TOTAL PREMIUM WILL DECREASE BY THE AMOUNT OF THE RIDER PREMIUM IF A BENEFIT TERMINATES BEFORE THE POLICY END DATE.

BASIS OF RESERVE COMPUTATION: STATUTORY RESERVES ARE BASED ON MORTALITY RATES FROM THE SEX-DISTINCT, SMOKER OR NONSMOKER 2017 COMMISSIONERS STANDARD ORDINARY (CSO) ULTIMATE, AGE NEAREST BIRTHDAY MORTALITY TABLES AND AT THE CURRENT STATUTORY VALUATION INTEREST RATE.



AMENDMENT TO APPLICATION WITH HEALTH STATEMENT

NAME OF INSURED CARLOS BLANCO SANCHEZ

POLICY B01130915

The application to PROTECTIVE LIFE INSURANCE COMPANY for the policy named above is hereby amended by the undersigned to conform in every respect to any and all changes indicated below:

Table with 3 columns: Amount of Insurance: \$30,000,000; Plan of Insurance: TERM LIFE INSURANCE; Premium Payable: \$33,071.60 ANNUAL

Other Changes:

Part II Question (#1b) shall be answered: Saw Dr. Ibraheim for lab work on 4/25/2024. Only lab work was done, no physical exam or other testing performed.

Part II Question (#4b) shall be answered: Saw Dr. Ibraheim in 2023 for general wellness. Took supplements to build muscle but discontinued use of the supplements in 2023.

Application Section #(IV), Question #(1). The total amount of insurance currently in force and applied for with all companies including any coverage being replaced or whether owned by the proposed insured(s), another person or entity is \$61,535,024.

Policy issued with Non-tobacco rates.

HEALTH STATEMENT: I represent that I have not consulted any physician or other practitioner since the date of my medical examination (or date I signed the last application with Protective Life Insurance Company, if no medical examination was required). It is further agreed that, except as stated above, all insured persons are in the same health as that stated in the last application, or medical examination with Protective Life Insurance Company.

It is agreed by the undersigned that the changes shown above shall be an amendment to and form a part of the application and the policy, and that the changes shall be binding on any person who shall have or claim any interest in the policy. A copy of this form shall be as valid as the original.

Any person knowingly and with intent to injure, defraud, or deceive any Insurer files a statement of claim or an application containing any false, or misleading information is guilty of a felony of the third degree.

Signed at _____ this _____ day of _____, 20____

X _____

X _____ Witness to Signature(s) Signature of The Insured(s) (Not required for ages under 18)

X _____

X _____ Signature of Adult Applicant/Owner(s) (if other than Insured)

If Corporation - full name of Corporation and Signature of officer other than the insured. By: X _____

PERMANENT POLICY COPY

IMPORTANT NOTICE

If any change is incorrect or incomplete, correct information should be written on this form. If any change is made, the policy and this form must be returned to the Company. No insurance will take effect until such changes have been reviewed and accepted by the Company.

B01130915 678

LAN390 - M 08803-LCM@P83 -05/24/2024-13055074-DCLCI

INDIVIDUAL LIFE INSURANCE APPLICATION

SECTION I: INSURED AND OWNER INFORMATION

1. PROPOSED INSURED

Carlos Blanco Sanchez
Name (First, Middle, Last)
Male
Gender
02/17/1984
Date of Birth
Spain
Birth State
Married
Marital Status
B452100840570 FL
Driver's License Number and State
269-45-6004
Social Security Number

Home Phone
Work Phone
(954)895-3835
Cell Phone
Address 1 (Street or P.O. Box Number)
445 Grand Bay Dr,
Address 2 (City, State, Zip Code)
Key Biscayne FL 33149
Number of Years at Address
chartybls@gmail.com
Email Address

2. SURVIVORSHIP PRODUCTS ONLY

(Provide Proposed Insured 2 Name and Date of Birth below. An additional application must be completed for the Proposed Insured 2.)

Proposed Insured 2 Name

Proposed Insured 2 Date of Birth

3. EMPLOYMENT INFORMATION

ESP Apartments
Employer's Name
1395 Brickell Ave, Ste 620
Address 1 (Street or P.O. Box Number)
Miami, FL 33131
Address 2 (City, State, Zip Code)
Founder CEO - Chairman
Occupation

+5
Number of Years with Employer
\$4,000,000.00
Annual Income
-
Spouse/Domestic Partner Annual Income
\$77,000,000.00
Net Worth

4. OWNER

(If other than Proposed Insured, must complete information below. If Trust, include Name and Date of Trust.)

Same as Insured
Owner's Name or Name of Trust
Date of Trust (if applicable)
Birthdate Phone Number
Relationship to Proposed Insured

Social Security Number/Taxpayer I.D. Number
Address 1 (Street or P.O. Box Number)
Address 2 (City, State, Zip Code)
Email Address

JOINT OWNER

(If applicable.)
Joint Owner's Name or Name of Trust
Date of Trust (if applicable)
Birthdate Phone Number
Relationship to Proposed Insured

Social Security Number/Taxpayer I.D. Number
Address 1 (Street or P.O. Box Number)
Address 2 (City, State, Zip Code)
Email Address

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LAN390 - M 08803-LCM@P83 -05/24/2024 -13055074 -DCLCI

041724 16:18:44

SECTION VI: PERSONAL HISTORY

(If additional space is needed, use Section VII and follow the directions provided.)

1. Has the Proposed Insured used tobacco or nicotine of any kind over the last 5 years? Yes No

- | Type | Frequency | Date Last Used |
|---|-----------|---|
| 2. Has the Proposed Insured consulted a physician or had treatment for the use or possession of: (If Yes, complete the appropriate questionnaire for Alcohol and Drug Use.) | | |
| A. Alcohol? | | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| B. Narcotics, stimulants, sedatives, hallucinogenic drugs? | | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 3. In the past 5 years, has the Proposed Insured been convicted of (I) two or more moving violations, (II) driving under the influence of alcohol or other drugs, or (III) had driver's license suspended or revoked? | | |
| | | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 4. Has the Proposed Insured ever been convicted of, or pled guilty or no contest to a felony, or had any such charge pending against them? | | |
| | | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 5. Has the Proposed Insured flown as a pilot, student pilot or crew member, or intend to fly as such within the next 2 years? (If Yes, complete the Aviation Questionnaire.) | | |
| | | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 6. Has the Proposed Insured been a member of, or applied to be a member of, or received a notice of required service in the armed forces, reserve, or National Guard? (If Yes, provide details below. If on active duty, please complete the Military Questionnaire.) | | |
| | | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |

- | Branch of Service | Rank | Duties | Mobilization Category | Current Duty Station |
|--|------|--------|-----------------------|---|
| 7. Has the Proposed Insured engaged in any of the following activities in the past 2 years? (If Yes, complete the appropriate questionnaire.) | | | | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| <input type="checkbox"/> Motor Vehicle Racing <input type="checkbox"/> Scuba Diving <input type="checkbox"/> Hang Gliding <input type="checkbox"/> Mountain/Rock Climbing <input type="checkbox"/> Sky Diving <input type="checkbox"/> Parachuting | | | | |
| 8. Is the Proposed Insured a U.S. citizen? (If No, provide details below and complete the Foreign National Questionnaire.) | | | | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |

- | Spain | E2 | 12/02/2026 | +3 years |
|---|-----------|-----------------|---|
| Country of Citizenship | Visa Type | Expiration Date | Length of U.S. Residency |
| 9. Has the Proposed Insured traveled or resided in Afghanistan or Iraq in the past 2 years? (If Yes, provide details below and complete the Foreign Travel and Residence Supplement.) | | | |
| | | | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |

- Travel Details
10. Does the Proposed Insured intend to travel or reside in Afghanistan or Iraq in the next 12 months? (If Yes, provide details below and complete the Foreign Travel and Residence Supplement.) Yes No

To Where	Why
When	For How Long

11. Has the Proposed Insured filed for or declared bankruptcy in the past ten (10) years? (If Yes, provide details below.) Yes No

Type of Bankruptcy (Chapter)	Date Filed	Date of Discharge or Reorganization	Status

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SECTION VII: SPECIAL REMARKS AND DETAILS

(For each question that requires additional information, provide the section number, question number, date, details or reason. Where applicable, also include any attending physician, hospital, or medical facility name, address, and phone number.)

[Empty box for special remarks and details]

DECLARATIONS

I have read or have had read to me the completed application before signing below. I represent that all statements and answers made in all parts of this application are full, complete and true, to the best of my knowledge and belief. It is agreed that:

- All such statements and answers shall be the basis of any insurance issued, and my answers are material to the decision as to whether the risk is accepted by Protective Life.
- No representative or medical examiner can make, alter or discharge any contract, accept risks, or waive Protective Life's rights or requirements.
- Acceptance of a policy by the Owner shall constitute ratification of any changes made by the Company. In those states where it is required, changes as to plan, amount, age at issue, classification or benefits will be made only with the Owner's written consent.
- No insurance shall take effect unless: (I) a policy is delivered to the Owner, (II) the full first premium is paid while the Proposed Insured is alive, and (III) there has been no change in health and insurability from that described in this application. However, if the premium is paid as set forth in the attached Conditional Receipt Agreement or the Temporary Life Insurance Receipt (Collectively known as the "Receipt") and the Receipt is delivered to the Owner, the terms of the Receipt shall apply. No representative or medical examiner has any authority to waive or to alter these terms and conditions or to bind coverage under any other circumstances.
- I have reviewed the attached Receipt and understand and agree that it provides a limited amount of life insurance for a limited period of time, and that such coverage is subject to the terms and conditions set forth in the Receipt.
- The representative taking this application has made no statement or representation different from, contrary to or in addition to these Declarations and the terms and conditions of the attached Receipt.

IMPORTANT INFORMATION ABOUT IDENTIFICATION VERIFICATION

To help the government fight the funding or terrorism and money laundering activities, Federal Law requires all financial institutions to obtain, obtain, verify, and record information of its customers. We may ask for information or identifying documents that will allow us to verify the identity of our customers.

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 in the third degree.

Signed at: <u>Key Biscayne</u>	<u>FL</u>	<u>4/16/2024</u>
<small>DocuSigned by:</small>	<small>State</small>	<small>Date</small>
(X) <u>Carlos Blanco Sanchez</u> <small>Signature of Proposed Insured</small>	(X) _____ <small>Signature of Owner (if other than Proposed Insured)</small>	
(X) <u>Carlos Machado</u> <small>Signature of Agent</small>	(X) _____ <small>Signature of Joint Owner (if applicable)</small>	
<u>Carlos Machado</u> <small>Printed Name of Agent</small>	<u>W074303</u> <small>FL License I.D. Number</small>	

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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. In this form, family means the Owner or Insured's spouse and anyone who is related to the Owner or Insured or the Owner's or Insured's spouse by the following degree by blood, marriage, divorce, adoption or operation of law: parents, in-laws, grandparents, siblings, children, grandchildren, aunts, uncles, nephews and nieces.

Print Name of Proposed Insured(s): Carlos Blanco Sanchez

- | 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 within 2 years of the effective date of coverage?
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?
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?
If Yes, complete the "Trust Certification" (Application Supplement – Part III) | <input type="checkbox"/> | <input checked="" 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?
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 and are full, complete and true. I (We) understand that the information being provided in this Supplement is being relied upon in considering the application for life insurance.

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.

Signed in FL this 4/16/2024 day of _____, _____ (Year).
(State) (Month)

Signature(s) of Proposed Insured(s): X Carlos Blanco Sanchez 

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

Signature of Witness: X Carlos Machado 

AGENT 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: Fort Lauderdale FL 4/16/2024 W074303
(City and State) Date Florida Agent License Number

X Carlos Machado 
Agent Signature Agent Name (Print)



Application Part II
 Statements Made to Examiner

BO1130915 682

Proposed Insured Cielos Blanco Sanchez Birth Date 07-17-1984
 First Name Middle Initial Last Name

1. a. Name and address of your personal physician? (If none, check box) None
Ibrahim George 2715 North Australian Ave, West Palm Beach FL 33407
 b. Date and reason last consulted? 02-2024 Annual check-up 833-838-4276
 c. What treatment was given or medication prescribed? None

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): _____

6. Have you ever tested positive for exposure to the HIV infection or been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection? Yes No
 Yes No

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

7. a. Are you now under medical treatment or observation? Yes No
 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? Yes No

9. Do you participate in a regular, supervised exercise program, or any organized sport? Yes No

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 45
 Yes No

10. b. Did any die prior to age 60 due to any of these conditions? Yes No

11. Have you ever had military service deferment, rejection or discharge because of a physical or mental condition? Yes No

12. Are you pregnant? Yes No

4. Other than above, have you within the past 5 years:
 a. Had a checkup, consultation, illness, injury, surgery? Yes No
 b. Been a patient in a hospital, clinic, sanatorium or other medical facility? Yes No
 c. Had electrocardiogram, x-ray, other diagnostic test? Yes No
 d. Been advised to have any diagnostic test, hospitalization, or surgery which was not completed? Yes No
 e. Had any mental or physical disorder not listed above? Yes No

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

4a) Hip calcification 2023 consultation
 Dr. Ross Medical Group Coral Gables, FL
 Plasma therapy & Physical Therapy. (8200sw 117 Ave, Miam, FL 33183, 305-279-7687)
 Sports related tear (Tennis)

4a) Dermatological consultation for moles, 02-2024 Mole Removal Dr. Denise +86-503-1602
 470 Biltmore Way, Coral Gables, FL 33134

9) Tennis, gym monday to saturday

10a) Father had throat cancer diagnosed

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? Yes No
 b. Have you ever used narcotics, sedatives, depressants, stimulants or hallucinogens, other than under a doctor's prescription and direction? Yes No
 c. Have you ever been or are you currently a member of any alcohol or drug rehabilitation program? Yes No
 d. Had more than 2 moving violations in the past 3 years? Yes No
 e. Been convicted for reckless driving or driving under the influence of alcohol or drugs within the past 7 years? Yes No
 f. Have you ever been treated for alcohol or drug use? Yes No
 g. Do you or have you ever smoked marijuana? Yes No
 h. Do you or have you ever used cocaine? Yes No
 i. Have you ever been convicted of a felony? Yes No

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. 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.

Signed at Miami (City) FL (State) Date: 04-15-2024

Witness [Signature] (X) _____
 Medical Examiner or Interviewer Signature of person proposed for insurance if age 15 or over, or Parent of proposed insured is under age 15

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MEDICAL EXAMINER'S REPORT

Part III

14. a. Height 5 ft. 07 in.
 Weight 151 lbs.
 b. Did you weigh and measure applicant? Yes No
 c. Is appearance unhealthy or older than stated age? Yes No

Chest (Full Inspiration) 39 in.
 Chest (Forced Expiration) 38 in.
 Abdomen, at Umbilicus 34.5 in.

Applicant's identity was established by:
 Drivers License # R452-100-84-0570
 Social Security # _____
 Other _____

15. Blood Pressure (If Above 140/90 Record Additional Readings.)
 (Record all readings)
 Systolic: 1st 126 2nd 124 3rd 122
 Diastolic (5th phase): 82 80 82

16. Pulse: Exercise if irregular, over 90 or less than 50 per min.
 At Rest 57 After Exercise _____ 3 Minutes Later _____
 Rate _____
 Irregularities per min. None

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

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

Details of Positive Findings by MD

106 at 454/0 and passed away from a heart attack at 591/0

	Murmur 1.	Murmur 2.	
Location	<input type="checkbox"/>	<input type="checkbox"/>	Indicate: Apex by <u>X</u>
Constant	<input type="checkbox"/>	<input type="checkbox"/>	Murmur area by <u>O</u>
Inconstant	<input type="checkbox"/>	<input type="checkbox"/>	Point of greatest intensity by <u>O</u>
Transmitted	<input type="checkbox"/>	<input type="checkbox"/>	Transmission by <u>→</u>
Localized	<input type="checkbox"/>	<input type="checkbox"/>	
Systolic	<input type="checkbox"/>	<input type="checkbox"/>	
Diastolic	<input type="checkbox"/>	<input type="checkbox"/>	
Soft (Gr. 1-2)	<input type="checkbox"/>	<input type="checkbox"/>	
Mod. (Gr. 3-4)	<input type="checkbox"/>	<input type="checkbox"/>	
Loud (Gr. 5-6)	<input type="checkbox"/>	<input type="checkbox"/>	
After exercise:			
Increased	<input type="checkbox"/>	<input type="checkbox"/>	
Absent	<input type="checkbox"/>	<input type="checkbox"/>	
Unchanged	<input type="checkbox"/>	<input type="checkbox"/>	
Decreased	<input type="checkbox"/>	<input type="checkbox"/>	

MCL

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).	<input type="checkbox"/>	<input type="checkbox"/>
(b) Skin (include scars); lymph nodes; varicose veins or peripheral arteries?	<input type="checkbox"/>	<input type="checkbox"/>
(c) Nervous system (include reflexes, gait, paralysis)?	<input type="checkbox"/>	<input type="checkbox"/>
(d) Respiratory system?	<input type="checkbox"/>	<input type="checkbox"/>
(e) Abdomen (include scars)?	<input type="checkbox"/>	<input type="checkbox"/>
(f) Genitourinary system?	<input type="checkbox"/>	<input type="checkbox"/>
(g) Endocrine system (include thyroid and breasts)?	<input type="checkbox"/>	<input type="checkbox"/>
(h) Musculoskeletal system (include spine, joints, amputations, deformities)?	<input type="checkbox"/>	<input type="checkbox"/>

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). Yes No

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 15 day of April (month), 2024 (year)

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

Signature of Examiner [Signature] Telephone No. (786) 220-8420

(Legibly print, type or rubber stamp name of examiner and office address below)
 Name CHRISTY COSSON
 Address 3000 S Dixie Hwy
 City, State & Zip Miami, FL, 33133

1. Name of agent requesting exam Julio Vinciguerra
 2. Name of person examined Carlos Blanco Sanchez
 Address 495 Reickell Ave
 City, State & Zip Miami, FL, 33131

Part 2

Complete questions 5-8 only if applying for business coverage.

5. Purpose of business coverage:

Key Person Buy/Sell Stock Repurchase Creditor Deferred Compensation

Other (explain): _____

6. If buy/sell, is a written buy/sell agreement in effect? (if Yes, please attach a copy) Yes No

Percentage of Ownership	_____ %
Fair Market Value of Company <i>(Provide details on how value was determined in "Remarks" section below)</i>	\$ _____
Are other partners being covered? <i>(Provide details in "Remarks" section below)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Date Business Started	____ / ____ / ____

7. If Creditor:

Name of Lender	
Amount of Loan	\$ _____
Purpose of Loan	
Length of Loan <i>(how many years?)</i>	
Will the Loan be Collaterally Assigned?	<input type="checkbox"/> Yes <input type="checkbox"/> No

8. Financial Details of Business:

	Last Year	Prior Year
Total Assets <i>(cash, accounts receivable, equipment, inventory, etc.)</i>	\$ _____	\$ _____
Total Liabilities <i>(wages/interest/dividends payable, loans, etc.)</i>	\$ _____	\$ _____
Gross Sales or Revenue	\$ _____	\$ _____
Net Income <i>(before taxes)</i>	\$ _____	\$ _____

Remarks (questions 5-8)

Part 3

I agree that 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.

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 in the third degree.

<u>Carlos Blanco Sanchez</u> Signature of Proposed Insured	4/16/2024 Date	Carlos Machado Agent's Name Printed
<u>Carlos Machado</u> Signature of Agent	4/16/2024 Date	W074303 FL License ID Number

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

IMPORTANT! Complete this entire form if you are a Canadian Citizen, or a Non-U.S. Citizen legally residing in the U.S. with a permanent or temporary Visa. If you need additional space for details, please use the Continuation of Information Form.

SECTION I FOREIGN NATIONAL QUESTIONNAIRE

Name: Carlos Blanco Sanchez Policy #: _____

Gender: Male Female Date of Birth: 02/17/1984 U.S.(or Canadian) SSN or T.N: 269-45-6004

English Language Comprehension: Speak Read Write Email Address: charlybls@gmail.com

Country of Current Citizenship: Spain If Dual Citizen, Which Country(ies)? _____

SECTION II

1. Please provide the financial background listed below:

<u>Verifiable Net Worth</u>	<u>Assets (Verifiable)</u>	<u>Liabilities</u>	<u>Net Worth</u>
U.S. Total	\$ <u>91,879,763</u>	\$ <u>15,589,400</u>	\$ <u>76,290,363</u>
Foreign (Non-U.S.) Total	\$ <u>900,000</u>	\$ _____	\$ <u>900,000</u>
Worldwide Total	\$ <u>92,779,763</u>	\$ <u>15,589,400</u>	\$ <u>77,190,363</u>

U.S. Bank or Brokerage Account Information:

Name: Chase Bank Date Account Opened: _____

Address: _____

Name: _____ Date Account Opened: _____

Address: _____

Name: _____ Date Account Opened: _____

Address: _____

2. Other than as described above, do you own personal or business assets or property in the U. S.? If so, please list and describe:

Home Residence / Business (3 properties in USA value of \$43,810,471)

3. Will anyone other than the owner at the time of application obtain any right, title, ownership, or interest in any policy issued on the life of the Proposed insured as a result of this application? Yes No

If Yes, provide details: _____

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3. U.S. Employer: _____
Street Address

_____ *City* _____ *State* _____ *Zip Code*

4. Foreign Employer: _____
Street Address

_____ *City* _____ *State* _____ *Postal Code*

_____ *Foreign Country* _____ *Province* _____ *Region*

5. Visa Type & Symbol: _____

Visa Number: _____

Visa Issue Date: _____ Visa Expiration Date: _____

6. Passport Number: _____ Country Issuing Passport: _____

Passport Issue Date: _____ Passport Expiration Date: _____

SECTION V

ACKNOWLEDGEMENTS:

I acknowledge that I have carefully reviewed this form in its entirety, and that I understand and agree to the following:

- All information is complete, true and correctly recorded.
- All solicitation, underwriting requirements, applications and exams related to the purchase of life insurance products, as well as the completion and signing of the life insurance application must be completed in the United States.
- The delivery and placement of the insurance policy, including delivery by mail, must take place within the United States.
- All premiums shall be paid in U.S. dollars from an existing U.S. bank account.
- Required medical records must be provided in English within the United States.
- A copy of the Green Card (if applicable), Visa and Passport must accompany the application for insurance.
- A complete copy of the Trust (if applicable) must be included with the application for insurance.
- No person other than the owner at the time of application will obtain any right, title, ownership, or interest in any policy issued on the life of the Proposed Insured as a result of this application.
- The Proposed Insured must be legally residing in the United States for a continuous period of 1 year.
- The Proposed Insured must be a citizen of a country (or Canadian Province) approved by the Company.

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 in the third degree.

Signed at: Key Biscayne FL (City & State) Date: 4/16/2024

Carlos Blanco Sanchez _____
Proposed Insured Name (Print) Signature of Proposed Insured

Carlos Blanco Sanchez _____
Owner Name (Print) Signature of Owner (if other than the Proposed Insured)

Carlos Machado _____
Name of Agent/Producer (Print) Signature of Agent/Producer

Address of Agent/Producer _____

Agent/Producer Number W074303
Agent/Producer FL License ID

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PROTECTIVE LIFE INSURANCE COMPANY

A Stock Company; Domiciled in Tennessee
www.protective.com

P. O. Box 2606; Birmingham, Alabama 35202; (800) 866-9933

NOTICE

If you have any questions concerning your policy, need information regarding your coverage, have a complaint that needs to be resolved, or any other request concerning your policy, please call your Protective Life agent or the Protective Life Home Office:

Telephone: 1-800-866-9933

If you prefer, you may direct correspondence to:

**Policyholders Service Department
Protective Life Insurance Company
P. O. Box 12687
Birmingham, AL 35202-2687**

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TERMS USED IN THIS POLICY

The terms below have the specific meaning associated with them each time they are used in this Policy. Other terms may be defined elsewhere in this Policy and will have that meaning when they are used.

Administrative Office: The location at which administrative services for this Policy are performed.

Age: The age of the Insured on the Policy Effective Date as of the nearest birthday, plus the number of complete Policy Years since the Policy Effective Date.

Beneficiary: The primary Beneficiary(ies) is the person(s) or class of persons designated to receive the Proceeds of this Policy upon the death of the Insured. You may designate a contingent Beneficiary(ies) to receive the Proceeds if there is no primary Beneficiary(ies) living at the time of the Insured's death.

There may be one or more than one Beneficiary in a class. If one or more persons in the class die before the Insured, the living members of the class will share the Policy's Death Benefit Proceeds equally unless you instruct us otherwise. By Written Notice, you may change a Beneficiary and may designate an Irrevocable Beneficiary. If you designate an Irrevocable Beneficiary it may limit your ability to change that designation in the future or to make other Policy changes.

Code: The Internal Revenue Code of 1986 as amended, or its successor.

Effective Date: Any Monthly Anniversary on which insurance coverage or other benefit provided by this Policy begins, resumes or changes. The "Policy Effective Date" is the Policy's initial Effective Date. Confirmation of an Effective Date will be sent to you in writing.

Insured: The person shown on the Policy Schedule upon whose life this Policy insures.

Irrevocable Beneficiary: A Beneficiary whose rights in this Policy are irrevocable unless the designated Irrevocable Beneficiary agrees to such change in writing.

Monthly Anniversary: The same day of the month as the Policy Effective Date shown on the Policy Schedule in each subsequent month during which the Policy remains in force.

Owner: The person, persons or entity entitled to all rights in this Policy while the Insured is living. These rights are subject to any assignment and to the rights of any Irrevocable Beneficiary. You may name a contingent Owner who will own this Policy if you die while this Policy is in force. If you die before the Insured, any contingent Owner named in the application, or subsequent endorsement, will become the new Owner. If no contingent Owner is named, your estate becomes the new Owner. You may change the Owner (including a contingent Owner) by Written Notice.

Policy Year: A 12-month period beginning on the Policy Effective Date or any anniversary of the Policy Effective Date.

Proceeds: The net amount payable from this Policy as a result of claiming a benefit. Benefit amounts will be adjusted as provided in this Policy prior to the payment of the Proceeds.

Written Notice: Any information we receive at our Administrative Office which is written, signed and dated by you and is acceptable to us. No change in this Policy is valid unless it is by Written Notice and, unless otherwise specified, will be effective as of the date it is signed. No agent or other person has the authority to change this Policy. Instructions, requests and assignments are subject to any payment we made and any action we took prior to receiving the Written Notice.

GENERAL PROVISIONS

Entire Contract: This Policy is a legal contract between you and us. We entered into this contract in consideration of a complete application and the payment of premiums. The Policy, including its applications, both initial and supplemental, all endorsements, amendments, riders and Policy Schedules, both initial and supplemental, constitute the entire agreement between you and us.

Representations and Contestability: We relied on the statements in the application made by and for the Insured in determining whether to issue this Policy. These statements are representations, not warranties, but we have the right to contest the validity of this Policy or resist any claim based on a material misrepresentation in any application we accept and make part of this Policy. However, we cannot contest the validity of this Policy or resist any claim after the Policy has been in force for two years during the life of the Insured, except for the non-payment of Premium.

If an application to change this Policy requiring evidence of insurability is accepted, a benefit is added or changed, or the Policy is reinstated after it has terminated and the application is made part of the Policy, we cannot bring any legal action to contest the change, addition, or reinstatement after it has been in force for two years during the life of the Insured, except for the non-payment of Premium. The contestability period for a reinstated policy is based only on statements made in the reinstatement application, unless the original contestability period has not yet expired.

Error in Age or Sex: If statements in an application regarding the Insured's age or sex are not correct, we will adjust the Proceeds to those that the premium would have purchased based on the correct age and sex. For purposes of this Policy, any reference to gender also means sex.

Assignments: You may assign some or all of your rights in this Policy (as they exist at the time of the assignment) either irrevocably or for a limited period of time. However, this Policy may not be assigned where prohibited by law or regulation in the state in which it is delivered. We must receive a signed copy of the assignment along with the Written Notice, and the consent of any Irrevocable Beneficiary, if the assignment is to be binding on us. We are not responsible for the validity of the assignment.

Suicide Exclusions: If, while sane or insane, the Insured commits suicide within two years of the Policy being in force, our total liability under the Policy is limited to the Premiums paid from that date to the date of death.

Termination: This Policy will terminate, and all the insurance coverage and any other benefit it provides will end, upon the earliest of any of the following:

- a) by Written Notice;
- b) at the end of the Grace Period for any unpaid premiums;
- c) a full conversion of this Policy to another plan of insurance;
- d) the Policy End Date; or
- e) the Insured dies, and we pay all Proceeds legally due under the Policy.

Minimum Values: The benefits available under this Policy are at least equal to the minimum required by the state in which it is issued. The method of computing the minimum values has been filed with the insurance supervisory authority of that state.

PREMIUMS

Premium Payments: Premiums are the payments you must make to us to keep this Policy in force. They are shown on the Policy Schedule. The premium may change if a benefit is added, terminated or modified after the Policy Effective Date.

Premium payments are due in advance beginning not later than the Policy Effective Date and continuing through the earlier of the Policy End Date or the Insured's date of death. Premium Payments are payable at our Administrative Office. If you request it in writing, we will send a receipt for your premium payment.

Premium Payment Modes: You may select a premium payment mode from those available. The table on the Policy Schedule entitled "Total Premium for All Benefits on the Policy Effective Date" shows the premium required to keep this Policy in force for each of the payment modes available on the Policy Effective Date. Regardless of the payment mode, each premium payment is due on the Monthly Anniversary date.

Generally, you may change the premium payment mode by Written Notice in advance of the premium due date on which you wish to make the change. However, you may not change the payment mode when premiums are being waived on account of any "Waiver of Premium" benefit, or if the requested change would result in a modal payment of less than \$10. The method we use to calculate the premium payable for any mode other than annual is consistent for all Policy Years.

Grace Period: A 31-day Grace Period follows each premium due date. Policy benefits continue through the Grace Period. If we have not received the premium payment by the end of the Grace Period following any premium due date, this Policy will terminate as of the date the unpaid premium first became due. You have the entire Grace Period to make the payment. Payments sent by US mail shall be postmarked within the Grace Period.

Reinstatement: If the Policy terminates at the end of a Grace Period you may request a reinstatement. Reinstatement must be made prior to the Policy's End Date, during the life of the Insured and within 5 years of the last day of the Grace Period. Further requirements depend on when this Policy is reinstated.

Prompt Reinstatement - This is reinstatement within 31 days after the end of the Grace Period. Evidence of insurability is not required. All overdue premiums must be paid.

Later Reinstatement - This is reinstatement more than 31 days after the end of the Grace Period. Evidence of insurability satisfactory to us is required. All overdue premiums must be paid with interest from their due dates to the date of reinstatement. Interest will be computed at an annual effective rate of 6%.

ELECTED FACE AMOUNT DECREASES

While this Policy is in force, you may make a written request to decrease the Face Amount of this Policy.

An Elected Face Amount Decrease will become effective as of the Monthly Anniversary on or following the date we approve the request. No agent or other person has the authority to change this Policy and no change is effective until it is entered into our records.

You may not elect to decrease the Face Amount if:

- a) the request is made prior to the third Policy Anniversary;
- b) the request is made within one year of any earlier face amount decrease;
- c) it results in a face amount lower than the Minimum Initial Face Amount allowed for this Policy as shown on the Policy Schedule;
- d) it results in the Policy failing to qualify as life insurance under the applicable definition of the Code.

CONVERSION

On or before the Standard Latest Conversion Date shown on the Policy Schedule, you may by Written Notice convert this Policy (the "Original Policy") or convert a portion of this Policy's Face Amount (a "Partial Conversion") without evidence of insurability to a new policy (the "Conversion Policy"). You may not convert this Policy if any portion of the Death Benefit has been accelerated under any rider or endorsement attached to this Policy. The conversion is subject to the following terms:

- a) The Conversion Policy must be a plan of permanent insurance, such as, a flexible premium adjustable life insurance, whole life insurance or other similar plan of life insurance available for conversion at the time of your Written Notice. We will always have at least one such policy available. We are not required to have more than one Conversion Policy available.

- b) The Face Amount of the Conversion Policy may not be greater than the face amount of the Original Policy at the time of the conversion and may not be less than the minimum amount available for the new plan of insurance. You cannot request a Partial Conversion that would result in a Face Amount for the Original Policy that is less than the Minimum Initial Face Amount, shown on the Policy Schedule.
- c) The Conversion Policy will not be placed in force until we receive the first premium for that policy. Premiums for the Original Policy must be paid to the effective date of the Conversion Policy. The Original Policy will terminate upon the effective date of the Conversion Policy. If the Conversion Policy is a result of a Partial Conversion, both policies will be in effect and the combined face amount may not be greater than the face amount of the Original Policy at the time of the conversion.
- d) The Conversion Policy will be issued at the Age of the Insured. The Conversion Policy will be issued with a risk classification that, in our judgment, most closely corresponds to the risk classification of the Original Policy. Premiums for the Conversion Policy will be based on the Age and risk classification of the Insured and may differ from the Original Policy at the time of the conversion.
- e) The Contestability and Suicide Exclusion periods of the Conversion Policy will be measured from the Effective Date of the Original Policy or, if applicable, the Effective Date of the latest reinstatement.
- f) The issuance of any available rider attached to the Conversion Policy may be subject to underwriting. Any evidence of insurability required by us will be obtained at the Owner's expense.

DEATH BENEFIT

Death Benefit: When we receive a claim that includes a properly completed claim form and due proof the Insured died while this Policy was in force, we will pay the Death Benefit to the Beneficiary. We pay the Death Benefit Proceeds in a lump sum as soon as administratively possible after we receive a valid claim in good order, unless instructed otherwise in writing.

Calculating the Death Benefit: The Death Benefit is equal to the Face Amount of this Policy, shown on the Policy Schedule, plus any benefits due under an optional rider that was in force when the Insured died.

Adjustments to the Death Benefit Proceeds: If we have accepted premium that paid for insurance coverage beyond the month in which the Insured died, we will add the amount of the excess premium to the Death Benefit Proceeds. If the Insured died after the Policy entered the Grace Period but while insurance coverage is still in force, we will deduct the amount of the unpaid premium from the Death Benefit Proceeds.

Settlement of the Death Benefit Proceeds: Settlement resulting from the death of the Insured terminates all insurance and other benefits provided by this Policy. For the purposes of this provision, a refund of Premiums under the Suicide Exclusion is the settlement resulting from the death of the Insured. We will pay interest on Death Benefit Proceeds from the date we receive written due proof of the death of the Insured until the date the claim is paid at a rate of Interest according to Florida statutory regulations in effect at the time of the Insured's death.

Settlement Options: Depending on the needs of the Beneficiary, a selection of settlement options may be available. Settlement Options are used to distribute Policy Proceeds over a period of time rather than paying them in a lump sum. Proceeds from the Death Benefit may be applied to a settlement option. You may select or change a settlement option from those available while this Policy is in force and prior to the death of the Insured. If you do not select a settlement option, the Beneficiary may select a settlement option from among those available at that time, or may take the amount due immediately in a lump sum.

PROTECTIVE LIFE INSURANCE COMPANY

A Stock Company; Domiciled in Tennessee
www.protective.com

P. O. Box 2606; Birmingham, Alabama 35202; (800) 866-9933

TERMINAL ILLNESS ACCELERATED DEATH BENEFIT ENDORSEMENT

Effective Date: JUNE 23, 2024

Policy Number: B01130915

We have issued this endorsement as part of the policy to which it is attached ("the Policy"). Where the terms of this endorsement and those of the Policy conflict, the terms of this endorsement will apply.

NOTICE: This endorsement is intended to provide an accelerated death benefit which will qualify for favorable tax treatment under Section 101(g)(1)(A) of the Code, except as provided in Section 101(g)(5) of the Code. As with all tax matters, you should consult a personal tax advisor to assess the impact of any benefit received under this endorsement.

Any benefit received under this endorsement may impact the recipient's eligibility for Medicaid or other government benefits.

Any benefit paid under this endorsement will impact the Policy. The impact on the Policy is discussed in the Impact on the Policy section of this endorsement.

This endorsement provides for a single accelerated death benefit payment to the Owner or the Owner's Estate, during the life of the Insured and while this endorsement is in force. The Insured must be diagnosed as being a Terminally Ill Individual by a Physician. All of the terms and conditions of this endorsement must be met.

NOTICE: For inquiries or information about Policy coverage or for assistance in resolving complaints, the Owner may contact the agent who sold the Policy or may call the Company at 1-800-866-9933.

DEFINITIONS

The following terms have the specific meanings associated with them each time they are used in this endorsement. Other terms may be defined elsewhere in this endorsement and they will have that meaning when used.

Claims Office: The location at which the claim services for the policy to which this endorsement is attached are performed.

Code: The Internal Revenue Code of 1986 as amended, or its successor.

Company: Protective Life Insurance Company. Also may be referred to as "we", "us", or "our".

Family Member: Means the Insured's or Owner's spouse and anyone who is related to the Insured, Owner, Insured's spouse, or Owner's spouse by the following degree of blood, marriage, adoption or operation of law: parents, grandparents, brothers, sisters, children, grandchildren, aunts, uncles, nephews, and nieces.

Insured: The person whose life the Policy insures. If Joint Insureds are the persons whose lives the Policy insures, Insured means the last surviving Insured.

Physician: Any physician as defined in Section 1861(r)(1) of the Social Security Act, as amended, or its successor, who is a duly licensed physician practicing within the scope of his or her license. It does not include the Insured, the Owner, a Family Member, or a person who lives with the Insured, Owner, or Family Member.

Policy Debt: Is the sum of all outstanding policy loans plus accrued policy loan interest.

Terminally Ill Individual: Means an individual who has been certified by a Physician as having a non-correctable illness or physical condition which can reasonably be expected to result in death in twelve (12) months or less after the date of certification.

BENEFIT

Accelerated Death Benefit: The Accelerated Death Benefit is the portion of the face amount of the Policy requested by the Owner for acceleration. The amount requested may not exceed the Maximum Accelerated Death benefit calculated as of the Accelerated Death Benefit payment date. It is paid in a single, lump sum dollar amount equal to:

- (a) The amount requested by the Owner for acceleration; minus
- (b) The administrative charge of not more than \$100; minus
- (c) The Policy Debt, if any.

The amount deducted from the Accelerated Death Benefit under (c) above, if any, will be used to repay any Policy Debt on the Accelerated Death Benefit payment date.

Maximum Accelerated Death Benefit: The Maximum Accelerated Death Benefit is equal to:

- (a) The lesser of 60% of the current face amount of the Policy or \$1,000,000; minus
- (b) Any outstanding lien amount against the Policy resulting from any other accelerated death benefit rider or endorsement attached to the Policy.

Eligibility for Benefits: The Accelerated Death Benefit becomes payable, during the life of the Insured, when each of the following conditions have been met:

- (a) The Insured is first diagnosed as being a Terminally Ill Individual by a Physician;
- (b) We receive written consent from any irrevocable beneficiary or assignee of record named in our records for the policy;
- (c) The Policy is not in force under the Grace Period, non-forfeiture option or paid-up endowment option;
- (d) An Accelerated Death Benefit payment has not been made under this endorsement;
- (e) The Insured is certified as a Terminally Ill Individual at least six months prior to the Maturity Date / Policy End Date of the Policy;
- (f) We receive Notice of Claim; and
- (g) We receive Proof of Claim.

In determining eligibility under (a) and (f) above, we reserve the right to independently assess the Insured's Terminal Illness. As part of this assessment, we have the right to require that the Insured be examined by a Physician of our choice. We will pay for this examination. In the event of conflicting opinions, the status of the Insured as a Terminally Ill Individual shall be determined by a third medical opinion provided by a Physician who is acceptable to both the Insured and the Company.

IMPACT ON THE POLICY

Lien: A lien will be established against the Policy in the amount of the Accelerated Death Benefit. Interest will be charged on the lien beginning on the Accelerated Death Benefit payment date. Interest on the lien will be compounded annually and will accrue daily at a rate computed as of the Accelerated Death Benefit payment date. The lien interest rate will not be greater than the greater of (1) the current yield on a 90-day Treasury Bill or (2) the policy loan interest rate stated in the Policy or 8% if a policy loan interest rate is not stated in the Policy. Interest accruing on the portion of the lien which is equal in amount to the Policy Value of the Policy, if applicable, on the Accelerated Death Benefit payment date shall be no more than the policy loan interest rate stated in the Policy.

Interest on the lien will be due on each Policy anniversary date. Interest as it accrues is considered part of the lien. Once the lien is established it will continue against the policy until the earlier of the Policy termination date or the date the lien is repaid. The effect of a lien will be as follows:

- (a) The lien amount will be subtracted from the death benefit or death benefit proceeds, as applicable, of the Policy.
- (b) If applicable under the Policy, access to the cash value for full surrender, partial surrender, withdrawal, partial withdrawal, automatic premium loan or non-forfeiture option will be limited to the cash value of the Policy minus any Policy Debt and minus the lien. The lien will be repaid, if the Policy is continued in force as paid-up life insurance under a non-forfeiture option.
- (c) Access to the cash value for policy loan or policy loan interest will be limited to the cash value of the Policy minus any Policy Debt and minus the lien. If this limit is negative, the Policy may terminate in accordance with the terms of the Policy.

Non-forfeiture Option: While a lien exists, extended term insurance, if applicable under the Policy, is not available as a non-forfeiture option.

Continuing Premium Requirement: Any premium payments due under the Policy will need to be paid by the Owner in accordance with the terms and conditions of the Policy.

Accidental Death Benefit: Any Accidental Death Benefit Rider attached to the Policy will be unaffected by the payment of an Accelerated Death Benefit, provided the Accidental Death Benefit Rider remains in force.

Waiver of Premium or Disability Benefit: If the Insured is a Terminally Ill Individual, the Owner will not qualify automatically for a waiver of premium or disability benefit provided by any Waiver of Premium or Disability Benefit Rider attached to the Policy. Qualification will be based on the terms of the Rider.

Acceleration Statement: Prior to or at the election to accelerate the death benefit, we will provide the Owner and any irrevocable beneficiary a statement demonstrating the effect of the Accelerated Death Benefit on the Policy's death benefit, cash value, if any, Policy Debt and the premiums / cost of insurance as applicable.

CLAIMS

Notice of the Claim: We must receive written notice of claim at our Claims Office. Notice of claim means notice that the Insured is a Terminally Ill Individual and that a claim may be made under this endorsement. The notice should include at least the Insured's name, the Policy number shown on the endorsement, and the address to which claim forms should be sent. Notice given by or for the Owner shall be notice of claim.

Proof of Claim: Proof of claim means written proof satisfactory to us supported by clinical, radiological or laboratory evidence that the Insured is a Terminally Ill Individual. Proof of claim must be given by or for the Owner and it must be received at our Claims Office. We have forms to be used in making a claim. These forms will be sent to the Owner or the Owner's legal representative within 15 days of the date we receive notice of a claim.

Payment of Claim: After all of the terms and conditions of this endorsement are met, the Accelerated Death Benefit will be paid, during the lifetime of the Insured and while this endorsement is in force, as follows:

- (a) If the Owner is the Insured, we will pay the benefit to the Owner; or
- (b) If the Owner is not the Insured, we will pay the benefit to the Owner, if living, otherwise to the Owner's estate.

The Owner may request in writing for the benefit to be paid other than as described in (a) or (b) above no later than the time the Owner files the Proof of Claim. To make a change, we must receive a written request satisfactory to us at our Claims Office. Any change is effective on the date the request was received at our Claims Office. We will not be liable for any payment we have made before such request has been received and acknowledged at our Claims Office. The election of the Accelerated Death Benefit will be cancelled and the death benefits paid as per the Policy provisions if we receive due proof of death of the Insured after the election has been made and prior to the payment of the Accelerated Death Benefit.

GENERAL PROVISIONS

Termination: If the death benefit proceeds of the Policy minus the lien against the Policy is equal to or less than zero, the Policy will terminate. This endorsement will terminate upon termination of the Policy to which it is attached. Termination will not prejudice the payment of an Accelerated Death Benefit that became payable while the endorsement was in force.

Contestability: This endorsement is contestable on the same conditions as the Policy to which it is attached.

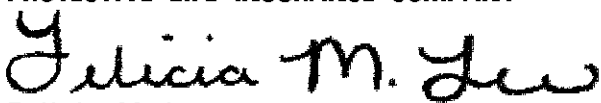
Suicide: The suicide exclusion provision of the Policy applies to this endorsement.

Reinstatement: If the Policy terminates at the end of the grace period of the Policy, reinstatement of the policy shall be subject to:

- (a) The requirement that we receive payment of or reinstatement of a lien which existed at the end of the grace period of the Policy; and
- (b) The reinstatement requirements of the Policy.

Signed for the Company as of the Effective Date of this endorsement.

PROTECTIVE LIFE INSURANCE COMPANY



Felicia M. Lee
Secretary

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TERM LIFE INSURANCE POLICY
RENEWABLE TERM COVERAGE TO AGE 95
POLICY IS CONVERTIBLE

NON-PARTICIPATING - DOES NOT PAY DIVIDENDS

A DEATH BENEFIT IS PAYABLE IF THE INSURED DIES BEFORE THE POLICY END DATE

Protective Life Insurance Company

P. O. Box 2606
Birmingham, AL 35202
Phone: (800) 866-9933
www.myaccount.protective.com

Dear Policyholder:

We thank you for choosing one of our products and are pleased to welcome you to the Protective Life Insurance Company policyholder family.

The following items are enclosed to help you better understand your insurance policy:

Statement of Policy Cost and Benefit Information. This illustrates the guaranteed death benefits and cash values as well as projected death benefits and cash values based on certain assumptions.

Life Insurance Buyer's Guide. This guide was prepared by the National Association of Insurance Commissioners to aid you in determining how much and what kind of coverage you may need. It also allows you to determine how the cost of your policy compares with other similar policies.

Although this information is not a part of your legal contract, please read it over carefully and let our agent or us know if there are any points that you feel have not been explained to your satisfaction.

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STATEMENT OF POLICY COST AND BENEFIT INFORMATION
PROTECTIVE LIFE INSURANCE COMPANY
P O BOX 2606
Birmingham, AL 35202
205-268-1000

OWNER: CARLOS BLANCO SANCHEZ
445 GRAND BAY DR
KEY BISCAWAYNE FL 33149

AGENT: CARLOS E MACHADO
530 MISTY OAKS DRIVE
POMPAÑO BEACH FL 33069

THIS INFORMATION IS PROVIDED TO ASSIST YOU IN BETTER UNDERSTANDING YOUR POLICY. THE BASIC LIFE INSURANCE COVERAGE AND ANY BENEFITS PROVIDED BY RIDER ARE SHOWN BELOW. YOUR POLICY IS THE ENTIRE CONTRACT WHICH FULLY DESCRIBES YOUR BENEFITS. READ YOUR POLICY VERY CAREFULLY.

INSURED: CARLOS BLANCO SANCHEZ

POLICY NUMBER: B01130915 **ISSUE AGE:** 40

DESCRIPTION OF COVERAGE	INITIAL BENEFIT	INITIAL ANNUAL PREMIUM
LIFE INSURANCE	\$30,000,000	\$33,071.60

LIFE INSURANCE COST INFORMATION	YEAR 10	YEAR 20
SURRENDER COST INDEX	1.102	1.102
NET PAYMENT COST INDEX	1.102	1.102

THE INDICES ABOVE ARE BASED ON GUARANTEED RATES OF INTEREST AND MORTALITY AND ARE USEFUL TO COMPARE COSTS. A LOW INDEX NUMBER GENERALLY REPRESENTS A LOWER COST THAN A HIGHER ONE. THE SURRENDER COST INDEX ASSUMES YOU SURRENDER THE POLICY AT THE END OF THE PERIOD SHOWN AND IS USEFUL WHERE THE CASH VALUE IS OF IMPORTANCE. THE NET PAYMENT COST INDEX ASSUMES PAYMENT OF PREMIUMS WITHOUT TAKING CASH VALUE AND IS USEFUL WHERE THE AMOUNT OF DEATH BENEFIT IS OF IMPORTANCE. THE ACTUAL COST MAY INCREASE OR DECREASE DEPENDING UPON FUTURE MORTALITY CHARGES AND THE TIME WHEN SURRENDER OCCURS, BUT IT WILL NEVER EXCEED THOSE COSTS SHOWN AS GUARANTEED FOR THE YEAR INDICATED.

STATEMENT OF POLICY COST AND BENEFIT INFORMATION

INSURED: CARLOS BLANCO SANCHEZ

POLICY NUMBER: B01130915

DESCRIPTION OF BASE POLICY: TERM LIFE INSURANCE POLICY

DATE POLICY SUMMARY PREPARED: MAY 24, 2024

PREMIUMS AND BENEFITS

YEAR	LIFE INSURANCE	
	GUARANTEED ANNUAL PREMIUM	GUARANTEED DEATH BENEFIT
1	\$33,071.60	\$30,000,000
2	33,071.60	30,000,000
3	33,071.60	30,000,000
4	33,071.60	30,000,000
5	33,071.60	30,000,000
6	33,071.60	30,000,000
7	33,071.60	30,000,000
8	33,071.60	30,000,000
9	33,071.60	30,000,000
10	33,071.60	30,000,000
11	33,071.60	30,000,000
12	33,071.60	30,000,000
13	33,071.60	30,000,000
14	33,071.60	30,000,000
15	33,071.60	30,000,000
16	33,071.60	30,000,000
17	33,071.60	30,000,000
18	33,071.60	30,000,000
19	33,071.60	30,000,000
20	33,071.60	30,000,000
21	142,265.00	30,000,000
22	246,965.00	30,000,000
23	351,365.00	30,000,000
24	456,065.00	30,000,000
25	560,765.00	30,000,000
26	665,465.00	30,000,000
27	769,865.00	30,000,000
28	874,565.00	30,000,000
29	965,465.00	30,000,000
30	1,068,065.00	30,000,000
31	1,188,665.00	30,000,000
32	1,331,765.00	30,000,000
33	1,502,765.00	30,000,000
34	1,701,665.00	30,000,000
35	1,928,465.00	30,000,000
36	2,181,365.00	30,000,000
37	2,458,565.00	30,000,000

STATEMENT OF POLICY COST AND BENEFIT INFORMATION

INSURED: CARLOS BLANCO SANCHEZ

POLICY NUMBER: B01130915

DESCRIPTION OF BASE POLICY: TERM LIFE INSURANCE POLICY

DATE POLICY SUMMARY PREPARED: MAY 24, 2024

PREMIUMS AND BENEFITS - continued

YEAR	LIFE INSURANCE	
	GUARANTEED ANNUAL PREMIUM	GUARANTEED DEATH BENEFIT
38	\$2,763,665.00	\$30,000,000
39	3,101,165.00	30,000,000
40	3,486,365.00	30,000,000
41	3,930,965.00	30,000,000
42	4,451,165.00	30,000,000
43	5,033,465.00	30,000,000
44	5,711,165.00	30,000,000
45	6,496,865.00	30,000,000
46	7,410,365.00	30,000,000
47	8,467,865.00	30,000,000
48	9,684,665.00	30,000,000
49	11,060,765.00	30,000,000
50	12,553,865.00	30,000,000
51	14,146,265.00	30,000,000
52	15,781,565.00	30,000,000
53	17,416,865.00	30,000,000
54	19,034,165.00	30,000,000
55	20,552,465.00	30,000,000
AGE 60	142,265.00	30,000,000
AGE 65	665,465.00	30,000,000

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LIFE INSURANCE BUYER'S GUIDE

Prepared by the National Association of Insurance Commissioners

The National Association of Insurance Commissioners is an association of state insurance regulatory officials. This association helps the various insurance departments to coordinate insurance laws for the benefit of consumers.

This guide does not endorse any company or policy

Reprinted by

PROTECTIVE LIFE INSURANCE COMPANY
Birmingham, AL 35202

Before You Buy Life Insurance

Understand What Life Insurance Is

Life insurance pays a death benefit if you die while the policy is in effect, in exchange for premiums you pay before your death. You can use the death benefit to protect against financial hardships such as loss of your income, funeral expenses, medical or nursing care expenses, debt repayments, and child care costs after your death. You can get information from the NAIC InsureU Life Insurance website - www.insureuonline.org/insureu__type__life.htm

If You Need Life Insurance, Decide How Much Coverage to Buy

How much life insurance to buy depends on the financial needs that will continue after your death. Examples include supporting your family, paying for child(ren)'s education, and paying off a mortgage. Some questions you may want to ask about your own needs include:

- Does anyone depend on me financially?
- How much of the family income do I provide?
- How will my family pay my final expenses and repay debts after my death?
- Do I want to leave money to charity or family?
- If I have life insurance through my employer, is it enough to meet my financial obligations?

The answers to these questions can help you decide how much coverage you need. An insurance agent, financial advisor, or insurance company representative can help you evaluate your insurance needs and give you information about available policies.

If You Already Have Life Insurance, Assess Your Current Life Insurance Policy

It's important to compare your current policy with any new policy you might buy. Keep in mind that you may be able to change your current policy to get benefits you want. Also, know that any changes in your health may impact your ability to get a new policy or the premium you'll pay. Don't cancel your current policy until you get the new one.

Also, while you may have free or low-cost life insurance through your employer, the death benefit usually is less than you need. And if you leave the employer, you may not be able to take this coverage with you.

Compare the Different Types of Insurance Policies

There are many types of life insurance policies. You should choose a policy with features that fit your individual needs. Some things to consider are:

- **Term Insurance vs. Cash Value Insurance.** Term insurance is intended to provide lower-cost coverage for a specific period of time ("a term"). If you want coverage for a longer period of time, such as for your lifetime, cash value insurance may be more cost effective. Most term policies don't build up cash values that you can use in the future.
- **Renewable Term vs. Non-renewable Term.** Most term life insurance coverage can be continued ("renewed") at the end of the term, even if your health has changed. If you renew a term policy, the new premiums are higher. Ask what the premiums will be before you renew the policy. Also ask if you'll lose the right to renew the policy at a certain age. A Non-renewable term policy can't be continued. You'll have to apply for a new policy if you still want coverage.

- **Whole Life vs. Universal Life.** Whole life and universal life insurance are two types of cash value insurance. A key difference between the two is how you pay for the coverage. You typically pay premiums for whole life insurance according to a set schedule. In a universal life policy, you can choose a flexible premium payment pattern as long as you pay enough to keep your policy in force.
- **Variable Life vs. Non-variable Life.** The investments you will choose (such as stock and bond funds) in a variable life policy directly impact your cash value. These policies have the greatest potential to build cash value but also the greatest risk of losing cash value. Non-variable life policies often have guaranteed minimums for some features (interest or cash value, for example) but not all. Non-variable life policies also have less potential to build cash value than variable policies.

Be Sure You Can Afford the Premium

Before you buy a life insurance policy, be sure you can pay the premiums. Can you afford the initial premium? If the premium increases later, will you still be able to afford it? The premiums for many life insurance policies are sensitive to changes in the company's investment earnings, claims costs, and other expenses. If those are worse than expected, you may have to pay a much higher premium. Ask what might be the highest premium you'd have to pay to keep your coverage.

Understand the Application Process

You can apply for life insurance through life insurance agents, the mail, and online. In addition to basic information, such as your name, address, employer, job title, and date of birth, you'll be asked for more personal information. Depending on the type of policy, the insurer may require you to see a doctor, answer health-related questions, or have a medical professional come to your home or office to assess your health. Usually a policy that doesn't require detailed health information will cost more and provide less coverage than one that does.

It's important to tell the truth on the application. The insurance company will check your answers so review the application before you sign. If the insurance company discovers false statements on your application after it issues your policy, it could reduce or cancel your coverage.

Choose a Beneficiary

A beneficiary is the person(s) or organization(s) you name to receive your life insurance policy's death benefit. You'll need to know the Social Security or tax identification number for all beneficiaries. Experts advise you not to name a minor child as a beneficiary. Insurance companies won't pay a minor. Instead, consider leaving the money to your estate or trust.

Evaluate the Future of Your Policy

Does your policy have a cash value? In some cash value policies, the values are low in the early years but build later on. In other policies the values build up gradually over the years. Most term policies have no cash value. Ask your insurance agent, financial advisor, or an insurance company representative for an illustration showing future values and benefits.

After You Buy Life Insurance

Read Your Policy Carefully

After you carefully read your policy, you should be able to answer the following important questions:

- Is your personal information correct?
- Do premiums or policy values vary from year to year?
- What part of the premium or policy value isn't guaranteed?
- How will the timing of money paid and received affect any interest the policy might earn?

Your insurance agent, financial advisor, or an insurance company representative can help you understand anything that isn't clear.

If you're not satisfied with your new policy, you can return it for a full refund within a certain period, usually 10 days after you receive it. The review period usually is stated on the first page of the policy.

Review Your Life Insurance Program Every Few Years

Review your policy with your insurance agent, financial advisor, or an insurance company representative every few years to keep up with changes in your policy and your needs.

- Have the premiums or benefits changed since your policy was issued?
- Do the death benefits still meet your needs?
- Do you need more or less coverage after life events, such as birth, adoption, marriage, job change, death, or divorce?

The insurance company can provide policy statements and illustrations to help with this review. As the policy owner, you can change beneficiaries at no cost. Be sure to review your beneficiaries every few years, especially after major life events that affect your life insurance needs.

